

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. itinerary	Visit of Chelsea Clinton to Minsk, Belarus (2 pages)	1/15/94	b(6)
002. report	Director of the Ballet School [partial] (1 page)	1/8/94	b(6)
003. report	Director of the Ballet School [partial] (1 page)	1/8/94	b(6)
004. memo	From: Alicia Smith, To: Neel Latimore, Re: A Friend of HRC in Moscow (1 page)	12/10/93	Personal Misfile
005. memo	From: National Security Council, To: Ambassador Pickering (1 page)	n.d.	P1/b(1)
006. report	US Government Report (7 pages)	12/29/93	P1/b(1)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3977

FOLDER TITLE:

Russia January 1994 Backup Material [1]

2014-0483-S

sb379

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

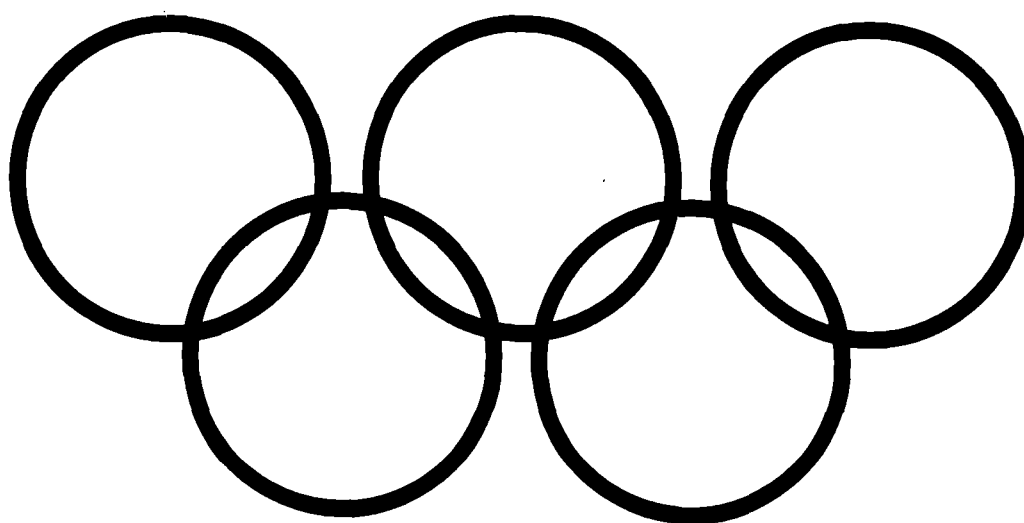
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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Russid
Jan. 1994

Backup
material



LILLEHAMMER

1994

01-05-94 06:10p
Free:275,456,000

Directory C:\WP\DOCS\HILLARY*.*

. Current	<Dir>	.. Parent	<Dir>
BALLETB .	2,057 11-22-93 08:53a	BALLETR .	3,847 11-22-93 08:17a
BOLSHOY .	4,160 11-22-93 08:57a	CHERNOBL.	3,812 11-22-93 08:53a
CUSTOMS .	2,220 11-22-93 08:55a	HEALTHB .	3,489 11-22-93 08:55a
HEALTHR .	6,595 11-22-93 08:57a	HOSPITAL.	6,257 11-22-93 10:12a
IMAGEB .	1,738 11-22-93 08:53a	IMAGER .	2,731 11-22-93 10:11a
LIFEB .	2,838 11-22-93 08:54a	PICKERNG.	11,121 11-22-93 08:55a
STATUSR .	3,571 11-22-93 08:17a	WOMENB .	2,656 11-22-93 08:52a
WOMENR .	3,398 11-22-93 08:56a		

PHOTOCOPY
PRESERVATION

Clinton Presidential Records

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the former location of a 3.5 floppy diskette. The files from this diskette have been processed and are available on compact disc.

The compact disk will be placed in a folder located at the end of this collection in the Electronic Records section.

Collection/FOIA: **2014-0483-S**

Diskette Title: **[no label] [Russia Backup Material] [disk]**

New Folder Title: **[Electronic Media] [Liz Bowyer Disks]**

Clinton Library Transfer Form

Case #, if applicable	2014-0483-S	Accession #		
Collection/Record Group	Clinton Presidential Records	Series/Staff Member	Liz Bowyer	
Subgroup/Office of Origin	First Lady's Office	Subseries		
Folder Title	Russia January 1994 Backup Material [1]	OA/ID Number	3977	Box Number

Description of Item(s) One (1) 3.5" floppy disk containing 15 wordperfect files

Donor Information

Last Name:		First Name:		Middle Name:		Title:	
Affiliation:			Phone (Wk):			Phone (Hm):	
Street:			City:		State (or Country):		Zip:

Transferred to:	Audio/Visual Department
Other (Specify):	

Transfer Point	During Processing
New Location	12-2-3-6 AV regular storage

Transferred by:	Dan Brogden
Received by:	John Keller

Date of Tranfer	3/27/2014
Date of Receipt	3/27/2014

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Moscow

Divider Title: _____

MRS. CLINTON'S UPCOMING VISIT TO SAVIOR'S HOSPITAL
BACKGROUND INFORMATION

- o Savior's Hospital for Peace and Charity
(formerly Hospital # 70)
17 Federativniy Prospekt
Moscow, Russia 111396

Contact: Alexander Goldberg, M.D., President and Chief
Physician of Savior's 304-49-39, 301-15-02
Rachel Mays, Magee Representative
Rebecca Kalisher, Director of Russian Programs,
AIHA 116-36-81, 237-34-06
- o In March 1992, Magee Women's Hospital in Pittsburgh,
Pennsylvania partnered with the second largest hospital in
Moscow, Savior's Hospital. Partnership was possible due to
an A.I.D. grant to Magee as part of the A.I.D./AIHA health
partnership program for the NIS.
- o Partnership focuses on improving health care conditions for
women and children, including
 - the introduction of birth houses,
 - post-partum and new baby care classes at the birth
houses,
 - general women's health seminars (family planning,
self breast exams) at work places throughout Moscow.
- o Woman and Child Center (birth house) opened in July 1993
and provides childbirth preparation, general health and
infant massage classes. Center currently averages 125
Russian women per week. Services eastern portion of Moscow
and two outlying rural regions. The Center is being
developed as a modern regional birthing house facility.
- o The Magee-Savior's partnership has been a recipient of an
estimated \$3 million in excess medical equipment provided
by the Department of Defense.
- o The partnership is supported by the Moscow Main Medical
Administration. A certification program for educators and
labor support personnel trained by the Woman and Child
Center is offered by Dr. Yuriy Bloshanskiy, Chief
Obstetrician/Gynecologist, City of Moscow.
- o Savior's proposes to show Mrs. Clinton this model birthing
house. A walk through would be action-oriented:
observation of the modern birthing suite (where much of the
DOD-donated equipment is located), visit to the children's
ward, visit to the non-profit women's auxiliary which will
be conducting a craft and folk art sale to benefit the
hospital.

SAVIOR'S HOSPITAL FOR PEACE AND CHARITY

Savior's Hospital for Peace and Charity, formerly Municipal Hospital Number 70, is a 1,100 bed facility, specializing in maternity, neonatal and pediatric care, general and specialty surgery and internal medicine. Established 35 years ago, in 1950, the hospital employs 300 physicians and a staff of 1,200. Chief physician of Savior's Hospital for Peace and Charity is Alexander Goldberg, MD, who joined the hospital staff nine years ago as chief of surgery and held that position for three years before becoming chief administrator.

Until 1992 Savior's Hospital for Peace and Charity was known as Municipal Hospital Number 70. The hospital is situated on grounds with a 300 year old Russian Orthodox Church. The church was built by a noble Russian family and used by ordinary people until 1941 when it was taken over by the Russian military which used the church for some time to train police dogs. The church was reopened in 1991. The joint venture between the hospital and the church was blessed by the Patriarch Alexey II and the new name of the hospital reflects both the relationship with the church and the expanded mission of the hospital.

MAGEE WOMANCARE INTERNATIONAL

In March 1992, Magee-Womens Hospital in Pittsburgh, Pennsylvania began an unprecedented program to improve health care conditions for women and infants in the former Soviet Union. Working in partnership with the second largest hospital in Moscow, Savior's Hospital for Peace and Charity (formerly Municipal Hospital #70), Magee-Womens Hospital is proud to be one of the 21 American hospitals participating in the U.S. AID's health partnerships program of the American International Health Alliance.

The Magee-Savior's partnership is also a recipient of an estimated \$3 million dollars in medical equipment distributed to the former Soviet Union through the U.S. State Department's Operation Provide Hope.

As a world leader in women's health, Magee-Womens Hospital is responding to the needs of Russian women:

- to develop a culturally-sensitive model of improved obstetric care which can be easily and economically replicated throughout the former Soviet Union
- to develop a model consumer and community education program for women and their families
- to strengthen health care administration
- to encourage the growth of the Russian voluntary sector as it pertains to women's issues.

Results, 1992 - 1993

- Legal registration of the Russian non-profit "**Woman & Family Foundation**," the first non-government fundraising arm affiliated with a Russian hospital.
- Establishment of the "**Woman and Family Center**": opened July 1993, innovative education programs to Russian women and their families. Currently offering childbirth preparation, general health, and infant massage. **6 childbirth educators trained and registered with the International Childbirth Educators Association (ICEA) Serving eastern region of Moscow and two outlying rural areas: presently averaging 125 Russian women per week.**
- **Printing and distribution of educational materials: Pregnancy Guide & Calendar, Family Planning, Conception, Women's Health brochures & Breast Self-Exam cards.**
- Joint construction planning and funding obtained for renovated birth house with Western standards and a model of improved obstetric care. **Target: 3,000 births and 350 Russian obstetricians trained annually.**
- **100 Russian professionals trained in basic infection control technique.**
- **Over 80 Russian professionals trained in family-centered childbirth model.**
- **9 exchange trips resulting in over 1,000 clinical training hours in obstetrics & gynecology.**
- **Model of new health care administration: management training & planning practice, over 400 training hours.**
- **Dissemination Conference planned January 1994 in collaboration with the Moscow Main Medical Administration: *Partners in Birth, the Role of Labor Support in the Medical Management of Labor.* Expected attendance: 150 Russian obstetricians and midwives.**
- **Co-sponsorship of the Moscow Celebration of Women, May 1994, Speakers, workshops, and exhibits for Russian women. Guest speakers include Ella Pamfelova, Minister of Social Welfare for the Russian Federation.**

Resources

first 21 months of program operation

- AID total funding (U.S. government) \$ 215,000
- Russian government funding (Moscow Main) \$ 500,000 (ruble equivalent)
for birth house construction
- Magee-Womens Hospital - in-kind funding \$ 300,000
- Private sector funding, individual & corporate \$ 40,000 (cash)
- Private sector in-kind funding \$ 600,000

Russian Government Support

- The Magee-Savior's partnership is supported by the Moscow Main Medical Administration. A certification program for educators and labor support personnel trained by the Woman and Child Center is offered through Dr. Yuri Bloshanskii, Chief Obstetrician/Gynecologist, City of Moscow. The Administration has provided the ruble equivalent of \$500,000 in support of birth house reconstruction.
- The Magee-Savior's partnership is personally endorsed by Vice Minister of Health Vaganov, Ministry of Health of the Russian Federation.

U.S. Contacts:

Magee-Women Hospital
100 Halket Street
Pittsburgh, PA 15213
Irma Goertzen, President & CEO 412-641-4010
Tanya Kotys, Coordinator 412-641-1189

Russian Contacts:

Savior's Hospital for Peace and Charity
17 Federativnii Prospekt
Moscow, Russia 111396
Alexander Goldberg, M.D., President 304-49-39
Woman and Family Center 301-15-02
Rachel Mays, Magee Representative
Marina Korotyennina, M.D., Director



MAGEE-WOMENS HOSPITAL

January 6, 1994

Mr. G. Neel Lattimore
The White House
1600 Pennsylvania Avenue
Washington, DC 20500
FAX: (202) 456-7805

Dear Neel:

Thanks for reviewing the plans for the upcoming trip to Moscow with me. I'm delighted that you will be managing the media for the event. As promised, here is some background information on the partnership between Magee-Womens Hospital and Savior's Hospital for Peace and Charity. I have also included a biographical sketch of the President and CEO of Magee, Irma Goertzen.

I understand from our Moscow office that there may be some other activities including a visit to the childbirth classes by members of Mrs. Clinton's entourage.

You asked for the list of people who will be with Mrs. Goertzen. Tanya Kotys, Rachel Mays, Melissa Zahniser, Bernice Bennett, Rebecca Kalisher and I will be with Irma. Please let me know if you need Social Security Numbers or other identification for security clearance.

My last day in the office will be Friday, January 7. I look forward to having the opportunity to speak briefly with you before I leave for Moscow on Sunday to see if the arrangements have changed.

Feel free to call me at (412) 641-1861 or (412) 682-7332.

Sincerely,

Pam Golden
Director of Communications

Attachments

MAGEE WOMANCARE INTERNATIONAL

FOR IMMEDIATE RELEASE

CONTACT: Pam Golden
412-641-4016 (USA)

301-15-02 (MOSCOW --
through January 17)

TWO-YEAR HEALTH CARE PARTNERSHIP NETS BIG GAINS FOR RUSSIAN WOMEN
MOSCOW, January 10, 1994 -- Nearly two years into a historic partnership, the staffs of both Savior's Hospital for Peace and Charity, Moscow, and Magee-Womens Hospital, Pittsburgh, Pennsylvania have learned much about each other's cultures, while developing strong professional relationships. The real payoff, however, has been for Russian women and infants who benefit from educational programs and materials, and from better health care before, during and after childbirth.

Developed in response to the tremendous need for modern medical care in the former Soviet Union, the Magee project, under the auspices of Magee Womancare International, is one of 21 American hospital programs funded by the U. S. Agency for International Development's health partnerships program of the American International Health Alliance.

The partnership was initiated in the spring of 1992 to develop a culturally-sensitive model of improved obstetric care which can be easily and economically replicated throughout Russia; to develop a model consumer and community education program for women and

-over-

their families; to strengthen health care administration; and, to encourage the growth of the Russian voluntary sector as it pertains to women's issues.

"It has been a phenomenal two years," says Magee President and CEO Irma Goertzen. "We're well on our way to accomplishing our four major goals. The Russian women and their families, as well as the many health professionals we are working with have been very eager to learn a new approach to the birth process. We are now looking forward to completion of the birth house remodeling so that we can actually put the model into practice. Along the way, I hope we have also contributed to world peace by promoting better understanding and acceptance of cultural differences."

Some of the achievements of the Magee-Savior's partnership are:

- * Establishment of the Woman and Family Center, which opened in July, 1993, offering innovative education programs to Russian women and their families on such topics as childbirth preparation, nutrition and general women's health. Six Russian childbirth educators have been trained and registered with the International Childbirth Educators Association, and more than 125 Russian women attend classes each week. One class is offered off-site in a factory, and another at a secondary school.

- * Translation, production and distribution of educational materials (offered for free or at a nominal fee), including a pregnancy guide and calendar, and brochures on family planning, conception, breast care and women's health. Some educational videos are also available.

-more-

- * Training of 100 Russian professionals in basic infection control techniques.

- * Training of more than 80 Russian professionals in family-centered childbirth.

- * Joint construction planning and funding obtained for a renovated birth house to accommodate western standards of care.

- * Nine exchange trips resulting in more than 1,000 clinical hours of training in obstetrics and gynecology.

- * 400 hours of training in management and planning.

- * Legal registration of the first non-government, volunteer fundraising organization affiliated with a Russian hospital.

- * Support and cooperation from the Moscow Main Medical Administration.

- * Planning for a spring, 1994 conference for Russian women.

The Magee-Savior's partnership, which is supported by the Moscow Main Medical Administration, has received more than \$700,000 in U. S. and Russian government funding, plus another \$1 million of in-kind support from individuals, corporations and Magee-Womens Hospital.

Magee-Womens Hospital is the obstetric, gynecologic and reproductive sciences specialty hospital of the University Health Center of Pittsburgh, and the teaching hospital for the University of Pittsburgh School of Medicine. More than 650 physicians, nurses and allied health professionals train at Magee each year, while nearly 45,000 consumers attend one of the hospital's education programs.

-over-

More than 9,000 babies are born at Magee annually. The hospital's neonatal intensive care unit, the largest in the state, provides state-of-art care to the most critically ill newborns.

Magee also has centers of excellence in female oncology, urogynecology, infertility evaluation and treatment, and in clinical genetics, and operates one of the largest breast cancer screening programs in the nation.

The Magee-Womens Research Institute, which is the nation's only research facility dedicated to women's health issues, will provide opportunities for research between Magee-Womens Hospital and Savior's Hospital for Peace and Charity.

###

BASIC EXPRESSIONS

English

Phonetic Translation

Hello	Zdravstvuyte
Good morning	Dobroye utro
Good evening	Dobroye vyecher
Goodbye	Da svidaniya
Yes	Da
No	Nyet
Please	Pozhaluysta
Thank you	Spasibo
Excuse me	Prostitye
My name is	Menya zovut
Nice to meet you	Ochen priyatno poznakomitsa
Do you speak English?	Vy govoritye po-angliskiy?
I (don't) speak Russian	Ya (nye) govoryu po-ruskiy
Please speak slower	Govoritye myedlineye pozhaluysta
I (don't) understand	Ya (nye) ponimayu
Please repeat	Povtoritye pozhaluysta
We (I) need a translator	Nam (mnye) nuzhen perevodchik
Please	Pozhaluysta
tell me	skazheet'e mnye
show me	pokazhitye mnye
help me	pomogitye mnye
Entrance (no entrance)	Vkhod (vkhoda nyet)
Exit (no exit)	Vykhod (vykhoda nyet)
Crossing (no crossing)	Perekhod (perekhoda nyet)
Stop	Stoytye
Go	Iditye
Men's restroom	Muzhskoy tualyet
Women's restroom	Zhenskiy tualyet
where, when, who	gdye, kogda, kto
why, what, how	pochemu, shto, kak
How much does it cost?	Skol'ko eto stoyit?
May I try it on?	Mozhno primyerit?
Whom should I pay?	Komu slyeduyit zaplatit?

DAYS OF THE WEEK

Monday	Ponedel'nik
Tuesday	Vtornik
Wednesday	Sreda
Thursday	Chetvyerg
Friday	Pyatnitsa
Saturday	Subbota
Sunday	Voskresenye

NUMBERS AND PHRASES

1	uh- <u>deen</u>
2	dvah
3	tree
4	che-ty-reh
5	pyaht
6	shehst
7	syehm
8	vo-syem
9	<u>dye</u> h-vhut
10	<u>dye</u> h-suht
11	uh- <u>deen</u> -nuh-tsuht
12	dvi- <u>nah</u> -tsuht
13	tree- <u>nuh</u> -tsuht
14	chi- <u>tyr</u> -nuh-tsuht
15	pyaht- <u>nah</u> -tsuht
16	shyst- <u>nah</u> -tsuht
17	sim- <u>nah</u> -tsuht
18	vuh-sim- <u>nah</u> -tsuht
19	di-vuht- <u>nah</u> -tsuht
20	<u>dvah</u> -tsuht
21	<u>dvah</u> -tsuht-uh-deen
22	<u>dvah</u> -tsuht-dvah
23	<u>dvah</u> -tsuht-tree
30	<u>tree</u> -tsuht
40	<u>sow</u> -ruk
50	pyaht-di- <u>syah</u> t
60	shyst-di- <u>syah</u> t
70	<u>syem</u> -di-suht
80	vo-syem-di-suht
90	dye-vuh- <u>no</u> -stuh
100	stoh
200	<u>dvyes</u> -ti
300	<u>trees</u> -tuh
400	chi- <u>ty</u> -ris-tuh
500	pyaht- <u>soht</u>
600	shyst- <u>soht</u>
1000	<u>ty</u> -suh-chuh
5000	pyaht- <u>ty</u> -sahch

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Director of the Ballet School - Lyudmila Korobkina

002
Lyudmila Korobkina was born in [REDACTED] (b)(6) In 1966, she graduated from the Minsk School of Music and in 1979, upon completion of her studies at the Minsk Gorky Pedagogical Institute, became a teacher of music and singing. All of her life, Lyudmila Korobkina gave her knowledge and experience to the cultural activity of the Belarussian Republic.

Lyudmila Korobkina has worked in the cultural sphere for twenty seven years. She worked as a teacher in musical theater in a middle school which emphasized music. She has conducted an abundance of methodological work in the musical upbringing of children. From August 1980, Lyudmila Korobkina, the teacher of musical literature and concert director of the Choreographical School of the Republic of Belarus, educated many future ballet artists.

In 1986, Lyudmila Korobkina, on her own initiative, went to work as director of the school of art at the Red Banner state farm in the Volozhinovski Region. Her name is associated with the organization and establishment of the first state farm school of art in the Belarussian Republic.

On March 28, 1989, Lyudmila Korobkina, with a directive from the Ministry of Culture of the Republic, displayed her special talents as a director at the State Academy of Ballet. Valentina Elizar'eva, the chief ballet director of the State Academy of Ballet, recommended Lyudmila Korobkina for the position.

Students at Lyudmila Korobkina's School were involved in a variety of competitions throughout the Soviet Union and abroad.

Because of the business prowess of Lyudmila Korobkina, a new building for the school was constructed in 1992.

Lyudmila Korobkina emerged as the chief organizer of the first international festival of choreographic art, named "I Love Ballet", which took place in Minsk in 1991. Various choreographic schools of the Republics of the Commonwealth of Independent States participated in this festival. Choreographic schools from countries around the world also participated in the festival. This festival contributed to the widening and strengthening of cultural contacts between choreographic schools in different countries. The festival also included a gala concert of the stars of the ballet.

SAVED AS \BALLET2

The Choreographical School of the Republic of Belarus

The school was first established in 1939 as a department in the theatrical school and its first class of professional artists graduated in 1941. In 1945, the Choreography School began its own work. The first director of the school was a National Artist of the Republic, Z. A. Vasilieva, and in subsequent years other directors included A. V. Nikolaeva, A. I. Kolyadenka, I. N. Saveleva, and K. N. Malisheva (all National Artists of the Republic). Today, a National Artist of the USSR, Valentin Yelizarev, the director of the Ballet of the Republic of Belarus, is the primary consultant in the professional and creative decisions of the school. The leading soloists and ballet artists at the Theater of Ballet of the Republic of Belarus are all graduates of the school.

Instructors at the School include numerous distinguished and prominent artists from around the country, in addition to teachers from Switzerland. Graduates of the school work and perform in theaters in Minsk, Moscow, St. Petersburg, and other cities. Many of these graduates have also received distinguished medals and awards.

Today, about 280 students from cities around the CIS, Australia, Poland, and Japan attend the school. On January 5, 1994, the students performed the premiere of the ballet "Cinderella" to the music of Strausse, with choreography and libretto by Bernard (Switzerland). The students of the school are active in the majority of the ballet shows performed by the Theater of Opera and Ballet of the Republic of Belarus. In addition, many successful graduates have performed as touring artists in Poland, Turkey, Germany, Japan, the Philippines, and Canada.

The first professional ballet in Russia was performed in 1742 during the coronation of Elizabeth, daughter of Peter the Great. Russian ballet became famed for vivid, realistic impressionism and dramatism. While the popularity of ballet faded in Western Europe in the 1880s, Russian ballet, led by the St. Petersburg Maryinskiy and the Moscow Bolshoy companies, achieved new heights. Russian dancers and choreographers transformed ballet, then a mere imperial court spectacle, by fusing dance with highly emotional drama. Unable to gain wide acceptance at home, Russian ballet masters took their ballet to Western Europe where they won great praise in Paris in 1909 and in London in 1911.

In 1917 Lenin himself saved the ballet, perceived to be a tsarist trapping by many Bolesheviks, insisting that it be protected and dedicated to the proletariat. Some of the most talented Bolshevik artists fled to the West, most notably Mikhail Fokin. Moving the capital from Petrograd to Moscow established the predominance of the Moscow style of the Bolshoy over the classical style of the Kirov (formerly Maryinskiy).

The 1920s was a period of experiment in Soviet ballet. Feodor Lopukhov revived many of the 19th century classics such as Sleeping Beauty and encouraged the vivid expression of emotions. Technical innovations by Lopukhov included the new Soviet style of pairing, with the ballerinas carried high above the heads of male dancers.

Under Stalin free artistic expression in the ballet suffered greatly. Abstract, mythical, and fanciful ballets fell into disfavor. Socialist Realism emphasized characterization, storytelling, and human expression. In the 1930s, literary ballet based on the works of Pushkin, Balzac, Gogol, and Shakespeare became popular. Romeo and Juliet is the finest example of this genre.

"Glasnost" ushered in a new generation of Russian ballet, particularly in contemporary and abstract thematic composition. Modern dance and jazz now enjoy wider acceptance. The Kirov ballet has revived formerly banned works by Balanchine, Apollo and Tchaikovsky Pas de Deux, and staged Anthony Tudor's Leaves are Falling. However, Russian ballet remains classical and disciplined, while fiery and spontaneous.

Star dancers have gone to the West to take advantage of higher salaries and better living standards. Subsidies to support the ballet have also been reduced. Yuriy Grigorovich, artistic director of the Bolshoy Ballet, is attempting to establish a contract system to allow the Bolshoy to retain and retire dancers and to improve incentives to remain in Russia. Grigorovich has established a Bolshoy company specifically designed to earn hard currency overseas. Not required to satisfy the ballet establishment in Moscow, the Grigorovich company provides an opportunity for a fresh, creative start. Fierce competition among Russian ballets for the overseas market is expected. Nevertheless, it is likely that renowned companies such as the Bolshoy and the Kirov will survive.

Drafted by: EUR/ISCA: BRNaranjo
01/03/94 x7-8696 SESOVUK 1755
Spell checked by: BRN

cc:
Cleared: EUR/ISCA: JSchumaker
EUR/ISCA/WST: JPurnell
EUR/ISCA/RUS: SCoffey

Bolshoy Theater

The Bolshoy has played a long and honored role in the history of Russian theater. Originally constructed in 1776 as the Petrovskiy Theater, its core repertoire consisted of ballets and operas by Russian composers.

In 1805 the theater was destroyed in a fire and did not reopen until 1825. The Triumph of the Muses, staged on opening night, concentrated on enriching the national style based on traditional song and melodies, and championing folk traditions. The Bolshoy soon became the center for the development of a unique Russian style in the performing arts. In 1842, however, the Bolshoy lost its artistic independence when it was placed under the imperial direction of St. Petersburg where classical treatment of the performing arts prevailed.

In March 1853, fire destroyed the Bolshoy once again, leaving only a shell. In 1856, the Bolshoy, rebuilt by Albert Cavo, reopened. A new statue of Phoebus in the Sun Chariot was placed on the ionic portico, and this remains the Bolshoy's most distinctive architectural feature. The repertoire of the Bolshoy, however, became distinctly less Russian as it was leased to an Italian company.

By the turn of the century, the Russian style had regained favor, beginning with Tchaikovsky's Eugene Onegin. Boris Godunov (Mussorgsky), The Snow Maiden (Rimsky-Korsakov), and Prince Igor (Borodin) established the national characteristics of Russian opera, including realistic imagery, mass folk scenes, and profound psychological symbolism.

For the past century, the Bolshoy Theater has been recognized as one of the world's most important centers of drama and music. The October Revolution transformed the Bolshoy into an instrument of culture intended for the masses, imposing constraints once again on the Bolshoy's artistic freedom. In 1927, The Red Poppy, the first opera based on Communist ideology, opened. Since the mid-1950s, the Bolshoy opera and ballet companies have traveled the world extensively.

In 1991, the Bolshoy Opera made its second-ever American tour, visiting New York and Washington and performing Tchaikovsky's Eugene Onegin and Maid of Orleans, and Rimsky-Korsakov's Plaza. The revival of these three grandly scaled 19th century operas reflects a desire to stay true to classical roots. Prokofiev operas, which had fallen into official disfavor, have been restored.

The Bolshoy has now entered a new era of greater freedom and less money. While the censor has been removed, so have the subsidies. Amidst stiff competition from other theaters, the Bolshoy is producing more foreign tours, both ballet and opera, to win hard currency. The Bolshoy also plans to stage more new productions each year, and is seeking to attract western co-producers and sponsors. In 1995, the Bolshoy theater will close for two years for renovations. Without a home, the competitiveness of the Bolshoy theater may be jeopardized.

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003. report	Director of the Ballet School [partial] (1 page)	1/8/94	b(6)

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Russia January 1994 Backup Material [1]

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Freedom of Information Act - [5 U.S.C. 552(b)]

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Director of the Ballet School - Lyudmila Korobkina

003

Lyudmila Korobkina was born in [REDACTED] (b)(6) In 1966, she graduated from the Minsk School of Music and in 1979, upon completion of her studies at the Minsk Gorky Pedagogical Institute, became a teacher of music and singing. All of her life, Lyudmila Korobkina gave her knowledge and experience to the cultural activity of the Belarussian Republic.

Lyudmila Korobkina has worked in the cultural sphere for twenty seven years. She worked as a teacher in musical theater in a middle school which emphasized music. She has conducted an abundance of methodological work in the musical upbringing of children. From August 1980, Lyudmila Korobkina, the teacher of musical literature and concert director of the Choreographical School of the Republic of Belarus, educated many future ballet artists.

In 1986, Lyudmila Korobkina, on her own initiative, went to work as director of the school of art at the Red Banner state farm in the Volozhinovski Region. Her name is associated with the organization and establishment of the first state farm school of art in the Belarussian Republic.

On March 28, 1989, Lyudmila Korobkina, with a directive from the Ministry of Culture of the Republic, displayed her special talents as a director at the State Academy of Ballet. Valentina Elizar'eva, the chief ballet director of the State Academy of Ballet, recommended Lyudmila Korobkina for the position.

Students at Lyudmila Korobkina's School were involved in a variety of competitions throughout the Soviet Union and abroad.

Because of the business prowess of Lyudmila Korobkina, a new building for the school was constructed in 1992.

Lyudmila Korobkina emerged as the chief organizer of the first international festival of choreographic art, named "I Love Ballet", which took place in Minsk in 1991. Various choreographic schools of the Republics of the Commonwealth of Independent States participated in this festival. Choreographic schools from countries around the world also participated in the festival. This festival contributed to the widening and strengthening of cultural contacts between choreographic schools in different countries. The festival also included a gala concert of the stars of the ballet.

CARMINA BURANA

Carmina Burana was composed by Karl Orf, a German composer born in 1895. It is a combined opera and ballet in one act.

The performance is divided into three parts and a prologue. In the prologue, a portrayal of Fortune, several circles of dancers representing Fate slowly come to life on the stage. Once all the dancers are fully animated, the main character, called the Poet, in an attempt to escape the circles of Fate breaks loose from the circle and other dancers follow him. However, the circles of fate are too strong and the Poet and his friends are absorbed back into them. Another character, called the Abbot, also attempts to break out of the circle and stands in its center. However, Fate does not make an exception for him either and he too is pulled back into the circle.

Part 1 of the show opens with a solo by a ballerina portraying the Poet's inspiration and hope. Six pairs of dancers join the poet and the girl and their dance represents the lyricism and purity of spring. The first ballerina then disappears and a her nemesis appears on the stage. This second ballerina appears similar to the first, except that her movements express passion and promise and she represents temptation.

In part two of the performance, this dancer representing temptation plays the main role. She tempts the Poet and seduces the Abbot. The Poet is on the verge of taking the path the Abbot points out to him when an orgy organized by the temptress opens his eyes and he realizes the hypocrisy of churchmen.

Part III of the performance is called "Triumph of Love." To the music of a choir singing songs of love, a group of girls escorts the Poet's love back on stage, and the Poet begs her forgiveness. Once again, the circle of dancers representing Fortune appears on the stage for a final round dance.

BELARUSIAN BALLET

Although private touring ballet companies have performed in Belarus for over a century, the first permanent Belarusian ballet troupe was formed in Minsk in 1933. Directed by masters from Leningrad (St. Petersburg) and Moscow, the Belarusian ballet company and school has acquired a solid reputation in the former Soviet Union and abroad as a first class ballet institution. The Minsk Ballet Troupe performs most of the traditional Russian ballets but has also branched into more avant garde pieces. The Belarusian Children's Ballet School has also established a reputation for quality.

The State Opera and Ballet Theater was constructed in 1933 in the so-called "Stalinist modernist" style. The building survived wartime devastation under Nazi occupation and was rapidly restored to hold its first post-liberation production in 1944.

NAINA IOSIFOVNA YELTSINA

Mrs. Yeltsina was born in 1932 in the Orenburg region of the southern Urals where her father worked as an office employee. In 1950 she entered the Urals Polytechnical Institute. After graduation, she worked as a construction engineer.

She met Boris Yeltsin while they were in college together. A year later, after their graduation, they were married.

Mrs. Yeltsina has two daughters and three grandchildren.

In addition to her love of classical Russian literature, she has a special preference for art exhibitions and the theater, and she enjoys nature.

B - BIOS - RUSSIANS

12/7/93

TO: Kim T.
FROM: John Beyrle *JB*
SUBJ: Weather and Dress in Moscow

Kim -- I had this ready for you Monday 12/6 as agreed but was out of the office unexpectedly. As far as dressing do's and don'ts go, Mrs. Clinton should simply be aware that Russian women in general tend to dress conservatively because a) there's not much of a selection of new or fashionable clothing available and b) what is available is out of the price range of the average woman. The category of "nouveau riche" Russians is growing under the current circumstances of economic reform, but these people (and the flashy, expensive clothes they wear) are resented by a large segment of the population. With this in mind, Mrs. Clinton would probably do well to chose a more conservative wardrobe than if she were going only to Paris or Rome. There are no colors that are off-limits. Furs are obviously OK from the Russian perspective, as we discussed -- domestic considerations are yours to sort out on that score.

Give me a call or stop by if you have more questions. We need to get together soon to discuss exactly which papers we will want to task for preparation for her briefing book. Thanks --jrb

Strobe Talbott's

647-3113

*Victoria Newlands his asst - FSO
will brief HRC in Jan.*

MOSCOW JANUARY CLIMATOLOGY

WASHINGTON, DC - January is the coldest month of the year with average temperatures ranging from the upper 20's near daybreak to the lower 40's by mid afternoon. The minimum temperature falls to the freezing point on 75% of the days. Precipitation generally falls as rain, but also as snow on colder days. The average snowfall for January stands at about six inches. Blustery northwest winds are common and can significantly enhance winter's chill.

MOSCOW, RUSSIA - Very cold temperatures and damp, breezy conditions prevail throughout much of western Russia in January under generally cloudy skies and frequent snow flurry activity. Afternoon highs average 20 F, while overnight lows drop to near 5 F. Sub-zero temperatures can be expected on about 10 days during the month. The ground is covered with snow virtually every day of the month.

CLIMATE STATISTICS

LOCATION	TEMPERATURES (F)				AVERAGE # DAYS PER MONTH			RH (%)
	HIGHEST ON RECORD	MEAN DAILY HIGH	MEAN DAILY LOW	LOWEST ON RECORD	RAIN	SNOW	TSTMS	
Washington	79	43	28	-14	7	3	<1	62
Moscow	39	20	6	-44	<1	15	0	85

*Minsk is
essentially
identical
to Moscow,
in terms of
winter
weather.*



MAGEE-WOMENS HOSPITAL

December 28, 1993

Ms. Karen Finney
Deputy Press Secretary
The White House
1600 Pennsylvania Avenue
Washington, DC 20500
FAX: (202) 456-6244/(202) 456-7805

Dear Ms. Finney:

By way of introduction I am Director of Communications for Magee-Womens Hospital in Pittsburgh, Pennsylvania. We have a joint partnership with Savior's Hospital for Peace and Charity in Moscow and are delighted that Mrs. Clinton will visit the hospital in January.

Obviously, our highest priority is to organize everything for the visit in the appropriate manner. I wondered about some of the details regarding the members of the press who will accompany Mrs. Clinton. (Specifically: Are they permitted in the hospital? Do they follow her to the various sites or should there be areas roped off for them within the rooms? Knowing how things are in Russia, shall I attempt to make arrangements for additional power for lights, malt boxes, etc. for the electronic media?)

I would like to prepare press packets about the American-Russian hospital partnership for distribution during or prior to the visit.

Please let me know about clearance as I will hire a photographer to assist me.

I can be reached by phone at (412) 641-1118 or at home (412) 682-7332 or by FAX at (412) 641-1202.

Many thanks for your assistance.

*President of M-W will be in
moscow during that time*

Sincerely,
Pam Golden
Pam Golden
Director of Communications

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004. memo	From: Alicia Smith, To: Neel Latimore, Re: A Friend of HRC in Moscow (1 page)	12/10/93	Personal Misfile

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NOTES TO STAFF

WEATHER: Moscow has been unseasonably warm recently (high 30's), but it may change at any moment to more seasonable temperatures (-10 to 20 degrees F). Although it is cold outside, all Russian buildings are overheated. We recommend you wear warm outerwear (hat, gloves, scarf and warm coat) and mid weight clothes for indoors. The Russian custom is to check your coat at the door of all buildings, so don't worry about lugging your stuff around. It can snow at any moment, so be prepared.

FOOTWEAR: Wear boots that will keep your feet warm and dry, but which can be slipped off easily and replaced with dress shoes inside the buildings. Make sure your boots have treads, as the sidewalks are ALWAYS slippery.

FOOD: DO NOT DRINK ANY WATER EXCEPT BOTTLED WATER. Do not have ice cubes in your drinks. The cold water at the hotel has been purified, so you can use it to brush your teeth and wash, but I wouldn't recommend that you do much else with it. The hot water is the color of Jack Daniels Bourbon. We will try to provide good food in the holding rooms. There is an Embassy control room on the 7th Floor of the Hotel where you can purchase snacks, etc..

BAGGAGE: Bring a day bag with you to Spaso House so you can shower and change. We'll get the day bags brought to the Kremlin or your hotel, where it will meet the rest of your luggage. PLEASE TAG YOUR LUGGAGE KREMLIN or HOTEL, depending upon where you will be staying. The Saturday baggage call will be real early (about 5:00 AM), and we'll advise you as soon as it has been locked in.

PASSPORTS/CUSTOMS: An embassy representative will meet the plane and take all of your passports for processing. They will be returned to you at the place you will be spending the night (hotel or Kremlin). Please have someone collect all passports and visas (including HRC's) and be ready to hand them to me when I meet the plane.

JET LAG: There is an eight hour time difference from D.C., so you should try to sleep as much as possible on the plane.

ELECTRICITY: Moscow has 240 current, which will fry your blow drier unless you have a switch for that current and an adapter. Mary Streett has already lost several appliances.

SEE YOU IN MOCKBA!

Pat Halley
Mary Streett
Kim Putens

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005. memo	From: National Security Council, To: Ambassador Pickering (1 page)	n.d.	P1/b(1)

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006. report	US Government Report (7 pages)	12/29/93	P1/b(1)

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FOR: WILLIAM ITOH, NATIONAL SECURITY COUNCIL; AND BRADY WILLIAMSON, MOSCOW LEAD ADVANCE, WHITE HOUSE; AND STROBE TALBOTT, S/NIS, STATE DEPARTMENT.

FROM: PICKERING

SUBJECT: PROGRAM FOR MRS. CLINTON IN MOSCOW [DATE SENT: 29 NOV.]

1. EMBASSY HAS CONTACTED MRS. YELTSIN REGARDING SUGGESTIONS FOR MRS. CLINTON'S MOSCOW PROGRAM ON JANUARY 14. MRS. YELTSIN WOULD LIKE TO TAKE MRS. CLINTON TO A MOSCOW HOSPITAL SO SHE CAN SEE FIRST HAND SOME OF THE "PARTNERSHIP" WORK THAT IS CURRENTLY UNDERWAY HERE. WHILE MRS. CLINTON IS AT THE HOSPITAL, THE RECTOR OF THE MOSCOW ACADEMY OF BALLET WOULD LIKE TO HOST CHELSEA CLINTON. CHELSEA COULD WATCH THE CHILDREN REHEARSE, PARTICIPATE IF SHE WISHES, AND TALK WITH THE STUDENTS AFTERWARD. THE RECTOR OF THE ACADEMY, WHO HAS MET THE CLINTONS, WOULD LIKE TO TAILOR CHELSEA'S VISIT TO THE ACADEMY TO CHELSEA'S WISHES.

2. FOLLOWING THE VISIT TO THE HOSPITAL, MRS. PICKERING WOULD LIKE TO ORGANIZE A SMALL LUNCHEON AT SPASO HOUSE. GUESTS COULD INCLUDE PEOPLE FROM THE ARTS AND EDUCATION AS WELL AS LEGAL EXPERTS AND OTHERS. WE SUGGEST ALLOWING ABOUT 30 MINUTES ON THE SCHEDULE PRIOR TO THE ARRIVAL OF THE OTHER GUESTS FOR MRS. CLINTON TO HAVE TIME WITH MRS. YELTSIN TO DISCUSS HEALTH CARE IN A MORE PRIVATE SETTING. WE CAN PROVIDE BRIEFING PAPERS ON MRS. YELTSIN'S PROJECTS AS WELL AS ON OTHER HEALTH CARE PROJECTS CURRENTLY BEING CARRIED OUT IN THE MOSCOW AREA. WE WOULD PLAN TO INCLUDE CHELSEA IN THE LUNCHEON UNLESS SHE HAS OTHER PREFERENCES. IF SHE HAS OTHER PLANS OR PREFERENCES, PLEASE ADVISE.

IN THE AFTERNOON MRS. YELTSIN WOULD LIKE TO SHOW MRS. CLINTON AND CHELSEA THE KREMLIN COMPLEX.

4. FOR PLANNING PURPOSES, WILL MRS. CLINTON BE ACCOMPANIED BY AN INTERPRETER? MRS. YELTSIN MADE IT CLEAR THAT SHE WOULD LIKE TO SEE HELEN SEMLER BE CHOSEN. WE UNDERSTAND THAT STATE DEPARTMENT LANGUAGE SERVICES HAS CONTRACTED WITH HELEN IN THE PAST AND THAT SHE, IN FACT, WORKED THE VANCOUVER SUMMIT. THE SEMLERS' ADDRESS IS: 9208 COLUMBIA BLVD., SILVER SPRINGS, MD 20910 AND HELEN'S PHONE NUMBER IS 301-587-5526 (HOME), 703-892-5619 (WORK), 718-279-3012 (FAX)

5. PLEASE ADVISE WHETHER THE PROGRAM AS OUTLINED ABOVE IS ACCEPTABLE. WE WOULD LIKE TO BEGIN TO COORDINATE WITH THE OFFICE OF PROTOCOL OF THE RUSSIAN FEDERATION AS SOON AS POSSIBLE. MRS. YELTSIN WILL BE OUT OF TOWN NEXT WEEK.

6. WE ASSUME THAT MRS. CLINTON AND CHELSEA WILL BE ARRIVING ON A SPECIAL PLANE. PLEASE CONFIRM. WOULD THEY LIKE TO PROCEED TO RON LOCATION BEFORE BEGINNING MORNING PROGRAM? CAN WHITE HOUSE PROVIDE EXACT ARRIVAL DETAILS?

7. WE LOOK FORWARD TO VISIT AND HOPE TO DESIGN A PROGRAM THAT WILL REFLECT BOTH MRS. CLINTON'S AND CHELSEA'S WISHES.
END TEXT

KT-

as promised.

JB

p.s. "2010" is
non-fiction, so
I owe you
another title.

Gift being
presented
to HEC!

BIOGRAPHY OF PATRIARCH TIKHON

Tikhon (full name: Vasili Ivanovich Belavin) was born in the Pskov region of Russia in 1865. In 1898 he was sent to Lublin, Poland as bishop and later that year transferred to the Aleutian Islands. The following year he was sent to New York, where he remained as Bishop of the Russian Orthodox Church until 1907.

Among his accomplishments while in the U.S. were the founding of a seminary in Minneapolis, and of the Tikhonovsky Monastery in Scranton, Pennsylvania. In addition, Tikhon was active in producing English language translations of liturgical literature. In 1907, he opened the first Russian Orthodox church in North America, at Mainfield, Alaska.

In 1907, Tikhon returned to Russia, where he was made Patriarch of Moscow and all of Russia in 1917. He died in 1925. He was canonized and made a saint of the Russian Orthodox Church in 1989.

Patriarch Tikhon was the first Patriarch of the Russian Orthodox Church since 1700, when Peter the Great dissolved the Patriarchy.

ART AND ARCHITECTURE

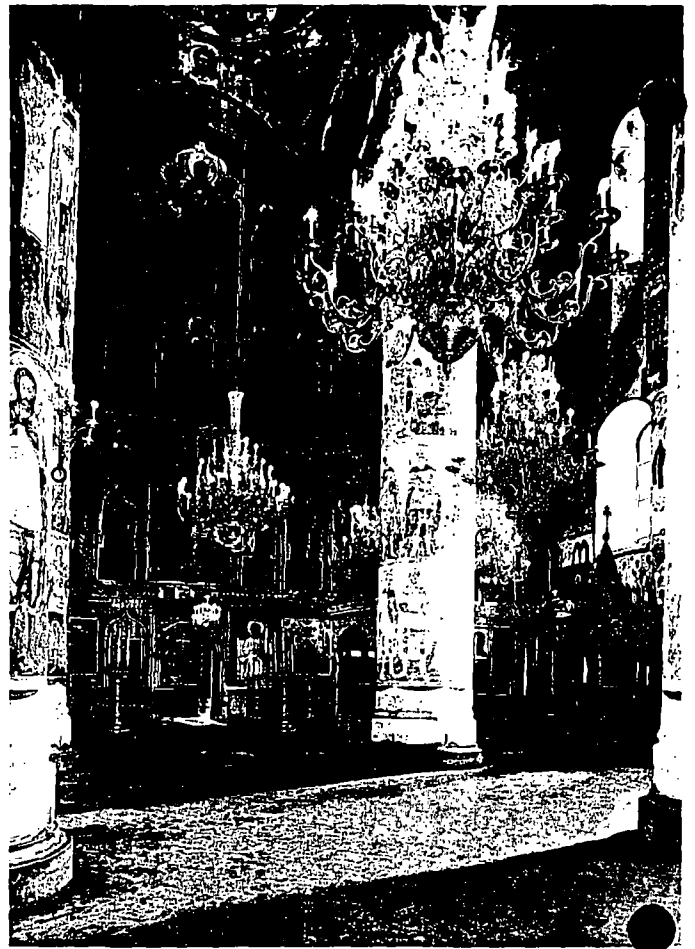
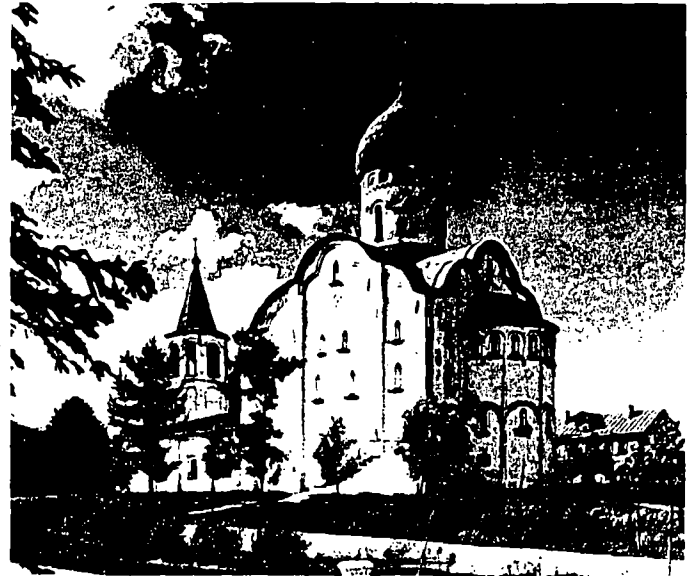
Architecture: Medieval Times to the Present

Churches and monasteries

The natural and most ubiquitous building material in Russia was wood, but owing to its inflammable nature only isolated examples survive from before the 17th century. Masonry came into use with the introduction of Christianity. The earliest and one of the finest monuments is the Church of Holy Wisdom (Sophia) in Kiev, begun in 1037—a five-aisled vaulted structure, surmounted by 13 domes and adorned with magnificent mosaics at the east end. The exterior was remodelled in the 18th century.

From the mid-12th-century the principal centre of building activity was the Vladimir area, where a good quality of white limestone was available. The traditional form for a church was usually a cube surmounted by a dome (symbolizing the earth with heaven above) with one or more apses at the east end. In larger churches massive rectangular piers supported the vaults and galleries. Externally blind arcading often girdled the building. Although officially the Orthodox Church* did not encourage the use of sculpture, some churches in this area were adorned with low-relief carving representing figures, birds, animals and stylized plants. The principal monuments in date order are the church at Pereyaslavl' Zalesky (1152), the Cathedral of the Assumption (1158, enlarged after 1183) and the princes' church of St Dmitry (1195) in Vladimir; a fragment of the palace at Bogolyubovo and the nearby small Church of Pokrov (Protection of the Virgin's Veil) on the Nerl' (1165) and the latest in date, St George at Yur'ev Pol'sky (1234). This and St Dmitry are both richly adorned with sculpture, though probably not in its original order. The cathedral at Suzdal', begun in the 13th century and largely rebuilt during the 15th to 17th centuries, has retained its 13th-century doors with biblical scenes designed in gold on copper. On account of its many monasteries, bishop's palace and a quantity of small churches, Suzdal' has been declared a museum city.

In the 14th century building flourished mainly in the prosperous, independent city states of Novgorod and Pskov. The cathedral of Novgorod, a smaller version of that in Kiev and built only a few years later, was less lavishly adorned with frescoes instead of mosaics, and was badly damaged in 1941. One of its treasures is the pair of bronze doors from Magdeburg, reassembled by the Russian smith Abram in 1187. Two large monasteries and a number of small churches have survived, their walls usually divided into three sections by flat pilaster-like bands, sometimes ending in arches above, known as *zakomary*, and separate curved roofs. Many of these were later covered with flat roofs and are now being restored. In Pskov the



Top: the 14th-century church of St. Theodore Stratilates, Novgorod. Right: interior of Fioravanti's Assumption (*Uspenskiy sobor*) Cathedral, Moscow Kremlin

original cathedral was rebuilt in the late 17th century. Two monasteries, the Monastery of the Saviour on the Mirozha river and the Monastery of St John survive, and a number of small churches, some with belfries over the porch. A few 17th-century houses built of masonry for rich merchants still stand, but originally they had wooden living-quarters above.

By the mid-15th-century Moscow* was in a position to erect its most splendid and still surviving buildings. The Kremlin, or citadel, had been a wooden fort originally. Stone walls were built in the late 14th century and were now replaced by the present brick walls and towers, which continued to be embellished in later centuries. But Russian architects had lost their former skill and the Cathedral of the Assumption they began collapsed. Ivan III* then invited a number of Italian architects to Moscow. The first to come, Rodolfo Fioravanti, was sent to Vladimir to learn the requirements of Russian ritual and the cathedral he built so astonished the Russians that he was named Aristotle. Its size, spaciousness, acoustics and beauty were due to deeper foundations, slender round piers and iron tie-beams to support the thin vaults. The interior was later covered with murals and served as the coronation church for all subsequent monarchs. The square in front was planned as the ceremonial centre of the city and remains its most impressive sight.

Builders from Pskov, who were famous for their skill, erected the Church of the Annunciation, adjoining the palace, in 1484–9. It is smaller, but sumptuously adorned with finely carved doorways, a floor of jasper and nine gilded domes. In 1505 Alevisio Novo designed the Church of St Michael the Archangel as a burial-place for the princely families. This has many Renaissance features of ornament, although basically Russian in plan. The Faceted Hall, outwardly Italian, also follows the Russian plan of a single massive central pier supporting the vaults. The tall Belfry opposite completes the varied yet harmonious design.

The fortified monasteries on the south-east of Moscow and the Trinity Monastery at Zagorsk contain a remarkable range of buildings dating from the 15th to the 18th centuries. At Kolomenskoe the high steeple or tent shape was first used (1532) to replace the cupola and became widespread till forbidden by Patriarch Nikon.* It is the central feature of the Church of St Basil in Moscow (1555–60), a conglomeration of nine separate churches, all differently treated and covered with exuberant ornament, though the colour was added only in the 17th century. It was then, too, that the metropolitan of Rostov, Iona, built himself a residence to rival the Kremlin and a remarkable number of fine churches were built in Yaroslavl', where rich merchants vied with each other in the lavishness of their designs. Often adorned with coloured tiles on the outside and fine murals within, they are a very Russian expression of the Baroque spirit before the fashion for neo-classical severity and uniformity led to the replanning of many cities and conformity in church and house

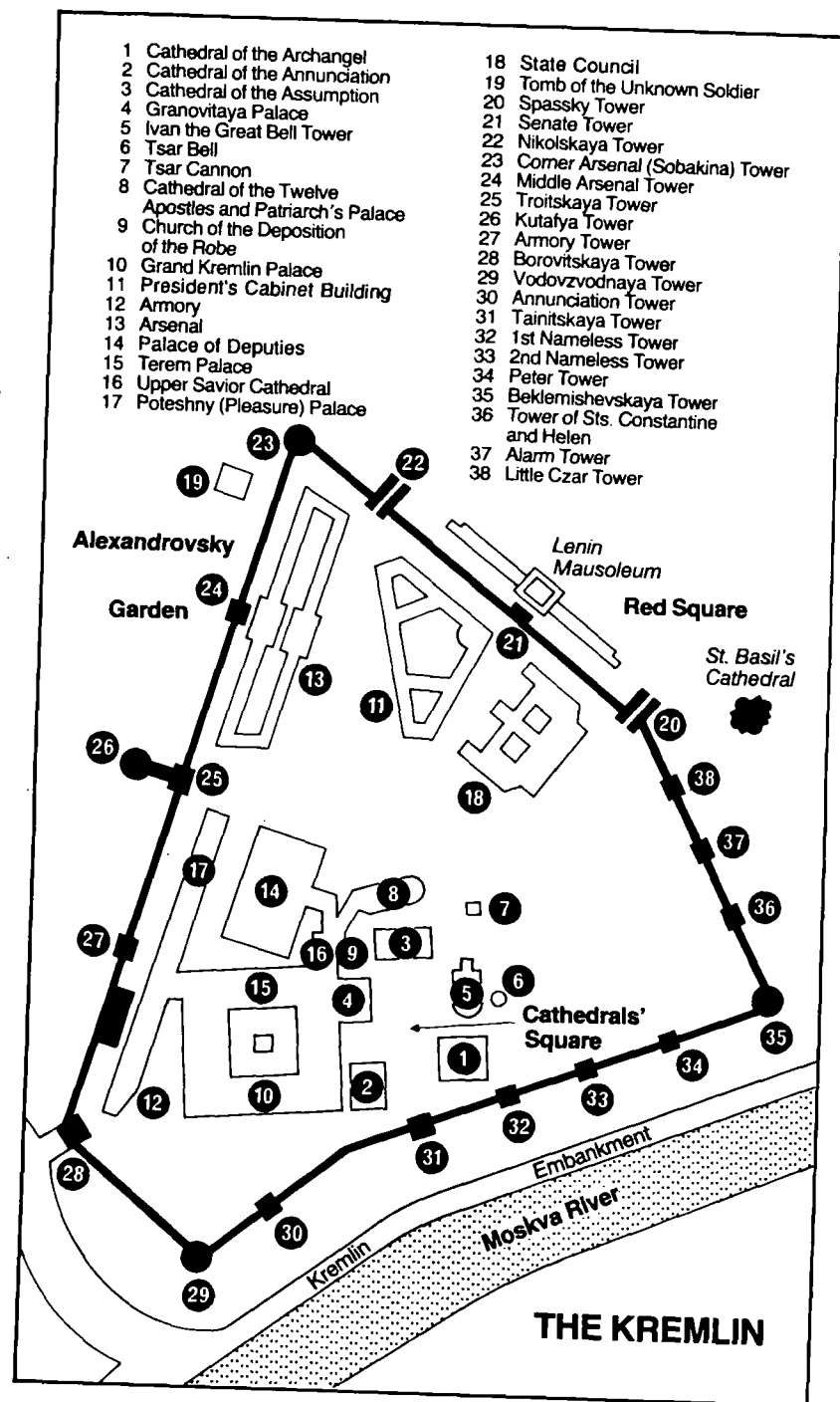
building. Meanwhile Moscow produced a change of plan in church design towards the end of the 17th century, when the New Cathedral in the Donskoy Monastery was built and the still more elaborate church at Fili. Both are quatrefoil in plan with the four domes placed over the apses at the cardinal points, instead of diagonally round the central rectangle. The Church of the Intercession at Fili was built by Lev Naryshkin and the new style came to be known as Naryshkin Baroque. M. C.

Wooden architecture

Throughout the Middle Ages all over Russia and especially in the north, churches as well as private houses continued to be built of wood, mainly pine, with no other tools but the axe. Beams were laid horizontally, interlocking at the corners, and the size of the building was determined by the length of the logs. The earliest surviving church is St Lazarus originally at Murom, c.1390, now in the Museum of Wooden Architecture on the island of Kizhi on Lake Onega. It consists of three rectangular blocks, the central cube, a porch at one end and the sanctuary at the other. The porch is lower but wider than the centre. In some buildings the floor level was raised on stilts or foundations to avoid damp and an outside covered stair led into the building. The octagonal plan allowed a larger area to be enclosed and was often used for churches. The ceiling was low to ensure warmth, but the outer walls were often extended upwards in diminishing width to produce the tent shape, later used in masonry,

Log church, 1766, from Glotovo; now at Suzdal'





Grand Kremlin Palace

This is a group of several buildings. The main section is the newest, built between 1838 and 1849 by the architects Chichagov, Gerasimov, Ton, and others. Its 375-foot-long front faces south, overlooking the Moskva River. This was for centuries the site of the palaces of the Grand Dukes and Czars, but the immediate predecessor of the present building, dating from the 18th century, was badly damaged in the 1812 conflagration. The building is now used by the Russian government, and is the seat of the Russian Parliament. It is not open to the general public, although you can sometimes make arrangements for a tour.

The main entrance leads into a spacious marble hall with several marble chambers on the left. These used to be the imperial reception rooms; today they are used for ceremonial signing sessions.

A sweeping staircase leads to the first floor. Here is the great St. George's Hall, named after the highest military decoration of Czarist Russia, the Order of St. George, whose members are commemorated on marble tablets. They include Suvorov and Kutuzov, two famous generals. Eighteen spiral zinc columns topped by sculpted figures support the roof, the work of Ivan Vitali. Six immense gilt chandeliers and 3,000 lamps provide illumination. The parquet flooring is made up of 20 different kinds of wood. The hall is used for government and diplomatic receptions, youth balls and children's New Year celebrations.

Mirrored doors lead into the octagonal Vladimir Hall, the so-called "sacred anteroom." Its foundations were laid in 1487. A beautifully carved, gilt door opens from here into one of the most ancient chambers, the Palace of Facets (Granovitaya Palata), so called because of the shape of the stone facings on the side nearest Cathedral Square. Built in 1473-91 by the Italian architects Marco Ruffo and Pietro Antonio Solario, it is a large low-vaulted chamber, the roof supported in the middle by a rectangular pier. The iron ribs of the vaulting are gilded with inscriptions.

From the Vladimir Hall there is access to the so-called Terem, or Golden Czarina Palace, also among the oldest parts of the Kremlin. It was in the gilt rooms of this palace that the Czarina received her official visitors. Another passage with wooden stairs and a gilt iron door leads to the Terem Palace, the residence of the early Czars; its furnishings have been preserved in the richly decorated vaulted chambers.

The Russian Parliament's council chamber is the second largest in the Kremlin, with seating for 3,000. It was created by combining two existing halls. Here the party congresses were held until 1967, when the modern steel-and-glass Palace of Congresses was completed.

Near the council chamber are the former apartments of the imperial family. Their marble walls are covered with silk tapestries. There are statuary and china of great value and substantial inlaid furniture. The walls of the so-called Catherine Chamber are supported by green malachite columns valued at several million gold rubles.

The Square of Cathedrals

After visiting the Grand Kremlin Palace, cross to the other side of the roadway and look down upon the Kremlin Garden, which is in the hollow below. The shady park has huge oaks and fir trees. If you return t

left side of the road, a few steps bring you to the ancient center of the Kremlin, the Square of Cathedrals. The paved square is framed by three large cathedrals in old Russian style, the massive bell tower and the Granovitaya Palace. The side entrance of the Uspensky (Assumption) Cathedral is opposite. This is one of the oldest edifices of the Kremlin. The present building, which became Russia's principal church, follows the style of the Uspensky Cathedral at Vladimir. It was built in 1475–79 by the Italian architect Aristotle Fiorovanti, who had spent many years in Russia studying traditional architecture. Topped by five gilt domes, it is both austere and solemn, with a spacious interior, illuminated by two rows of narrow windows. It contains rare ancient paintings, including the ikon of the Virgin of Vladimir (the work of an 11th-century Byzantine artist) and the icons of St. George (12th century) and the Trinity (14th century). The carved throne of Ivan the Terrible also stands here. The church is open for religious services on major church holidays.

The smaller, single-steeped Rispolozheniye (Church of the Deposition of the Robe), built 1484–86 by master masons from Pskov, stands to the left of the Uspensky Cathedral, on the northwestern corner of the square. This was for a while the personal church of the Patriarchs of Moscow. It was rebuilt several times and restored to its original 15th-century condition by Soviet experts. In 1965 it was reopened as a museum. The building boasts brilliant frescoes dating from the mid-17th century covering all its walls, pillars, and vaults. Its most precious treasure is the iconostasis by Nazary Istomin (1627).

The carved stone facade of the Granovitaya Palace stands on the west side, close to the Grand Kremlin Palace with the Blagoveshchensky (Annunciation) Cathedral next to it. This is a remarkable monument of Russian architecture, linking three centuries of art and religion. Its foundations were laid in the 14th century and a triangular brick church erected on them in the early Moscow style in the 15th century. Fire partly destroyed it; during the reign of Ivan the Terrible six new gilded cupolas were added when it was rebuilt. The 16th-century carved stone portals are particularly fine. Inside, look for a beautiful iconostasis and striking frescoes, which were restored in the early 1980s. These were painted in 1508 by the Russian artist Feodosy and his father and brother. The fine icons of the second and third tiers of the iconostasis were painted by Andrei Rublyev, Theophanes the Greek and Prokhor of Gorodets. The floor is covered with polished tiles of agate jasper, given by the Shah of Persia. The cathedral served as the private chapel of the Czars. In the South Gallery, icons and paintings are exhibited.

On its opposite side, the Square of Cathedrals is bordered by the Cathedral of the Archangel. This is a five-domed edifice, built by the Italian architect Alevisio Novi in 1505–09 to replace the original 14th-century church. Its ornate decorations have distinct elements of the Italian Renaissance. Between 1540 and 1700 this was the burial place of the Russian princes and Czars; their likenesses are painted on the walls above each of the 46 tombs, including those of Ivan Kalita (d. 1340) and Ivan the Terrible. The carved wooden iconostasis is 43 feet high. The icon of the Archangel Michael is believed to date back to the 14th century. In 1953–55 some outstanding medieval murals, depicting battle scenes, were discovered beneath the layers of centuries. Other murals depict historical, religious, and domestic scenes.

The tallest building of the square, and of the Kremlin, is the Ivan the Great Bell-Tower, which forms a splendid ensemble with the adjoining buildings. The octagonal main tower with its 329 steps is 263 feet high—three feet higher than the Hotel Rossia across the Square, in accordance with a tradition that the Tower must be the tallest building in Moscow. The Bell Tower is one of the most unusual structures built in the 16th century. The first tower was erected in 1505–08, the second in 1532–43. The first was rebuilt in 1600, when it was crowned with an onion-shaped dome covered with gilded copper. Originally it served as a watchtower; from it Moscow and its environs could be observed within a radius of 20 miles. The first tower has 21 bells, the largest weighing 64 tons. Both towers together have 52 bells, the largest weighing 70 tons. The Czar Bell, standing on a stone pedestal nearby, is the biggest bell in the world; cast in the Kremlin in 1733–35, it weighs more than 200 tons, is 20 feet high and 22 feet in diameter. The bas-reliefs on the outside show Czar Alexei Mikhailovich and the Czarina Anna Ivanovna. Not far from the Bell is the Czar Cannon, with the largest caliber of any gun in the world, cast in bronze in 1586 by Andrei Chokhov. It weighs 40 tons, its length is 17 ft. 6 in., and its caliber is 35 inches in a barrel six inches thick. It bears the image of Czar Fyodor Ivanovich. Its present carriage was cast in 1835, purely for display purposes.

Leaving the Czar Bell, walk around the large square into which you have emerged. It contains the Church of the Twelve Apostles and the Patriarch's Residence. The Church was built in 1655–56 and served as the Patriarch's private church. The buildings now house (since 1963) the Museum of 17th-Century Applied Art; the exhibits were taken from the surplus of the State Armory Museum and include books, items of tableware, clothing and household linen.

The Seat of Government

Passing the Cathedral of the Twelve Apostles and the former Patriarch's Palace you arrive at the most recent building of the Kremlin, the Palace of Congresses. A glass and aluminum building, it was added to the Kremlin complex in 1961 and completed six years later, much of it underground to avoid clashing with the old Kremlin architecture and ruining the skyline. Its vast stage is fully equipped for opera and ballet, concerts and recitals and wide-screen film projection. Simultaneous translation apparatus is built into the seats. Above the auditorium there is a banqueting hall for 2,500 people. The covered promenade circling this hall provides a splendid view. In addition there are more than 800 different premises—halls and lobbies, conference rooms, accommodations for the diplomatic corps and the press.

Beyond the palace you'll see the façade of the Arsenal, with the French cannon captured in 1812 by Kutuzov's forces.

On the other side of the square stands a two-storied, Classical building with a central dome. Once the Senate, this 18th-century building by Matvei Kazakov now houses the Russian President's cabinet. It was in this building that Lenin lived and worked; his fourth-floor study, with its original furniture and books, is sometimes open to the public. Next to it is the hall where Lenin chaired the meetings of the Council of People's Commissars and other committees. Lenin's apartment can be reached by a corridor from this hall. Four medium-sized and simply equipped rooms have also been preserved in their original condition.

The Washington Post

THE OTHER YELTSIN



The spotlight will fall on Naina Yeltsin this week, but she would prefer it if her husband were "just an ordinary man."

The Shy First Lady Who Lives Like the Rest of the Russians

By Helen Boldyreff Semler
Special to The Washington Post

MOSCOW
Naina Yeltsin leans closer, tightening the grip of her hands in her lap. "We live in fear for my husband's life," she says. The softly contoured face with typically Russian high cheekbones, framed by cropped russet hair, is amazingly fresh and unlined. The eyes are serious, but serene. There is no pathos, only a terse statement of fact.

Long after the October storming of the White House, the parliament building in Moscow, by troops loyal to her husband, Naina Yeltsin still finds it hard to talk about the days when Russia stood on the brink of civil war. "It was terrible," she says, worse than anything else she had lived through in a lifetime of political tumult.

At midday on Sunday, Oct. 3, Boris Yeltsin, the first democratically elected president of Russia, left the dacha outside Moscow that the Yeltsins had reluctantly taken over from the Gorbachevs ("Who in the world needs that many bathrooms, TV sets and servants?" asks Naina). She heard from him only once during the 3-day crisis as he worked feverishly in the Kremlin on the strategy for ending the mutiny.

Boris Yeltsin had waited tense weeks in the hope of a peaceful solution, but when the demonstrators attacked the main TV station, and Vice President Alexander Rutskoi, hero of the Afghanistan war, asked his followers to charge the Kremlin, Yeltsin knew that he had to act.

"We did not close our eyes that Sunday night," Elena, the elder of the Yeltsin daughters, says.

But by Monday afternoon, Boris Yeltsin had survived yet another crisis.

When President and Mrs. Clinton visit Moscow next week, the world may get a rare glimpse of Naina Yeltsin. Throughout the remarkable political odyssey of Boris Yeltsin, his wife has maintained a discreet profile. She has shown no desire to emulate Raisa Gorbachev in garnering publicity and notoriety.

Naina and Boris Yeltsin represent a different Russian world from that of the Gorbachevs, or, for that matter, such Communist luminaries as Lenin, Trotsky and Stalin. They are both engineers, builders eager to complete a project quickly and safely, and they are uninterested in seeking an ideological justification for what they are doing. Boris appears rarely on television and then his pronouncements are terse. Naina shuns the Russian media and scrupulously avoids the ceremonial functions required of an American First Lady. "I am only the president's wife," she says. "I shudder when people call me the First Lady."

Indeed, there is little time in Naina Yeltsin's day for ribbon-cutting. In addition to traveling with her husband and taking part in official entertainment, there is the exhausting shopping, cooking and baby-sitting her grandchildren. "The yoke of everyday living oppresses

Russia's First Lady

YELTSIN, From G1

us," she says. "For Russian women who work, keep house and raise children, the quest for the barest necessities of life is a horrendous experience."

She has other reasons for avoiding public statements. "Everything I do or say as the president's wife is made into an intrigue and is then held against my husband. I don't want to add to his burdens. We made a deal long ago that I would not mix our family life with politics. But I long to do something for children."

Her dream, she confided a year ago, is of a dental clinic for children. "Our dental care is a disaster. There are no proper painkillers, the drills are antiquated and children blanch at the sight of a dentist. . . . But what can I do? I cannot trouble my husband with this. We need so many things in Russia."

Naina Yeltsin's dream was conveyed to Hillary Rodham Clinton, who asked Ambassador Richard Armitage to arrange for dental equipment to be sent from a U.S. Army post in Germany to the Moscow Central Institute of Stomatology. More was to come: 40 containers of medical equipment and supplies worth more than \$4 million were en route to Children's Hospital No. 1 in Moscow. This facility is being remodeled through a joint project of Norfolk Children's Hospital and a foundation set up by National Symphony Orchestra conductor Mstislav Rostropovich, who gave a concert in Red Square a week after the storming of the Russian White House. All in all, as part of Operation Provide Hope, nine Russian hospitals will receive \$38 million worth of equipment and supplies from hospitals being dismantled by the Army's 7th Medical Command in Germany.

In addition, after the First Ladies meet next week, work may begin on the first private U.S.-Russian hospital in Moscow, under their joint chairmanship.

The two women have met before, during the Tokyo G-7 summit last July. Naina Yeltsin was impressed with Hillary Clinton, whom she describes as an "American woman of the new generation, on top of her job both as the president's wife and as a lawyer. . . . I cannot tell you how much I admire her." Both professionals and both wives of provincial politicians who became of state, the women found many common interests during their Tokyo talks. Above all, Naina Yeltsin praised Mrs. Clinton's work on health care.

She is eager to show Mrs. Clinton the new facilities at the Central Institute of Stomatology. She also hopes to introduce her to Russian culture, the music that require no interpretation. She is particularly keen on showing the paintings of late-19th-century Russian masters, virtually unknown to the American public.

And Naina Yeltsin is looking forward

to conveying her personal gratitude to the Clintons for the stand taken in support of her husband during the fateful days of October.

The upcoming meeting will be Naina Yeltsin's third encounter with a U.S. president and First Lady. The first was with Barbara Bush. She displays proudly a large framed photograph taken of the two women in June 1992 in Washington. "She is terrific," she says of Mrs. Bush.

A high point of that visit was the luncheon at Mount Vernon in Naina Yeltsin's honor. She kept thinking of the parallel between her husband and George Washington, who had said, "I walk on untrodden ground." Just as everything Washington did set the precedent for future U.S. presidents, she thought, Boris Yeltsin was creating precedents for the course of Russian democracy.

'A Family of Technocrats'

Born Anastasia Girina to a family of poor peasants in the southeastern Russian town of Orenburg in 1932, the young Naina knew work, privation and political repression. Her father survived Stalin's brutal collectivization of Russian agriculture, though the family's crucial farm livestock was confiscated. But if Naina's family fared better than that of Boris's, whose father was taken from his farm and shot, tragedy lurked in its future. The father she adored was killed in 1968 as he stood in the way of a drunken motorcyclist to protect her mother.

Naina Girina and Boris Yeltsin met at the Ural Polytechnical Institute in Sverdlovsk, one of the Soviet Union's leading engineering schools. They received their degrees in construction engineering in 1956. Boris Yeltsin wrote in his memoirs: "I fell in love with her then, tenderhearted and good, for the rest of my life. She accepted me the way I was, stubborn and prickly."

As Boris made his way up the Soviet ladder, Naina concentrated on their family and on supervising large projects for

the Institute of Waterways in Sverdlovsk, now rebaptized Ekaterinburg. There were not many free moments for the Yeltsins in Sverdlovsk, especially after their daughters were born, Elena in 1957 and Tanya in 1959. They celebrated Sundays at the Bolshoi Ural restaurant, where they ordered ice cream for all. Holidays were fun-filled escapes of camping, hiking and boating. Elena followed her parents' example and became a construction engineer; Tanya became a computer technician. "We are a family of technocrats," says Naina. The Yeltsins moved to Moscow in 1986, when Gorbachev summoned Yeltsin to the prestigious position of first secretary of Moscow's Communist Party Committee.

Gorbachev made a serious mistake. The "stubborn and prickly" Yeltsin broke all party big-shot rules by taking the Moscow trolleys and letting his wife stand in the long lines at the stores. He wanted to know firsthand the living conditions of the 9 million Muscovites. They in turn appreciated his willingness to share their problems. Soon he became the most popular politician in the Soviet Union.

Retreat

In a four-room apartment in an unfashionable section of the city, Naina Yeltsin has re-created the family home. The Yeltsins lived there with daughter Tanya and her husband and their only grandson, 12-year-old Boris, until recently, when they were forced for security reasons to spend most of their time at the dacha. Even by Moscow standards, the apartment is nothing special. Seated facing the television, Naina Yeltsin pats the arm of a comfortable red velvet chair.

"It needs reupholstering," she says. "In fact, all of our furniture needs reupholstering. We brought it with us from Sverdlovsk." She surveys the sofa and several more chairs covered in the same fabric. "It's old but homey," she says.

The same simplicity describes Naina Yeltsin. She wears little jewelry

and dresses in subdued clothes made locally. Warm and unassuming, she says she dreads causing problems for anyone. But she is always the analytical engineer, wanting to know how things run. Although she is an art lover, when she visited the National Gallery of Art in Washington last year, the innovative architecture of the East Building roof caught her attention as much as the exhibit she saw. When she visited a soup kitchen with Barbara Bush, she was not satisfied until she had mastered all the details—the caloric content of the food, the number of people fed each day, the cost of the program.

In her own kitchen she cooks her specialty, the Siberian dumplings called *pelemeni*, her family's favorite dish. Boris will arrive at 10 p.m. or later, eat, watch the late news and then resume work. Naina sleeps only when he does—which is about four hours a night.

She worries very much about her husband. Many years ago she watched him climb onto a huge crane careening about in a blinding rainstorm. "Get down," she screamed, "the crane will collapse." But Yeltsin, then working on his first construction project, kept climbing. He brought the huge contraption under control. For years afterward, Naina had nightmares about Boris being crushed by a crane.

He has faced other dangers as well. At the Oct. 21, 1987, Central Committee meeting, Yeltsin complained that Gorbachev's reforms were moving too slowly and that his efforts in Moscow were being sabotaged. He went too far. His colleagues deserted him. On Nov. 9, he collapsed and was rushed to a hospital with severe chest pains, shattered nerves and a splitting headache.

While Naina was in the hospital with Boris, a call came from the Kremlin—Gorbachev insisted that the sick Yeltsin come to a meeting of the Moscow Communist Party Committee at which he would be dismissed as first secretary. Naina pleaded, saying that she saw no point in Yeltsin being guarded if

his was going to kill. But Yeltsin went, pumped full of Valium and carried on a stretcher by four KGB agents. After his dismissal, thousands of letters and telegrams, many from Sverdlovsk, poured in. Yeltsin took heart and recovered.

During the attempted coup against Gorbachev in August 1991, Naina Yeltsin again heard only once in three days from her husband, who was holed up in the parliament building. A radio report falsely said that the hard-line Communist plotters had overrun the White House. "My heart stopped," she says. She told her daughters not to wake the grandchildren. If they were to be shot, she decided, they should die in their sleep.

"I prayed," she says.

The New Russia

For Naina Yeltsin, Moscow is a

"suffocating" place full of dirty intrigue against her husband.

"In Moscow," she says, "my husband's hair turned white. In Moscow, I also stopped believing in communism." She soured on the system when she came to know the lifestyle of the country's elite: special stores, limousines, private clinics, all spiced with venomous backbiting.

Today she is an optimist. She sees her children's generation forging ahead despite the chaos. She worries most about the losers in the difficult transition from state monopoly to private enterprise. These are the pensioners, the old, the sick whose savings have been wiped out by inflation, those who have lost their jobs in unprofitable state industries.

In the long run, she is convinced that Russia, with its human, natural and technological resources and its high level of education, will provide a good future for her grandchildren if not her children. But the transition to democracy, to a system that permits the peoples of Russia to be heard, is absolutely essential in her view.

Many deputies opposed a new constitution, Naina Yeltsin says, because "it is more difficult to govern men in a democratic state than under the old totalitarian rule. In democracy people speak, think, vote, make decisions. The power must be legitimate. This is why my husband wants a new constitution for Russia."

She defends her husband against accusations of "dismembering" the Soviet Union, of being a dictator. "Dictators want power for power's sake," she says. "Yeltsin seeks power to improve the lot of his people."

But she is against his running for president again. "I personally would prefer him to be just an ordinary man," she says.

Helen Boldyreff Semler, a business consultant on Russia and author of the guidebook "Discovering Moscow," served as the State Department interpreter for Mrs. Bush at her meetings with Naina Yeltsin.



Naina Yeltsin with Barbara Bush in 1992, and with her granddaughter Katia: "I am only the president's wife. I shudder when people call me the First Lady."

LEFT PHOTO BY KEITH JENNINGS—THE WASHINGTON POST; RIGHT BY DMITRY GONSKOY

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Minsk

Divider Title: _____

January 10, 1994

Mrs. Hillary Rodham Clinton
c/o American Embassy
Moscow, Russia

Dear Mrs. Clinton,

I am writing to invite you to come to Pittsburgh and to dedicate the Magee-Womens Research Institute, the nation's only research facility devoted solely to the study of women's health issues.

When it opened its doors last November, the Research Institute did so with an ambitious research agenda covering the continuum of a woman's life -- from young adulthood through menopause and aging. Pregnancy complications, ovarian and cervical cancer, osteoporosis, cardiovascular disease, and autoimmune diseases such as arthritis and lupus -- which affect women in much greater numbers than men -- are just some of the diseases being studied by scientists at the Magee-Womens Research Institute.

The Research Institute comes at an important time. Finally, after decades of neglect, women's health care is being paid the attention it deserves. There is much catching up to do, however, and your presence -- your visible support of our endeavors -- would draw badly needed attention to women's health needs and remind the entire nation of the importance of research on the medical problems that affect all of us.

Magee-Womens Hospital, an affiliate of the University of Pittsburgh School of Medicine, has stood at the forefront of the women's health movement since its founding 62 years ago. Today, Magee is one of only a few facilities in the United States devoted to the care of women and newborns.

Over the years, Magee researchers have contributed, significantly, to the understanding of premature labor, infertility, respiratory distress syndrome in newborns, and other health problems affecting women and infants.

Now, we have embarked on another critical venture -- one that will prepare us for the health problems that we, as a nation, will face in the years to come, as 50 million women of the "baby boom" generation enter menopause and grow older. Their needs -- and their sheer numbers -- will test our health care system like never before. It is crucial that we prepare with new treatments, and this requires quality research.

Because of your support of women's health issues, I invite you to dedicate and tour the Magee-Women's Research Institute, at your convenience, and see first hand how we are preparing to meet the challenges of the future.

Sincerely,

Irma E. Goertzen
President and CEO

leg/ami

INITIATIVES TO IMPROVE PEDIATRIC HEALTH CARE
IN THE REPUBLIC OF BELARUS

Priority Projects of
The Department of Pediatrics
Children's Hospital of Pediatrics
3705 Fifth Avenue
Pittsburgh, Pennsylvania
15213-2583 U. S. A.
in affiliation with
The School of Medicine
University of Pittsburgh

UNIVERSITY CHILDREN'S MEDICAL CENTER
REPUBLIC OF BELARUS

PROPOSAL

We propose the establishment of the University Children's Medical Center (UCMC) at the site of the Minsk Medical Institute to provide comprehensive pediatric medical and surgical care for children and education for health professionals as a joint venture of the Republic of Belarus and the United States of America. The availability of pediatric health care professionals and ancillary support services will permit diagnostic and therapeutic programs for all children with health care problems during the first two decades of life. The fiscal support for UCMC will be provided by public and private resources in the Republic of Belarus, the United States of America and other countries.

BACKGROUND

Unpredicted and rapid political developments throughout the world have propelled an unprecedented number of nations into a more representative form of government. Reacting to the many decades of inadequate funding of their health care system coupled, often, with a crippling central control and inappropriate representation of their indigenous health care capabilities, the leaders of Belarus have placed the highest priority on the health of their constituencies and the deficits in their system to provide preventive and curative medical services. They have given the highest priority to the needs of their children, and they have turned to the Children's Hospital of Pittsburgh to help restore their pediatric care system and the quality of their health care personnel.

The situation in Belarus has been significantly compounded by the Chernobyl nuclear reactor catastrophe in 1986. This singular event has had a profound influence on the direction and demand for medical services, particularly for children, in the Republic. It is estimated that 40% of the health care expenditures in Belarus have been diverted to the problems created by this accident. At least 70% of the radioactive fall-out from this accident occurred in Belarus. It is estimated that 1.5 million persons were exposed to significant amounts of radioiodine, of which 160,000 were young children less than 7 years of age. Recent reports already suggest an increase in the number of cases of thyroid cancer in children from these contaminated areas and it is estimated that 20,000 more children are at significant risk for developing this cancer in the near future.

Not surprisingly, a very high level of citizen stress and anxiety prevails whenever major transitions in governance occur. This is only amplified in Belarus by the events at Chernobyl. Distrust has increased, as unrealistic expectations remain elusive. This

consumer aversion is reinforced by a shortage of practically all of the effective pharmaceutical and biological products, particularly those in pediatric dosage forms. Furthermore, previous misinformation, often promulgated by public health officials, has served to increase the level of misgiving, doubt and suspicion of this already uninformed and burdened population.

While politicians on both sides debate what aid is appropriate for the former Soviet Union, there seems little argument that the economic health of these new Republics is important to the rest of the world. There is also no apparent disagreement that the productivity of a society is related to its health. Furthermore, good health for children, and a sustained ability to provide it, is essential for any society's future development. Without health, a child's ability to learn and grow into a productive member of society is restricted. This very concept has even had a recent re-awakening in the United States, as our own health care reform is formulated and deliberated.

A COMPREHENSIVE PROGRAM

The Department of Pediatrics of the Children's Hospital of Pittsburgh, together with the Minister of Health of Belarus and the Rector of the Medical Academy in Minsk, have defined several significant projects where the potential for a successful intervention is large and the commitment of the Belarussian medical community is high. Financial support for these four high priority projects is urgently needed.

I. UNIVERSITY CHILDREN'S MEDICAL CENTER:

Two Years

It is very evident to the authorities in Belarus that a major reform in health care delivery is required if the Republic is to meet the needs of the population during this period of economic strife. On the basis of population, there are twice as many physicians and three times as many hospital beds in Belarus as in the US. Yet the per capita health care expenditure is only 6% of that provided in America. Modeled after Russia, the Belarus system relies on large, under-utilized buildings providing disjointed, specialized care. In a city the same size as Pittsburgh, there are five children's hospitals and 9 pediatric units in general hospitals. None are able to provide comprehensive pediatric care.

This project will coordinate the efforts of the Ministry of Health and the Rector of the Minsk Medical Institute to consolidate the multiplicity of pediatric services into a

University Children's Medical Center adjacent to the medical school. This new program for inpatient and outpatient care for children will merge the existing pediatric specialty services now at general and adult hospitals, reduce the number of beds, integrate essential services, foster more appropriate ambulatory care, and increase the efficiency of the system, while reducing the cost. As importantly, this change will lessen the burden on families by creating a more comprehensive and more accessible pediatric service. Furthermore, this Institution for Pediatric Excellence will create a teaching hospital for health professionals throughout the Republic and a model for Eastern Europe and Asia.

As a true joint venture, the Belarus government will provide the land and the cost of construction. The US component will assist with the conceptual and programmatic design, consult on the site selection and have full responsibility to teach and train the medical staff. Procurement of the necessary medical equipment and supplies will be a joint effort.

II. FELLOWSHIPS IN PEDIATRIC MEDICINE:

Five Years

This project will provide concentrated and focused training in selected pediatric specialties for mid-career Belarussian health care professionals, to become the trained, contemporary medical providers who will then be able to establish and sustain programs on their own. In addition, these individuals will, in turn, develop the local sites for advanced training in pediatrics for their countrymen. Initially, these Fellowships will provide focused specialty training for the physicians, nurses, technicians and allied health personnel of Children's Hospital Number Four and the Radiation Medicine Institute in Minsk. At a later date, however, as clinical skills move closer to contemporary western levels, the focus will shift to include similar health care professionals from elsewhere in Belarus who will receive graduate-level specialty training at the University Children's Medical Center under the tutelage of both US and Belarussian faculty.

III. CHERNOBYL RELATED THYROID CANCER:

Five Years

The nuclear disaster at Chernobyl in 1986 has raised the fears of the entire world and created the real potential for life-stealing disaster for a large number of children in Belarus. The children of southeastern Belarus have received the highest exposure and seem to be the most affected. Since 1990, the incidence of both thyroid nodules and thyroid cancer has increased in these exposed children. From the known release of radioiodine into the environment, a further increase in malignant thyroid disease can be expected. This recent surge of new disease, not present before 1990, adds a certain urgency to any program designed to detect and treat these susceptible populations.

This first goal of this program will target these highly susceptible children. Multidisciplinary teams will apply contemporary methods of early detection, definition and treatment of thyroid nodules, shorten the time to appropriate diagnosis and increase the likelihood of successful therapy. The second goal will be initiate preventive therapy designed to reduce the number of high risk children developing thyroid cancer through close medical supervision and education. The third goal of the program will include the training of indigenous medical personnel in modern diagnostic procedures and therapy and the acquisition of modern equipment and supplies to reduce the morbidity and mortality in those children for whom preventive therapy is too late or ineffective.

IV. RADIATION RELATED DISEASES:

Five Years

This project will involve collaboration between the Department of Pediatrics at the University of Pittsburgh, the Minsk Medical Institute, the Radiation Medicine Institute in Belarus and several US institutions, such as The National Institutes of Health, to design, conduct and evaluate epidemiological and clinical studies of the pediatric population with respect to the prevalence of pediatric malignant diseases, with special attention to thyroid cancer, leukemia, immunologic disorders and chronic diseases, such as diabetes mellitus. The program will continue to monitor the exposed pediatric population for radiation related diseases and to manage affected children with contemporary treatment protocols.

These core issues will act as a catalyst for the broader pediatric issues that have a greater likelihood of improving the care of many more children without malignant disease.

THE CHALLENGE AND THE RESPONSE

Belarus can be a difficult place to work. The standards of care are antiquated, the equipment minimal and the facilities obsolete. Nevertheless, recent experience has shown us that effective and comprehensive medical programs, based on education, fostered by collaborative partnership and designed to modify health care practice, can be established with emerging, young colleagues who not only welcome, but crave the investment of time, personnel and expertise.

The prime methodology selected for Belarus is an educational model, using a clearly defined medical need as the nucleus for more broadly based educational programs designed to improve medical care delivery on a more comprehensive scale. Programs provide a well defined focus, with well described and points and a circumscribed process to serve both as a model and a catalyst.

The example already demonstrated by the Department of Pediatrics in Belarus has demonstrated a prototype for medical education programming in the former Soviet Union, whereby multiple resources are merged to reach specific goals. The educational focus assures an enhanced indigenous capability, sustainability and replication. Financial support has merged sponsorship from governmental, private corporate and private foundation sources. Finally, by combining multiple resources and broad expertise, the projects encompass the broad spectrum of pediatric health care in an integrated and coordinated fashion.

Thomas P. Foley, Jr. M. D.
Professor of Pediatrics
December 1, 1993

American International Health Alliance*1212 New York Ave., N.W. • Suite 750 • Washington D.C. 20005**Phone: (202) 789-1136 • Fax: (202) 789-1277***PITTSBURGH - MINSK PARTNERSHIP****US Partner Representative:**

Thomas P. Foley, Jr., MD
Children's Hospital of Pittsburgh
Pittsburgh, Pennsylvania

Belarusian Partner Representative:

Valentina Strugach, MD
Children's Hospital no. 4
Minsk, Belarus

US Partner Institution:

The Children's Hospital of Pittsburgh, a renowned pediatric health care facility affiliated with the University of Pittsburgh School of Medicine and Nursing, specializes in pediatric critical care and transplantation services.

Belarusian Partner Institution:

Children's Hospital no. 4, the Radiation Medicine Institute, and the Minsk Medical Institute participate in the partnership. These institutions specialize in general pediatric care, diagnosis and treatment of pediatric thyroid cancer and medical education respectively.

Areas of Partnership Focus:

Oncology
Pediatrics
Poison Control

Diagnosis and Treatment of Pediatric Thyroid Cancer
Hospital Administration and Management
Medical Education

Partnership Progress through November, 30, 1993:

Memorandum of Understanding signed: *March, 1993*

Implementation Plan completed: *June, 1993*

Partnership Milestones:***March, 1993***

A six member delegation traveled to Minsk to initiate partnership activities, including evaluation of clinical techniques, inventory of equipment, and discussions on the profound increase of cancer in the Minsk area following the Chernobyl nuclear accident.

April, 1993

The first Belarusian delegation arrived in Pittsburgh for orientation on the U.S. health care system, including meeting with hospital administrators and medical specialists from each major department at the Children's Hospital.

June, 1993

A U.S. delegation assisted in the development of a pediatric poison control center at Children's Hospital no. 4. In addition, members of the delegation conducted an in-depth evaluation of the thyroid cancer clinic, infectious disease and nuclear medicine facilities, and nursing at the Radiation Medicine Institute.

September, 1993

A delegation from Minsk participated in intensive seminars and discussions on pediatric care and hospital administration and conferred with their colleagues in Pittsburgh on methods of early detection and treatment of children with thyroid cancer.

October, 1993

A U.S. delegation traveled to Minsk to assess the implementation of immunology laboratory procedures and gastroenterology techniques which were introduced to the NIS partners on earlier exchanges and adapted to the institutions in Belarus.

October, 1993

The directors of the Minsk Medical Institute, and the Radiation Medicine Institute ^{CH 24} and a gastroenterologist traveled to Washington and Pittsburgh to participate in the 1993 AIHA Fall Partnership Conference where they discussed their successes in pediatric care and shared their dissemination strategies with other U.S. and N.I.S. partners.

January, 1994

An American delegation will travel to Minsk to assist in developing an English language training program for the partnership and to promote plans for Endocrinology and Diabetes Exchange Programs.

February, 1994

A U.S. partner team will conduct an extensive review of hospital administrative functions and will assist in further development of a new nursing education curriculum. In addition, Dr. Sergei Milnov, researcher from the Radiation Medicine Institute will begin a six month fellowship at Children's Hospital of Pittsburgh to work and study in the field of human genetics.

Person Trips:	35
Person days:	in Pittsburgh -- 288 in Minsk -- 266
In-kind Contribution:	\$622,259
AIHA -- USAID Contribution:	\$281,722
1993 Project Total:	\$903,981
1994 Estimated Projected Total:	\$1.1 million

THE WHITE HOUSE

WASHINGTON

DATE

1/3/94

MEMO FROM: PAM BARNETT

TO:

Milli

Alston

Diane

Limo

Anne

Bartley

Capricia

Marshall

Joyce

Bonnett

Alice

Pushkar

Lisa

Caputo

Patti

Solis

Karen

Finney

Ann

Stock

Sara

Grote

Marge

Tarmey

Gift

Unit

Kim

Tilley

Julie

Hopper

Usher's

Office

Carolyn

Huber

Melanne

Verveer

Neel

Lattimore

Maggie

Williams

Evelyn

Lieberman

The attached is
for your:

Information
Advice
Action

Comments:



UNIVERSITY OF DENVER

Office of the Registrar

December 27, 1993

Dear Representative Schroeder:

President, Mrs. Clinton and Chelsea will be in Minsk, Belorus on January 16. I hope you will assist in forwarding this message to Mrs. Clinton.

After talking with Volodya Ulahovich in Minsk yesterday, I believe that he will be hosting Mrs. Clinton and Chelsea while in Minsk. Volodya heads the Ministry for Youth and is also involved with the security of Belorus.

Volodya is an outstanding person who has been in the U.S. twice. He is married and has a daughter who is probably about 6 years old.

Scout Troop 195 in Denver initiated the reintroduction of scouting in Belarus a few years ago. Volodya was a leader and stayed in our home in Denver.

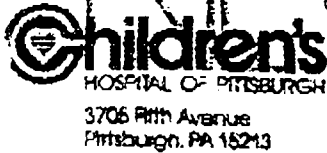
Here is a suggestion assuming there is a gift exchange. Volodya loves music and copied some of my tapes, e.g. Count Basie, Ella Fitzgerald, Louis Armstrong, Dave Brubeck, etc. At one point, his daughter needed multi-vitamins, and we provided school supplies.

Yes, this is a different kind of correspondence. At least it is not a complaint. We have a very warm feeling for the people of Minsk. They are very sincere and family oriented. Parents make many sacrifices for their children and are generous to guests.

Sincerely,

A handwritten signature in cursive script, reading "D. Jack Pommer".

D. Jack Pommer
Registrar



FOR IMMEDIATE RELEASE

Contact: Sue Cardillo
Public Relations Department
(412) 692-5016
NR#043/2/24/93

Children's Hospital of Pittsburgh Reaches Out to Former Soviet Republic

Pittsburgh, February 24, 1993 - Responding to the impending health care crisis in the New Independent States (NIS) of the former Soviet Union, Children's Hospital of Pittsburgh has formed a new hospital partnership in the republic of Belarus as announced today by the American International Health Alliance.

Children's Hospital of Pittsburgh will work with two hospitals, Children's Hospital Number 4 and the Radiation Medicine Institute, in Minsk, Belarus on cancer-related problems in children caused by the 1986 Chernobyl nuclear disaster. Children's will provide much needed assistance to its counterparts through a coordinated series of exchanges of medical professionals, addressing hospital management as well as clinical issues over the next 18 months.

Of particular concentration is the incidence of thyroid cancer in children in the six regions of Belarus and Minsk City from 1986 to the end of the first half of 1992. According to an article in Nature, 3 September 1992, "the overall incidence rose from an average of just four cases per year from 1986 to 1989 inclusive, to 55 in 1991 and is projected to be not less than 60 in 1992." (See attached table.)

The hospital partnership program is funded through the United States Agency for International Development (AID) and administered by the American International Health Alliance

-more-

Children's Hospital
Add One

(AIHA), a Washington, DC-based consortium of national hospital and hospital-related organizations. AIEA is now supporting 15 such hospital partnerships in nine NIS republics.

In addition to the Children's Hospital of Pittsburgh partnership, three other such relationships were also announced today.

- Tucson Medical Center in Tucson, Arizona, is leading a community-wide effort in a partnership with hospitals in Alma Ata, the capital city of the Central Asian republic, Kazakhstan.
- Hennepin County Medical Center of Minneapolis, Minnesota, is working with two hospitals in Chisinau, Moldova, in several areas, including trauma care, cardiac surgery and health care financing.
- A consortium of American hospital systems, including Henry Ford Health system of Detroit and Millard Fillmore Hospitals of Buffalo, will work with hospitals in the western Ukrainian city of Lviv.

"The AID-funded and AIHA-supported partnership between Children's Hospital of Pittsburgh and Children's Hospital Number 4 and the Radiation Medicine Institute in Minsk Belarus, will unite east and west as we work together to examine and address the significant medical problems of children, especially those children exposed to radiation from the Chernobyl nuclear accident," says Thomas P. Foley Jr., MD, director, Division of Endocrinology, Metabolism and Diabetes Mellitus, Children's Hospital of Pittsburgh, and professor of

-more-

Children's Hospital
Add Two

Pediatrics, University of Pittsburgh School of Medicine. "Our goals are to improve child health care to a level comparable to the United States and to establish Pediatric Health Centers of Excellence in Belarus."

The dissolution of the Soviet Union has greatly strained the health care delivery systems in the New Independent States. Like all institutions in the NIS, hospitals must both respond to the breakdown in central authority and quickly adapt to their emerging market economies. As the system of supply and distribution collapses, and as inflation continues to reduce already-scarce resources, hospitals increasingly are unable to provide adequate levels of care to millions of people for whom they are the sole health care providers.

"American hospitals can help their counterparts in the NIS develop the capacity to function in a market economy, and thus make an important contribution to stability in these emerging democracies," says James P. Smith, executive director of AIHA. Smith added that the four partnerships announced today "represent an important contribution of the United States government and the American hospital industry to the independence of the republics."

Proprietary to the United Press International 1993

February 24, 1993, Wednesday, BC cycle

SECTION: Regional News

DISTRIBUTION: Pennsylvania, West Virginia

LENGTH: 172 words

HEADLINE: Pittsburgh hospital to help kids with cancer in Belarus

DATELINE: PITTSBURGH, Pa.

BODY:

Children's Hospital of Pittsburgh is lending its expertise to hospitals in the former Soviet Union treating children with cancer caused by the 1986 Chernobyl nuclear disaster.

The American International Health Alliance announced Wednesday that Children's will provide the much needed assistance to Children's Hospital Number 4 and the Radiation Medicine Institute in the republic of Belarus through a series of exchanges of medical professionals.

The Pittsburgh doctors will devote particular attention to thyroid cancer cases in children. The number of cases jumped from four per year before the accident to 55 cases in 1991, and an estimated 60 cases in 1992.

The Pittsburgh hospital was involved in one of four new partnerships announced by AIHS Wednesday. Hospitals from Minnesota and Arizona, and a consortium of hospitals from around the country were also paired with facilities in New Independent States.

AIHS is now supporting 15 hospital partnership arrangements involving nine CIS Republics.

LANGUAGE: ENGLISH

С. Картеса, "Сівая легенда" Д. Смольскага, "Спежкае жыццё" Г. Вагнера, "Дзікае палаванне караля Стаха" У. Солтана. Цікавасць да балетнага тэатра праявілі кампазітары В. Залатароў, Г. Вагнер, Я. Глебаў, з п'яці пастаўленых балетаў якога два - "Альпійская баллада" і "Тыць Уленшпігель" дзесяцігоддзямі не знікалі з афішы.

Клапоцшыся аб стварэнні беларускіх спектакляў, тэатр пастаянна працуе над расшырэннем і ўдасканаленнем свайго класічнага рэпертуару. Ён першым сярод тэатраў былога Савецкага Саюза паставіў "Страшны абор" С. Мамоўці, "Аростю" С. Танеева, "Маддалену" С. Пракоф'ева, быў у ліку вядомых калектываў, што звярнуліся да спяччых Р. Штрауса. ДАТ Беларусі па праву ганарыцца такімі спектаклямі, як "Садко" і "Залаты птушнік", "Хаваншчына" і "Барыс Годуноў", "Вайна і мір", "Атала" і "Дон Карлас", "Лазніцы", "Казкі Гофмана", "Чароўная флейта". Некаторыя з іх утрымліваюцца ў сённяшнім рэпертуары тэатра.

performances: operas 'Naderzhda Durova' by A. Bogatyryov, 'The Venus Star' by Yu. Semenyaka, 'Giordano Bruno' by S. Kortes, 'The Grey Legend' by D. Smolsky, 'By the Path of Life' by G. Wagner, 'King Stakh's Wild Hunt' by V. Soltan. Composers V. Zolotaryov, G. Wagner, Ye. Glebov showed interest in the ballet theatre. Two of the five staged ballets of the latter ('The Alpine Ballad' and 'Thiel Oculenspiegel') were on for decades.

Paying much attention to the production of Belarusian performances, the company are incessantly enriching and improving their classical repertoire. They were the first in the former USSR to have staged 'The Terrible Court' by S. Monynahko, 'Oresteya' by S. Taneiev, 'Maddalena' by S. Prokofiev; it was one of the few companies that have addressed the heritage of R. Strauss. The State Academic Great Theatre of Belarus takes legitimate pride in such performances as 'Sadko' and 'The Golden Cockerel', 'Khovanshchina' and 'Boris Godunov', 'War and Peace', 'Othello' and 'Don

Сярод удалых уласабленняў балетаў класічнай спадчыны ў першыя дзесяцігоддзі існавання тэатра можна назваць "Капелію" Л. Дэліба, "Арлекінаду" Р. Дрыга, "Эсмеральду" Ц. Пуці. Не выходзяць са сцэны балеты А. Адана, Л. Мінкуса і, перш за ўсё, бессмяротныя творы П. Чайкоўскага. І зараз "Сільфіда", "Жызэль", "Карсар", "Дон Кіхот", "Шапэіян", "Лебядзінае возера", "Спячая красуня" ў лобовай адноўленай выглядзе ўпрыгожваюць балетную афішу. Гордасць трупы складаюць арыгінальныя аўтарскія версіі "Шчаўкунка" і тых балетаў кампазітараў XX стагоддзя, што трывала ўвайшлі ў класічны фонд харэаграфічнага мастацтва: "Вясна свяшчэнная" І. Стравінскага, "Рамэо і Джульета" С. Пракоф'ева, "Спартак" А. Хачатуряна. ДАВТ Рэспублікі Беларусь – адзін з тэатраў у краінах Усходняй Еўропы, дзе пастаўлена "Ундзіна" сучаснага нямецкага кампазітара Г. В. Хенца. Не мае аналагаў у свеце спэцыяльнае вырашэнне славутай кантаты К. Орфа "Карміна Бурана" як вакальна-харэаграфічнага прадстаўлення, дзе на новым узроўні сінтэзу аб'яднаны творчыя намаганні опернай і балетнай труп.

Вялікі тэатр оперы і балета Рэспублікі Беларусь шмат разоў з велізарным поспехам паказваў свае спектаклі на самай прэстыжнай сцэне былога СССР – у маскоўскім Вялікім тэатры, у кожным прыезд пацвярджаючы сваю рэпутацыю аднаго з самых цікавых і перспектыўных оперна-балетных калектываў краіны. Заслугі беларускага ДАВТ адзначаны прываеннем яму ганаровага наймення "акадэмічны" і вышэйшай узнагародай былога Саюза. Тэатр неаднаразова ўдзельнічаў ва ўсесаюзных фе-

Carlos', 'Lohengrin', 'Les Contes d'Hoffmann' ('The Tales of Hoffmann'), 'Die Zauberflöte' ('The Magic Flute'). Some of them are on nowadays.

Among successful realizations of classical ballets during the first decades of theatre's existence, 'Coppelia' by L. Delibes, 'Harlequinade' by R. Drigo, 'Esmeralda' by C. Pugni can be mentioned. A. Adam's, L. Minkus's ballets and, certainly, Tchaikovsky's immortal works are still on. 'La Sylphide', 'Gizelle', 'The Corsair', 'Don Quixote', 'Chopiniana', 'Swan Lake', so lovingly remastered, adorn the ballet repertoire of today. Original authors' versions of 'The Nutcracker' and those ballets by composers of the 20th century which have formed part of the classical fund of choreographic art, constitute the pride of the ballet troupe ('The Sacred Spring' by I. Stravinsky, 'Romeo and Juliet' by S. Prokofiev, 'Spartakus' by A. Khachaturyan). The Belarusian State Academic Great Opera and Ballet Theatre is the only one in the East European countries where a ballet 'Undine' by modern German composer H. W. Henze has been staged. There are no analogues in the world for the stage realization of the famous cantata 'Carmina Burana' by K. Orff as a vocal choreographic performance, which the joint creative effort of the opera and ballet troupes took to the heights of synthesis, yet unknown.

The Belarusian State Academic Great Opera and Ballet Theatre showed its performances many times with great success on the most prestigious stage of the former USSR – in the Moscow Bolshoi Theatre, confirming on every coming its reputation of one of the most interesting and promising opera and ballet companies of the

The music of the Belarusian State



Sergei Albertovich Korkes

Director of the Theater & Artistic Director
of the Opera Troupe.

Сярод удалых унаслабленяў балетаў класічнай спадшчы ў першыя дзесяцігоддзі існавання тэатра можна назваць "Капелію" Л. Даліба, "Арлекінаду" Р. Дрыга, "Эсмеральду" П. Пулі. Не зыходзяць са сцэны балеты А. Адана, Л. Мінкуса і, перш за ўсё, бессмяротныя творы П. Чайкоўскага. І зараз "Сільфіда", "Жызэль", "Карсар", "Дон Кіхот", "Шапэтыяна", "Лебядзінае возера", "Спячым красуня" ў любоўна-адноўленым выглядзе ўпрыгожваюць балетную афішу. Гордаць трупам складаюць арыгінальныя аўтарскія версіі "Шаўкункі" і тых балетаў кампазітараў XX стагоддзя, што трывала ўвайшлі ў класічны фонд хореаграфічнага мастацтва: "Весна сапціопная" І. Стравінскага, "Раміо і Джульета" С. Пракоф'ева, "Спартак" А. Хачатуряна. ДАВТ Рэспублікі Беларусь – адзін тэатр у краінах Усходняй Еўропы, дзе застаўлена "Ундзіна" сучаснага нямецкага кампазітара Г. В. Хенца. Не мае аналагаў у свеце сцэнічнае вырабленне слаўтай кантаты К. Орфа "Карміна Бурана" як вакальна-хореаграфічнага прадстаўлення, дзе на новым узроўні сінтэзу аб'яднаны творчыя намаганні опернай і балетнай труп.

Вялікі тэатр оперы і балета Рэспублікі Беларусь імкнецца разам з велізарным поспехам паказваць свае спектаклі на самай прэстыжнай сцэне былога СССР – у маскоўскім Вялікім тэатры. У кожны прыезд папярэджаючы сваю рэпутацыю аднаго з самых цікавых і перспектывных оперна-балетных калектываў краіны. Заслугі беларускага ДАВТ ацэняюцца пражываннем яму гаваровага найменша "акадэмічна" і вышэйшай узнгародай былога Саюза. Тэатр неаднаразова ўдзельнічаў ва ўсесаюзных фестываллях опернага і балетнага мастацтва, некаторыя з іх праводзіліся на яго сцэне.

Carlos', 'Lohengrin', 'Les Contes d'Hoffmann' ('The Tales of Hoffmann'), 'Die Zauberflöte' ('The Magic Flute'). Some of them are on nowadays.

Among successful realizations of classical ballets during the first decades of theatre's existence, 'Coppelia' by L. Delibes, 'Harlequinade' by R. Drigo, 'Esmeralda' by C. Pugni can be mentioned. A. Adani's, L. Minkus's ballets and, certainly, Tchaikovsky's immortal works are still on. 'La Sylphide', 'Gizelle', 'The Corsair', 'Don Quixote', 'Chopiniana', 'Swan Lake', so lovingly remastered, adorn the ballet repertoire of today. Original authors' versions of 'The Nutcracker' and those ballets by composers of the 20th century which have formed part of the classical fund of choreographic art, constitute the pride of the ballet troupe ('The Sacred Spring' by I. Stravinsky, 'Romeo and Juliet' by S. Prokofiev, 'Spartakus' by A. Khachaturyan). The Belarusian State Academic Great Opera and Ballet Theatre is the only one in the East European countries where a ballet 'Undine' by modern German composer H. W. Henze has been staged. There are no analogues in the world for the stage realization of the famous cantata 'Carmina Burana' by K. Orff as a vocal choreographic performance, which the joint creative effort of the opera and ballet troupes took to the heights of synthesis, yet unknown.

The Belarusian State Academic Great Opera and Ballet Theatre showed its performances many times with great success on the most prestigious stage of the former USSR – in the Moscow Bolshoi Theatre, confirming on every coming its reputation of one of the most interesting and promising opera and ballet companies of the country. The merits of the Belarusian State

За 60-гадовую гісторыю тэатра ў ім змянілася некалькі пакаленняў майстроў сцэны. Сёння ДАТ Рэспублікі Беларусь мае таленавітых і добра падрыхтаваных оперную і балетную групы, здольныя вырашаць самыя складаныя творчыя заданні, высокапрафесійны аркестр і хор, аўтарытэтынае мастацкае кіраванне. Беларускі балет даўно заваяваў міжнароднае прызнанне. У юбілейны 60-ы сезон адбыліся першыя замежныя туры опернай групы.

Academic Great Opera and Ballet Theatre are marked by the honorary title 'academic' and the highest award of the former Soviet Union. More than once the theatre took part in all-union festivals of opera and ballet art, some of which it hosted.

Throughout the sixty year long history of the theatre several generations of masters of stage came and went. Today the Belarusian State Academic Great Opera and Ballet Theatre has talented and well-trained opera and ballet troupes, that can cope with difficult creative tasks, a highly-professional orchestra and choir, competent artistic management. The Belarusian ballet won international recognition long ago. In the 60th jubilee season the first tours abroad of the opera troupe took place.

ХРАНАЛОГІЯ

1930

5 кастрычніка

Створана Беларуская дзяржаўная студыя оперы і балета.

1931

12 чэрвеня

Паказаны першы спектакль студыі - "Залаты коўнік" М. Рымскага-Корсакава.

1933

23 маі

Пастанова камітэту народнага камісарыята асветы БССР аб адкрыцці Беларускага дзяржаўнага тэатра оперы і балета.

25 маі

Урачыстае адкрыццё тэатра і паказ спектакля "Казіма" у будынку БДТ-1 (цяпер Тэатр імя Я. Купалы).

1935

Закладзены фундамент будынка тэатра оперы і балета.

1937

Сячнік

Арганізаваны вытворчы камбінат.

CHRONOLOGY

1930

October 5

The Belarusian State Opera and Ballet Studio was established.

1931

June 12

The maiden performance of the studio - 'The Golden Cockerel' by Rimsky-Korsakov - was shown.

1933

May 23

The board of People's Commissariat of education of the BSSR enacted opening the Belarusian State Opera and Ballet Theatre.

May 25

The gala opening of the theatre and the show of 'Carmen' in the building of the Belarusian Drama Theatre (the Theatre named after Ya. Kupala nowadays).

1935

The foundation of Opera and Ballet Theatre's Building was laid.

1937

March

The productive workshops were organized.

1938

Лістапад

Закінчена будівництво театру.

1939

10 сакавіка

Адкрыццё будынка ўзатра і прэм'ера оперы Я. Цікоцкага "Міхаель Падгорны".

28 ліпеня

Прэм'ера оперы А. Багатырова "У пушчах Палесся".

3 лістапада

Прэм'ера балета М. Крошнера "Сяляк".

1940

31 студзеня

Прэм'ера оперы А. Туранкова "Кветка шчасця".

5-14 чэрвеня

Дзесяць беларускага мастацтва ў Маскве (театр прадставіў чатырма нацыянальнымі спектаклямі).

21 чэрвеня

Тэатру наддана ганаровае найменне "Вялікі".

1941

Присуджэнне Дзяржаўных прэмій СССР Л. Александровскай за вынікі даследавання ў галіне тэатральна-васкальскага мастацтва і А. Багатырову за оперу "У пушчах Палесся".

Ліпеня

Пачатак доўгага перапынку ў рабоце театру ў сувязі з акупацыяй Мінска нямецкімі захопнікамі.

1942

Урад рэспублікі пачынае збіраць калекцыю театру ў г. Горкім (цяпер Ніжні Ноўгарад).

1943

Трупа выехала ў г. Каўроў Іммануўскай вобласці, дзе пачалі лічыць спектаклі на сцэне Клуба металістаў.

1944

17 верасня

Вяртанне калекцыі театру ў Мінск.

24 снежня

Прэм'ера оперы Я. Цікоцкага "Алеся" на сцэне Дома офіцэраў.

1945

Люты

Адкрыццё ў Мінску хореаграфічнага вучышлішча.

Кастрычнік

Пачатак аднаўлення будынка театру, разбуранага ў час вайны.

1947

7 лістапада

Прэм'ера оперы Дз. Лукаша "Кастусь Каліноўскі" ў адноўленай будынку театру.

1938

November

The construction of the theatre was finished.

1939

March 10

The opening of the theatre's building and the first night of opera 'Mikhas Podgorny' by Ye. Tikotskiy.

August 28

The first night of opera 'In the Virgin Forests of Polesiye' by A. Bogatyryov.

November 3

The first night of ballet 'The Nightingale' by M. Kroshner.

1940

January 31

The first night of opera 'The Happiness Flower', by A. Turenkov.

June 5-14

Ten-day Festival of Belarusian Arts in Moscow (the theatre was represented by four national performances).

June 21

The theatre was awarded the honorary title 'The Great'.

1941

The State Prizes of the USSR were awarded to L. Alexandrovskaya for great successes achieved in theatrical-vocal art and to A. Bogatyryov for his opera 'In the Virgin Forests of Polesiye'.

July

A long break in the theatre's activity started because of the German invasion.

1942

The government of the republic began to gather the company of the theatre in the town of Gorky (Nizhny Novgorod nowadays).

1943

The company were moved to the town of Kovrov, Ivanov region, where they began to give performances on the stage of Metal-workers' Club.

1944

September 17

Company's return to Minsk.

December 24

The first night of opera 'Alesya' by Ye. Tikotskiy on the stage of the Officers' House.

1945

February

Opening of a choreographic school in Minsk.

October

The restoration of the theatre's building which had been completely destroyed during the war began.

1947

November 7

The first night of opera 'Kastus Kalinovsky' by D. Lukas in the renewed theatre building.



KULTURALNY POLSKA
PAŃSTWOWA OPERA W WARSZAWIE

1955

KONCERT SOLISTÓW

PROGRAM KONCERTU

L. ALEXANDROVSKA	W. NIRONOW
A. BIELIK	R. WESSER
L. WACHNIK	T. NIKITKOWA
R. BABICHENKO	R. OSIPENKO
S. MIYTSIN	A. OSTROMECKI
S. BIECZIN	L. NIAZHOVA
E. FROH	T. SEYMENKO
A. GERALOW	R. WODNICKI
W. WODNICKI	M. SZWAND

CONDUCTOR
S. TOCHACZOW

CONDUCTOR OF THE ORCHESTRA
T. KOLOMIJCZAK

1950

Pracownicy Dzierżyński warty GOSR B. Zolotarow,
S. Dretchyn, A. Nikolajew, K. Muller i S. Nikolajew
za balet "Kniaź Wołodymyr" w sztuce DABT Białoruś.

1955

11-21 lutego

Dzień Białoruskiej kultury i literatury w Moskwie
(teatr przedstawia spektakle "Dziwki z Polos-
cy", "Jędrzej Alceja", "Straszny dwór", "Palenisko
serca").

Koncert

Dni białoruskiej kultury w PNR. Udział grup solistów
DABT Białoruś i skomponowane przez Białoruską te-
atr "Straszny dwór".

1964

29 stycznia - 10 lutego

Goswizyt teatr w Moskwie na scenie Kremlowskiej Pa-
lacy z okazji.

14 stycznia

Pracownicy teatru przyznano imię "akademicki".

1950

The State Prize of the USSR was awarded to
V. Zolotarow, S. Dretchyn, A. Nikolajew, K. Muller and
S. Nikolajew for ballet 'The Lake Prince' on the stage of
the Belarusian State Opera and Ballet Theatre.

1955

February 11-21

Ten-day Festival of Belarusian Literature and Arts in
Moscow (the theatre was represented by performances
'The Girl from Polesya', 'Eugene Onegin', 'The Ter-
rible Court', 'The Flaming Hearts').

October

The days of Belarusian culture in Poland. A group of
soloists from the Belarusian State Opera and Ballet
Theatre participated in the performance 'The Terrible
Court' staged by the Warsaw Grand Theatre.

1964

January 20 - February 10

The Moscow tour of the theatre on the stage of the
Kremlin Palace of Congresses.

March 14

The theatre was awarded the honorary title 'academic'.

1967

28 верасня

Удзел салістаў оперы і балета ў Дні БССР на Сусветнай выставе ЭКСПО-67 у Манрэалі.

1968

15 мая

Адкрыццё на сцэне тэатра Усесаюзнага фестывалю майстроў опернага і балетнага мастацтва.

1970

Прысуджэнне Дзяржаўнай прэміі БССР Я. Цікоцкаму за оперу "Алеса".

Прысуджэнне Дзяржаўнай прэміі БССР Я. Глебаву за балет "Выбранніца".

1971

7-25 ліпеня

Гастролі тэатра ў Маскве на сцэне Вялікага тэатра.

1974

1-9 жніўня

Гастролі балетнай трупы ў Венгрыі.

Спектакль "Барыс Годунов" адзначаны 1-м праміям на Усесаюнным фестывалі, прысвечаным 175-годдзю з дня нараджэння А. С. Пушкіна.

1967

September 28

The participation of the company in Belarusian Days during the International Exhibition EXPO-67 in Montreal.

1968

May 15

The opening of the All-Union Festival of Opera and Ballet Art on the stage of the theatre.

1970

The State Prize of the BSSR was awarded to Ye. Tikotsky for his opera 'Alesya'.

The State Prize of the BSSR was awarded to Ye. Gilev for his ballet 'The Chosen One'.

1971

July 7-25

The Moscow tour on the stage of the Bolshoi Theatre.

1974

August 1-9

Ballet troupe's tour in Hungary.

The performance 'Boris Godunov' was marked by the first prize at the All-Union Festival dedicated to the 175th anniversary of A. S. Pushkin's birthday.

1976

16-27 красавица

На сцене театра проводилась I Всесоюзный фестиваль творческой молодежи театров оперы и балета.

Май

Гастроли балетной труппы в Польше.

1978

21 апреля - 16 июня

Гастроли театра в Москве на сценах Большого театра и Кремлевского Дворца Концертов.

1979

11-29 мая

На сцене театра проводилась II Всесоюзный фестиваль творческой молодежи театров оперы и балета.

2-15 июня

Гастроли балетной труппы в Кувейте.

1980

Присуждение Государственной премии СССР Д. Смолескому за оперу "Серая легенда" и Л. Шмидтовой за исполнение главной роли в этой опере.

1976

April 16-27

The First All-Union Festival of creative youth of opera and ballet theatres was held on the stage of the theatre.

May

Ballet troupe's tour in Poland.

1978

June 21 - July 16

The Moscow tour of the theatre on the stages of the Bolshoi Theatre and the Kremlin Palace of Congresses.

1979

May 11-29

The Second All-Union Festival of creative youth of opera and ballet theatres was held on the stage of the theatre.

July 2-15

Ballet troupe's tour in Kuwait.

1980

The State Prizes of the BSSR were awarded to D. Smolsky for the opera 'The Grey Legend' and L. Shmidtova for performing the main part in this opera.

1981

Чэрвень

Гастролі балета ў Балгарыі.

20 верасня - 10 кастрычніка

X Усеаўняны конкурс вышэйшага імя М. І. Глінкі ў Мінску. На сцэне тэатра адкрыццё і закрыццё конкурсу.

1982

18-29 красавіка

На сцэне тэатра праводзіцца III Усеаўняны фестываль творчай моладзі тэатраў оперы і балета

Жнівень

Гастролі балетнай трупы ў Сірыі.

1984

3-25 ліпеня

Гастролі тэатра ў Маскве на сцэне Вялікага тэатра і Крамлёўскага Палаца Конгрэсаў.

Снежэн

Пачатак дзейнасці Клуба сяброў оперы.

1985

27 жніўня - 20 кастрычніка

Гастролі балетнай трупы ў Іспаніі і Італіі.

1986

Ліпень - жніўня

Гастролі балетнай трупы ў Грэцыі.

1987

Лістапад

Гастролі вядучых мастстроў беларускага балета ў Егіпце.

1-12 снежня

На сцэне тэатра праводзіцца Усеаўняны фестываль музычных тэатраў (ДАБГ Беларусі прадставілі спектаклі "Вайна і мір", "Карміна Бурана", "Беларусь" і "Вясна акашчвання").

1981

Чэрвень

Ballet troupe's tour in Bulgaria.

September - 20 October 10

The 10th All-Union Contest of soloists named after M. I. Glinka. The opening and closing of the contest took place on the theatre's stage.

1982

April 18-29

The Third All-Union Festival of creative youth of opera and ballet theatres was held on the theatre's stage.

August

Ballet troupe's tour in Syria.

1984

July 3-25

The Moscow tour of the theatre on the stages of the Bolshoi Theatre and the Kremlin Palace of Congresses.

December

Opera friends' club began its work.

1985

August 27 October 20

Ballet troupe's tours in Spain and Portugal.

1986

July August

Ballet troupe's tour in Greece.

1987

November

Principal masters of Belarusian ballet toured Egypt.

December 1-12

The All-Union Festival of musical theatres was held on the theatre's stage (the Belarussian State Academic Opera and Ballet Theatre was represented by the performances 'War and Peace', 'Carmina Burana', 'Belarus' and 'The Sacred Spring').



1988

Сезонно - лето
Гастроли балетной труппы в Тайланде и Сингапуре.
Летом - зима
Гастроли балетной труппы в Югославии.

1989

Весна
Гастроли балетной труппы в Франции.
17 июня - 18 августа
Гастроли балетной труппы в Великобритании.
5-9 сентября
"Пять дней с Сергеем Прокофьевым" (наказ спектак-
лов ДАТ Беларуси и Прокофьевский чтецкий).

1990

Лето - осень
Гастроли балетной труппы в Индии.
Май - осень
Гастроли балетной труппы в Норвегии и ГДР.
22 и 23 апреля
Показ спектакля "Птица напавшая на карала Стала" в
Москве на сцене Большого театра.
Зима
Гастроли балетной труппы в Испании.

1988

January - February
Ballet troupe's tour in Thailand and Singapore.
November December
Ballet troupe's tour in Yugoslavia.

1989

June
Ballet troupe's tour in France.
August 17 - September 18
Ballet troupe's tour in Great Britain.
December 5-9
'Five days with S. Prokofiev' (the show of Belarussian
State Academic Great Opera and Ballet Theatre's per-
formances and Prokofiev readings).

1990

February - March
Ballet troupe's tour in India.
May - June
Ballet troupe's tour in Norway and GDR.
June 22, 23
The performance 'King Stakh's Wild Hunt' was shown
in Moscow on the stage of the Bolshoi Theatre.
August
Ballet troupe's tour in Spain.

Кастрычнік

Паказ спектакля "Кармэн" на Усесаюнным фестывалі "Операва панорама".

Лістапад

Гастролі балетнай трупы ў ФРГ.

30 снежня

Присуджэнне Дзяржаўнай прэміі БССР У. Салтану, Х. Башчаку, А. Ансімаву, В. Цюзе, В. Гейдэбрэхту, Н. Кастенка, В. Скоробагану, У. Эдмандасаву за оперу "Пілкае палівае каралі Стала" на сцэне ДАВТ Беларусі.

30 снежня

Першы спектакль Дзяржаўнага музычнага тэатра-студыі ары Тэатры оперы і балета Беларусі (адыіал А. Букіно "Пітер Пан").

1991

22-30 мая

Гастролі балетнай трупы ў Славеніі.

Верасень

Гастролі балетнай трупы ў Галікоўгу і Тайландзе.

19-29 лістапада

На сцэне тэатра праводзіцца фестываль "Амадеус", прысвечаны 200-годдзю з дня смерці В. А. Моцарта.

1992

28 лютага - 3 сакавіка

Камерны оперна-сімфанічны аркестр ДАВТ Беларусі і адуцыйнае рэпэтыўнае оперы ў Іспаніі.

15-21 красавіка

На сцэне тэатра праводзіцца і Міжнародны фестываль "Я люблю балет".

Жніўня

Паказ спектакля "Медыум" на Міжнародным фестывалі ў г. Патра (Грэцыя).

Верасень

Гастролі балетнай трупы ў Турцыі.

Лістапад

Гастролі адуцыйнага рэпэтыўнага оперы ў Буэнас-Айрэс.

1993

17-31 студзеня

Гастролі опернай трупы ў Іспаніі і Партугаліі на спектаклем "Тоска".

October

The performance 'Carmen' was shown at the All-Union Festival called 'The Opera Panorama'.

November

Ballet troupe's tour in FRG.

December 29

The State Prize of the BSSR was awarded to V. Salhan, Ya. Vashchak, A. Anisimov, E. Geidebrekht, N. Kostenko, V. Skorobogotov, V. Edmondosov for the opera 'King Stalk's Wild Hunt' on the stage of the Belarusian State Academic Great Opera and Ballet Theatre.

December 30

The maiden performance of the Children Music Theatre-Studio at the Belarusian Opera and Ballet Theatre (musical by A. Budko 'Peter Pan').

1991

May 22-30

Ballet troupe's tour in Slovenia.

September

Ballet troupe's tour in Hong Kong and Thailand.

November 19-29

The 'Amadeus' Festival in commemoration of the bicentenary of W. A. Mozart's death was held on the theatre's stage.

1992

February 28 - March 3

The concerts of the opera and symphony orchestra of the Belarusian State Academic Great Opera and Ballet Theatre and principal opera soloists in Spain.

April 15-21

The International Festival 'I love Ballet' took place on the theatre's stage.

August

The performance 'The Medium' was shown at the International Festival in Patra (Greece).

September

Ballet troupe's tour in Turkey.

November

Principal opera singers' tour in Buenos Aires.

1993

January 17-31

Opera troupe's tour in Spain and Portugal with the performance 'Tosca'.

Гэта самааблівае манументальнае збудаванне ўдала размяшчацца на адносна высокім месцы ў цэнтры Мінска — на Трасцкай гары, — абкружана скверамі, якія тэрасамі спускаюцца да ракі Свіслач, і добра ўспрымаецца з розных пунктаў горада. Тэатр узводзіўся ў 1935-1938 па праекту архітэктара І. Лангбарда, адкрыты ў 1939.

Першапачаткова задумваўся як універсальны са звышмэханізаванай сцэнай і глядзельнай залай на 3000 месцаў. Хаця грандыёзная задума не была рэалізавана ў поўным аб'ёме, тэатр усё ж уражае рэдкімі памерамі сцэны, прасторнасцю фая, зручнасцю службовых памяшканняў. Аснову кампазіцыі будынка ўтвараюць размешчаныя адна над адным тры цыліндрычныя аб'ёмы, да якіх прылягае з тыту развітая сцэнічная каробка. Глядзельная зала мела 1500 месцаў і вырашала як амфітэатр з балконам.

У час Вялікай Айчыннай вайны тэатр быў значна пашкоджаны, у 1947 адноўлены па праекту аўтара. Глядзельная зала цалкам рэканструйравана па традыцыйнай яруснай схеме. Зараз у партэры і трох неглыбокіх ярусах могуць размясціцца 1200 чалавек. У афармленні вострыбоў, фая і глядзельнай залы выкарыстаны лютныя дэталі (асабліва багата дэкарыраваны партал сцэны, скульптар А. Бембель), фая 2-га паверха адноўлена габеленамі (мастак А. Кішчанка).

This original monumental construction is well placed on a comparatively high spot in the centre of Minsk, known as the Trinity Hill, surrounded with public gardens that terrace to the river Svisloch and is acceptable to the eye from different parts of the city. Designed by the architect I. Langbard, the theatre was built in 1935-1938 and opened in 1939.

Originally it had been planned to be a universal one with a highly mechanized stage and to admit 3000 persons. Though the grandiose idea was not realized completely, the theatre, nevertheless, impresses with the uncommon size of its stage, spacious foyer, convenience of auxiliary premises. The basis of theatre's design is formed by three cylindrical structures placed one over another, a developed stage box adjoins it from the rear. The hall admitted 1500 persons and had a form of an amphitheatre with a balcony.

During the World War II the theatre was damaged to a considerable extent, but in 1947 it was renewed according to the author's design. The hall was totally reconstructed according to a traditional circle scheme. Today the stalls and three rather shallow circles admit 1200 persons. In design of the vestibules, foyer and hall the stucco mouldings have been used (the portal of the stage is especially richly decorated by sculptor A. Bembel), the first floor foyer is tapestried by painter A. Kishchenko.

Опера

ДЫРЭКТАР ТЭАТРА І МАСТАЎКІ КІРАЎНІК ОПЕРЫ СЯРГЕЙ АЛЬБЕРТАВІЧ КАРТЭС

Нарадзіўся ў 1935 у г. Сан-Антонію (Чылі), дзяцінства і юнацтва правёў у Буэнас-Айрэсе. Па мацярынскай лініі патомны расійскі інтэлігент. З 1954 жыве ў Мінску. Скончыў Беларускае кансерваторыю па класу кампазіцыі А. Багатырова.

Як кампазітар С. Картэс найбольш ярка праявіў сябе ў оперным жанры. Спектакль паводле першай яго оперы, "Гіардана Бруна" (лібрэта У. Халіпа), здзейснены на мінскай сцэне ў 1977 і праз год паказаны ў Маскве ў час гастроліў тэатра. Быў атрыманы крытыкай як падраа ва ўсім тагачасным савецкім оперным мастацтве. На трох сцэнах – у Калінасе, Кішынёве і Ялуцау – пастаўлена другая опера С. Картэса, "Магучае Кураж", па п'есе Б. Брэхта. Нядаўна завершаная опера "Візіт дамы" паводле п'есы Ф. Дзюжэнматэ яшчэ чакае свайго сцэнічнага ўвасаблення.

Балет С. Картэса "Апошні інка" пастаўлены Нацыянальным балетам Кубы і паказаны на XII Міжнародным фестывалі ў Гаване ў 1990.

Ім напісаны таксама араторыі, канцэрт для фартэпіяна з аркестрам "Капрычас", пяраг камерна інструментальных твораў і вакальных пьесаў, мульты да тэатрыіх драматычных спектакляў і кінафільмаў.

Заслужаны дзеяч мастацтваў, лаўрэат Дзяржаўнай прэміі Беларусі С. Картэс узначаліў тэатр і стаў мастацкім кіраўніком опернай трупы ў красавіку 1991.

Opera

DIRECTOR OF THE THEATRE AND ARTISTIC DIRECTOR OF THE OPERA TROUPE SERGEI ALBERTOVICH KORTES

He was born 1935 in San Antonio (Chile), spent his childhood and youth in Buenos Aires. He comes of a family of Russian intellectuals through his mother's pedigree. He has been living in Minsk since 1954. He has graduated from the Belarusian conservatoire in A. Bogatyrov's Class of composition.

As a composer S. Kortés has his worth in the opera genre. The performance based on his opera 'Giordano Bruno' on libretto by V. Halip was staged in Minsk in 1977 and one year later was shown in Moscow during theatre's tour. It was voted by critics a great event in the Soviet opera art of that time. Another opera by S. Kortés 'Mother Courage' based on B. Brecht's play was staged in Kanas, Kishinyov and Yakutsk. The opera 'Lady's Visit' based on F. Djuzhennat's play was finished not long ago and is still waiting for its stage realization.

The ballet 'The Last Inca' by S. Kortés was staged by the National Ballet of Cuba and shown at the XII International Festival in Havana in 1990.

He has written oratorios, a concerto for piano with the orchestra 'Caprichos', a number of chamber instrumental compositions and vocal series, music to numerous dramatic performances and movies, too.

Honoured Art Worker, State Prize of Belarus winner S. Kortés headed the theatre and became artistic director of the opera troupe in April, 1991.

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Current Digest of the Post-Soviet Press

December 23, 1992

SECTION: VOLUME XLIV, NO. 47; Pg. 12

LENGTH: 2343 words

HEADLINE: Novaya Zemlya Spreads Nuclear Contamination;
MAJOR TEST SITE SINCE 1955; HUGE AMOUNTS OF NUCLEAR WASTE SUNK
OFF ISLANDS; SECRET FEB. 1992 DECREE KEEPS SITE OPERATIONAL;
EX-WORKERS ON ISLANDS ARE DYING OF CANCER; RADIATION HITS
CHILDREN; SIBERIAN NUCLEAR WASTE POLLUTES MAJOR RIVERS;
PARLIAMENT KEPT IN DARK ON FACTS

SOURCE: Report on a News Assignment: NOVAYA ZEMLYA -- AN ARCTIC
CHERNOBYL By Lev Korsunsky. Chas pik, Nov. 10, p. 3, and Nov. 16,
p. 3. 4,500 words. Condensed text

DATELINE: Arkhangelsk and St. Petersburg

BODY:

Since 1955, 132 underground, underwater and surface nuclear explosions have been conducted in the archipelago. Their total energy yield -- 273 megatons -- is 94% of the yield of all nuclear explosions conducted in the USSR. Let us recall that Hiroshima was destroyed by an atomic bomb with a yield of only 15 kilotons. . . .

The total area of the archipelago is 81,300 square kilometers. The population is a garrison of thousands of men plus 2,146 officers' wives (most of them unemployed), 1,009 schoolchildren and 225 preschoolers. . . .

The first nuclear weapons tests were conducted in 1955 in Chernaya Bay. At that time, families of Russian commercial hunters and of Nenets who earned their living by hunting marine animals still lived on Novaya Zemlya. In 1961 the most powerful thermonuclear bomb in the entire history of nuclear-weapons testing, with a yield of 58 megatons, was detonated above the archipelago. . . .

The radiation situation (according to data provided by the official in charge of the nuclear test site): "On the islands of Novaya Zemlya, there are local zones with an elevated level of contamination caused by the radioactive products of underwater, above-water, surface and lower-atmosphere nuclear explosions conducted in the past. These zones are strictly localized and are remote from areas frequented by people. At present, the gamma-radiation dose does not exceed 1 milliroentgen per hour.

"The conducting of underground nuclear tests (starting in 1964) has not made a significant contribution to the radioactive contamination of the region."

The radiation situation (according to data from the St. Petersburg Radiation Hygiene Research Institute, presented to the Russian Federation Supreme Soviet): "Several dozen localized areas with elevated background radiation (up to 2 milliroentgens per hour), ranging from several hundred meters to 5 kilometers in diameter, were discovered by specialists from the USSR Ministry of Geology during aerial mapping of gamma radiation on the archipelago's southern island.

"Breaking through the blockade of criminal secrecy, in October 1991 USSR People's Deputies Andrei Zolotkov and Aleksandr Yemelyanenko gave the news media the coordinates for an a map of radioactive waste-burial sites in the Arctic. More than 11,000 containers of radioactive waste, as well as 15 damaged reactors from nuclear submarines and the icebreaker Lenin, have been sunk around Novaya Zemlya. Five reactors were sunk with their nuclear fuel unremoved.

"Today the Northern Fleet has accumulated 20 submarines with nuclear reactors whose service life has expired or which are otherwise unsuitable for operation." . . .

Thanks to the persistence of one of the organizers of the [recent international] conference [on "Ecological Problems of the Arctic and prospects for Nuclear Disarmament," held in Arkhangelsk] -- Aleksandr Yemelyanenko, a journalist from Sobesednik and chairman of the ecological movement Toward a New Earth -- officials from the military-industrial complex consented to a one-time showing of two documentary films that had never before been seen by civilians from foreign states, much less from Russia. . . .

The films were "Test of a 50-Megaton Clean Hydrogen Bomb" and "A Peaceful Underground Nuclear Explosion in Yenakiyevo." The horrible part was not the mushroom-shaped blast that split the skies over Novaya Zemlya -- we have seen plenty of those before. . . . What was horrible was the optimism-steeped voice that commented calmly on the skillful actions of the airmen who promptly donned dark goggles after dropping the superbomb from the plane and on the selflessness and fine training of the radiation-monitoring crews that appeared at the epicenter of the blast 60 minutes later, protected from radiation only by lightweight rubber suits -- and the curious faces of the boy soldiers who immediately peered out of their underground shelters in the face of the invisible hard gamma rays.

It was then that the USSR State Committee on Hydrometeorology's observation stations registered an increase in radioactive fallout levels in the country's northern regions two or three orders of magnitude higher than usual. And the maximum

density of radioactive fallout in terms of total beta activity in Amderma after the explosion of that superbomb was 11,000 (!) times higher than today's background radiation.

This film had obviously been made for the members of the Khrushchev-era Politburo of the CPSU Central Committee. The text devoted a great deal of attention to the strengthening of the nuclear might of the world's first workers' and peasants' state and the man who was then its head. The other film was made 18 years later, in 1979. . . .

In September 1979, an underground nuclear explosion was detonated in the Southern Communard Mine [sic], right outside the city of Yenakiyevo. n1 . . .

n1 [For a recent account of this experimental explosion, see Current Digest, Vol. XLIV, No. 26, p. 35. That article calls the mine Young [Yuny] Communard, not Southern [Yuzhny] Communard.]

Until the tragedy at Chernobyl, the people of Yenakiyevo did not know about Klivazh [the code name given to the secret experiment]. . . .

A secret resolution of the CPSU Central Committee, signed by Khrushchev on July 31, 1954, . . . condemned Novaya Zemlya -- its natural environment, its subsoil resources, its unique fauna -- to nuclear crucifixion, and all its inhabitants to eviction. . . .

The cold winds of the cold war created on Novaya Zemlya "Installation 700," as the nuclear weapons test site is called in classified documents. . . . Even today, the test site continues to prepare for the accelerated conversion of the unique archipelago into a gigantic atomic graveyard.

Everyone who is acquainted with the Russian President's decree of Oct. 28, 1991, in which he proclaimed a yearlong moratorium on nuclear testing and announced the closing of the test site on Novaya Zemlya, will exclaim, "That's impossible!" . . .

The general public could hardly know that on Jan. 21, 1992, the Russian president received a group of atomic scientists -- developers of nuclear weapons -- at his residence in the Kremlin. The meeting was held behind closed doors and lasted almost five hours. On Feb. 28, 1992, after a visit to Arzamas-16, B. N. Yeltsin repudiated his own decree of Oct. 28, 1991. The new decree is stamped, "Not for publication." . . .
* * *

. . . A. Veshnyakov, member of the Russian Federation Supreme Soviet, comments: "The decree of Feb. 28, 1992, was the exact antithesis of its predecessor. It declared the need to continue 'shaft-sinking and tunneling work' at the Novaya Zemlya test

site, which is now called Rossiisky Tsentralny [Russian Central]. The land occupied by the test site was made federal property. The President instructed the government to see to it that the test site remained operational and was prepared to conduct two to four tests a year if the moratorium ended. The President's decree was not cleared with either the Russian Supreme Soviet or the bodies of power in Arkhangelsk Province, in whose territory the test site is located. . . .

"The decision . . . was made within a narrow circle of high-ranking individuals. . . ."

Whereas the President's first decree, on halting nuclear tests on Novaya Zemlya, threw Rear Adm. Viktor Gorev, the officer in charge of the test site, into a state of shock and he publicly said that the action was against the people's interests, the decree of Feb. 28, 1992, made the nuclear military-industrial complex happy, since it directed that surface tests be financed "as a separate line item," lavishly and without supervision. So people will continue to perish from the plutonium and strontium rains that wash the tundra's reindeer moss, the taiga, and the rivers, seas and lakes after every explosion on Novaya Zemlya. . . .

The Russian commercial hunters who were removed from Novaya Zemlya to the mainland 34 years ago managed to hang on, one way or another; they settled down and even learned new occupations. But the Nenets hunters of marine animals, torn away from their lifelong homes and having lost not only their livelihood but their occupation, could not assimilate among the reindeer herders. Their decades of silence were only an apparent submission to fate. Their mute protest was terrible, but only for themselves. Drunkenness, tuberculosis, syphilis, suicide -- all this led to the disappearance of an entire ethnic branch of the

Nenets people, along with its way of life, world view and its linguistic uniqueness.

But the Russian older brother was not left untouched by the nuclear disaster either. . . . Lulling statements by high officials to the effect that "the radiological situation on the islands of Novaya Zemlya is normal and presents no danger for the residents of the garrison, much less for other regions of our country," met with a sharp reaction from former residents of Novaya Zemlya. V. Tsaubulin [chairman of the Petersburg Union of Novaya Zemlya Test Participants] said:

"No one ever kept or is now keeping statistics on the victims of Novaya Zemlya. But every year, more and more of our colleagues are dying prematurely of cancer. And how many people have lost their immune-system protection!" . . .

Medical personnel from Arkhangelsk who spoke at the conference

sadly confirmed that people who, carrying out secret orders from the "fathers of our peoples," exploded the world's most powerful nuclear charges above and beneath the archipelago are dying in local oncological hospitals today. Retribution in another form has also come for the military-industrial complex's relentless pressure on the ecosystem. A group of Russian and Norwegian doctors has found that 95% of all children in Arkhangelsk Province are now born weakened and physically underdeveloped, a percentage four (!) times as high as in 1946, right after the Great Patriotic War. Complications during pregnancy and birth are twice as common in Arkhangelsk Province as in Vologda Province. The frequency of blood diseases and oncological diseases among children has tripled in Arkhangelsk Province over the past three years.

For reindeer herders in the Nenets tundra, the internal radiation dose received through the "moss to reindeer to man" chain is 1,000 (!) times higher than the average level for the province. This accounts for the fivefold increase in oncological diseases among tundra dwellers. . . .

Readers, take a good look at the silhouette of Novaya Zemlya, at the spots where solid radioactive waste has been sunk and liquid radioactive waste has been poured into the sea, as published by Chas pik. Not shown here is the place where the atomic submarine Komsomolets went down. I got a chance to meet with surviving members of the crew, and the fellows told me that the vessel's nuclear reactor and two torpedoes with nuclear warheads lie at a depth of 1,680 meters, just 300 miles from Norway. Also not shown on the map are the areas where over 100,000 (!) cubic meters of liquid radioactive waste was poured out, or the secret burial place of the lighter Nikel, with its cargo of solid radioactive waste.

Besides the fact that the northern seas, which feed into the World Ocean, are being contaminated by the Novaya Zemlya test site, they are also vulnerable from the Southern Urals and the industrial regions of Siberia. Is this an exaggeration? Here are some official data, made public for the first time at the conference in Arkhangelsk.

"The scale of the production of radioactive waste at nuclear-complex installations in Chelyabinsk-65, Tomsk-7 and Krasnoyarsk-26 is such that if the waste were spread over the earth there would be a global catastrophe. In the 40 years of its activity, the Mayak [Beacon] Production Association alone has discharged into the basin of the Techa and Mishelyak Rivers (an area of 270 sq.km.) radioactive waste with a total radioactivity of more than 1 billion curies. If one imagines this entire amount spread throughout the CIS, that would be worse than Chernobyl. So far this danger has been localized within Chelyabinsk, Yekaterinburg, Kurgan and Tyumen Provinces, but there is no guarantee that in five years groundwater contaminated with radionuclides will not reach the Ob, and then the Kara Sea.

It has recently been learned that, for a distance of almost 900 km., the flood plain of the Yenisei is contaminated with artificial radioisotopes from Krasnoyarsk-26's reactors."

This is why open information about radioactive waste on land and in the sea is so important. The "Secret" stamp gives reason to doubt scientific forecasts and assessments of our safety, for even today, according to V. Menshikov, Vice-Chairman of the Russian Federation Supreme Soviet's Joint Committee on Questions of Ecology, and Yu. Dmitriyev, a member of the same committee, the Ministry of Defense blithely ignores the Supreme Soviet's joint committee. Deputies to the Russian parliament do not know from whom they can obtain an answer to the question of what is buried where, and how much. So far, no one has succeeded in breaking through the veils of departmental secrecy to get to the Rossia test site (what a name for a nuclear graveyard!) on Novaya Zemlya -- the decisions of generals are stronger than those of Deputies.

In my final report on my assignment to Arkhangelsk, I will tell about an explosion at the conference -- an information bombshell. Chas pik will be the first in the country and the world to publish sensational data that were presented to the newspaper by a Norwegian international research institute.

[For reports on a recent attempt by a Greenpeace research ship to measure radiation levels around Novaya Zemlya, see Current Digest, Vol. XLIV, No. 41, p. 21. See Vol. XLIII, No. 49, pp. 18-19, for an account of earlier Greenpeace charges of Soviet nuclear waste dumping.]

GRAPHIC: AREAS ALONG THE COAST OF NOVAYA ZEMLYA WHERE SOLID AND LIQUID RADIOACTIVE WASTE HAS BEEN SECRETLY SUNK OR POURED INTO THE SEA

- *1. The Novaya Zemlya Deep-Sea Trench. 1,450 containers, a barge carrying a damaged nuclear reactor (170,000 curies) and a lighter carrying liquid radioactive waste.
 - *2. Neupokoyev Bay. Solid radioactive waste with a total radioactivity of 3,400 curies.
 - *3. Tsivolka Bay. 4,750 containers, the lighter Nikolai Bauman and the midship section of the icebreaker Lenin, with three damaged reactors.
 - *4. Og Bay. 850 containers.
 - *5. Stepovoi Bay. 1,850 containers and a damaged atomic-powered submarine with two reactors still containing nuclear fuel.
 - *6. Abrosimov Bay. 550 containers and sections of four damaged nuclear submarines (eight reactors, three of them still containing fuel).
 - *7. Blagopoluchiye Bay. 650 containers of radioactive waste.
 - *8. Tehenia Bay. A damaged reactor without nuclear fuel. Total radioactivity, 1,850 curies.
 - *9. An area of open sea with 400 containers.
 - *10. An area of open sea with 250 containers.
- Map, NOVAYA ZEMLYA

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AP Worldstream

December 29, 1993, Wednesday 14:15 Eastern Time

SECTION: International news

LENGTH: 240 words

HEADLINE: Radioactive Christmas Trees Sold In Belarus

DATELINE: GOMEL, Belarus

BODY:

Some Christmas trees in the former Soviet republic of Belarus have been found to be radioactive, apparently because of the 1986 disaster at the Chernobyl nuclear power plant, a news agency said Wednesday.

The Belinform agency said many people preparing for the Russian Orthodox Christmas on Jan. 7 now prefer to buy artificial trees to avoid radiation dangers.

A tree bought by one man from a roadside salesman contained "unacceptably high levels of radiation," it said. The man later tested the fir tree with a home dosimeter, and the device "went off the wall."

Gomel was among the cities affected by fallout from Chernobyl, the world's worst nuclear accident. And trees, according to Belarus' Forest Institute, are one of the main repositories of radioactive elements.

In the former Soviet Union, fir trees were usually put up to mark New Year's Day, following a tradition established by the officially atheist state. But in recent years, many people have begun buying them to celebrate the Russian Orthodox Christmas.

(sms/lcr)

LANGUAGE: ENGLISH

LOAD-DATE-MDC: December 29, 1993

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Los Angeles Times

September 3, 1992, Thursday, Home Edition

SECTION: Part A; Page 1; Column 5; Foreign Desk

LENGTH: 2541 words

HEADLINE: SOVIET NUCLEAR BOMB DRIVE TOOK A VAST HUMAN TOLL;
RADIATION: SHOCKING EPISODES ARE REVEALED. IN ONE, WORKERS WERE
SENT INTO MINE A DAY AFTER AN ATOMIC BLAST.

SERIES: A NUCLEAR NIGHTMARE: The lethal legacy of the Soviets'
atomic obsession. Second of three parts.

BYLINE: By JOHN-THOR DAHLBURG, TIMES STAFF WRITER

DATELINE: CHELYABINSK, Russia

BODY:

Nobody told the villagers why the fish in the river turned blind. Or why bulldozers showed up one day to plow under the road. So, they continued to cut hay in the meadows. When these peasants were forced by soldiers to leave their cottages in the Urals, they still didn't get a frank explanation.

And even when they began to die, they were not told the truth.

The history of the Soviet nuclear program is one of both great scientific prowess and vast human suffering. Bled white by World War II and barreling toward Cold War confrontation with the West, the Soviets in the late 1940s were willing to pay any price to catch up with the Americans and to build an atom bomb.

One star of the crash program, the late physicist Andrei D. Sakharov, wrote about those frenzied times: "Above all, I felt myself committed to the goal, which I assumed was (Soviet dictator Josef) Stalin's as well: after a devastating war, to make the country strong enough to ensure peace."

There was to be no room for failure. The sadistic chief of secret police, Lavrenty P. Beria, was put in charge of the Kremlin's answer to the Manhattan Project; he reportedly drew up two lists. One was of scientists to decorate with medals, if the bomb worked, the other of scapegoats to shoot if it was a dud.

Toiling like slaves in all but name, prisoners by the tens of thousands without any means of radiation protection mined uranium ore in ghastly conditions and built veritable cities where Sakharov and his colleagues lived and worked in forced seclusion.

Later, the atom would claim victims of a different sort, as the Kremlin -- faced with the fact that, although most of the Soviet population lived in Europe, 80% of the fossil fuel reserves were in isolated Siberia -- embraced nuclear power as a panacea for its energy ills, and muzzled any hint of the risks.

"Soviet nuclear projects were sick from the moment of their conception with megalomania that backfired in a doomsday fashion," said Romuald A. Shatyrnik, a high-ranking official with the Belarus State Committee on Chernobyl. "This is a nightmare that doesn't go away when you wake."

Many episodes of this nuclear past, and their effects on people, are being discovered only now. Just this summer, for instance, it became known that a nuclear bomb was secretly detonated in 1979 in a mine in Ukraine's Donbass region near the town of Yunokommunarovsk. Why? Because scientists thought the blast would disperse methane gas.

One day later, thousands of coal miners were sent back to work, oblivious to any danger.

Until this year, the 8,000 townspeople were still being told by officials that the high levels of radiation in the area were caused by the Chernobyl power plant accident, although that incident, in which a reactor blew up and caught fire, occurred at the opposite end of the Ukraine.

But it was the peasants who lived in villages along the cattail-fringed Techa river in the Urals, some 1,000 miles east of Moscow, who were the first sizable civilian population to suffer from the Kremlin's drive to harness the atom.

And unlike Chernobyl, what happened along the Techa was intentional.

"The search for nuclear weapons led our country to wage nothing less than a nuclear war on its own people," Natalia I. Mironova, a Chelyabinsk lawmaker who chairs the regional nuclear safety committee, reflected grimly.

It was sometime in 1949 that the people in charge at the super-secret Mayak Chemical Combine, where the first lot of bomb-grade plutonium was being refined, decided to dump their wastes into the Techa. No one told the Russians, Tatars and Bashkirs who used the river for drinking, bathing and fishing.

From 1949 to 1956, about 2.6 billion cubic feet of waste laden with 2.75 million curies of radioactivity -- or more than half the long-term radiation released at Hiroshima -- were poured into the Techa, according to information Mayak engineers have given the Chelyabinsk Institute of Physics and Biology.

Because of the harmful effects of the wastes produced in plutonium refining -- in particular strontium 90 and cesium 137 -- tens of thousands of people downstream were exposed to dangerous doses that ranged as high as 350 rems per year, said Dr. Mira M. Kosenko, head of the institute's clinical department. (In comparison, a nuclear power plant employee in the West, experts say, should receive no more than five rems.)

The eyes of the pike that live in the Techa turned a dead, glassy white. Even today a gamma-ray detector placed on the bank reads 1,700 micro-roentgens per hour -- 100 times normal levels.

It was only when radioactivity showed up in waters 1,000 miles downstream, in the ocean off northern Russia, that the bomb builders turned off the stream of waste. Evacuation of the villages began in 1953 but dragged on for eight years.

When confronted by residents who were beginning to complain of health problems -- from nosebleeds and chronic listlessness to leukemia and cancers -- Kosenko and her fellow physicians were told by authorities to say nothing about radiation. "We were always feeling unwell," one woman from near the Techa remembered. "But at the Institute of Physics and Biology, the diagnosis was always the same -- blood pressure problems."

The Soviet obsession with nuclear secrecy dates from this period. Sixteen sprawling, hidden installations were built for the military-industrial complex; they were so secret they did not even have names but cryptic designations (Mayak is "Chelyabinsk-65") and did not figure on any map.

In Siberia, 100,000 convicted criminals toiled 600 feet below the surface to hack a cavern from solid rock as large as three Great Pyramids. That enormous man-made grotto, Krasnoyarsk-26, housed three reactors for the production of plutonium; it has polluted stretches of the great Siberian river, the Yenisey.

Deprived of the Techa to use as a sewer, Soviet bomb builders next began dumping high-level waste into an open lake, Karachai. Even today, environmentalists are stunned at the results.

"They made it into the single most polluted spot on the face of the planet," said Thomas B. Cochran, a senior scientist at the Washington-based Natural Resources Defense Council who has visited Mayak.

Today, the lake is so laden with radioactivity -- 120 million curies' worth, or almost 2 1/2 times as many long-lived isotopes as spewed from Chernobyl -- that "to stand on its bank, even for a half-minute, would be deadly," Kosenko said.

There were more large-scale releases of radiation, and more cover-ups. On Sept. 29, 1957, a deafening explosion shook the

Mayak complex. Only three years ago did the Soviets officially report what had happened.

The cooling unit on a vat used to store high-level nuclear waste failed. The waste grew so hot it exploded with the force of 10 tons of TNT. An airborne plume up to five miles wide traveled more than 600 miles, sprinkling the ground with radioactive dust. More than 10,000 people were evacuated in the following 18 months.

Now a wraith with hennaed hair, Fatima Dautova, the mother of three sons who have since turned sickly, was one of the evacuees. "In three years, I became as withered as a dried fish," the Tatar peasant woman, who looks fragile as glass, said. Her doctors wouldn't tell her why.

(In yet another incident, drought shrank Lake Karachai in 1967, exposing sediments on its bottom. A tornado picked up the dust laden with cesium 137 and other radioactive nuclides and scattered it over an area larger than Maryland.)

The impact on humans of the events at Mayak is still being assessed. Anatoly F. Tsyb, an academician and one of 50 Soviet medical specialists who studied the affected people, says no fewer than 400,000 of them were exposed to heightened radiation.

Records in local medical clinics were routinely falsified to eliminate any hint of radiation, so the toll in human terms will probably never be known.

The Soviet nuclear energy program grew directly out of the push for the ultimate weapon and predictably incorporated many of the bomb program's flaws: desire for secrecy; single-minded pursuit of the government's goals, and primacy of production over safety.

Sometimes, even the hardware was the same: The graphite-moderated RBMK reactor that blew up at Chernobyl in the spring of 1986 was developed, in part, because, as it heated water to steam to generate electricity, it also produced plutonium for the warheads of Soviet ICBMs.

Until Chernobyl brought things to an abrupt end, the country had a love affair with what Communist Party propagandists christened the "peaceful atom." Electricity generated by nuclear fission doubled in every five-year period between 1965 and 1985. Reactors were supposed to be so safe, Belarussian writer Ales Adamovich remembered ironically, that one could supposedly be built beside the Kremlin wall.

However, what was constructed, and still exists today, was described by one Western expert as no better than a "bargain-basement" version of a nuclear power industry, in some cases 20 years behind facilities in the United States, Britain

and other countries.

"The Soviets could make a reactor big enough to light up an entire city, but they didn't have the hang of producing a good, reliable Geiger counter," said John Large, who operates a London-based consulting business on nuclear engineering and safety.

How flawed -- in technology, safety and professional terms -- the Soviet civilian nuclear Establishment was can be gleaned from comments of the official in charge of safety at the troubled Balakovo power plant on the Volga, where there had been 30 emergency shutdowns in a 12-month period.

Half the stoppages were due to shoddy electrical equipment that gave frequent false alarms, the others to human error, the official, Yuri Vishnevsky, said a few years ago.

"Quite often beginners allowed to run the reactor without old-timers' supervision and help did something wrong and a shutdown followed," Vishnevsky told a Soviet reporter, without explaining why novices were left on their own in the first place.

Safety regulations written in some Moscow office were the last concern of operators, whose attitude was "we know best" and who even had disconnected alarm systems, Vishnevsky said.

As for the hardware, generators designed for 30 years' service were so poorly made they worked for only three, and the rock underneath Balakovo's reactors was giving way.

"The Russians are good scientists," said Morris Rosen, director of nuclear safety for the International Atomic Energy Agency. "But the whole philosophy of redundancy -- of putting in backups (to use in the event of primary system failures) -- didn't exist for them."

The RBMK reactor, for example, was built without a safety housing to catch radiation that might leak in the event of an accident. In fact, the reactor was so poorly designed that the "scram button," supposed to smother the reaction by dropping control rods into the atomic pile, actually accelerated the neutron storm inside -- "like hitting the brake pedal on a truck and feeding gas to the engine, instead," said Friedrich Niehaus, an IAEA reactor specialist.

Soviet nuclear equipment, Western engineers say, was milled to common industrial standards rather than the more exacting criteria used in the West. "Like in the Russian military, the pressure was mainly to get the job done," Large said.

Until Chernobyl shattered willful disinformation and professional complacency like that lamented by Vishnevsky, the

official position was that there had never been a serious accident at a Soviet nuclear station.

In fact, the details of even foreign nuclear mishaps became top secret, so as not to alarm the Soviet population. According to Grigori Medvedev, only heads of major government departments and their deputies had a right to exhaustive accounts of the 1979 emergency at the Three Mile Island plant in Pennsylvania. "For 35 years, people did not notify each other about accidents at nuclear power stations, and nobody applied the experience of such accidents to their work," Medvedev wrote in his eye-opening expose on Soviet nuclear power, "The Truth About Chernobyl."

Such secrecy -- and the illusion of safety it gave rise to -- prevailed until Chernobyl exposed the industry's grave problems, because a single government agency -- the Soviet Ministry of Energy and the Atomic Power Industry -- operated power stations and was responsible for policing them as well.

The cult of nuclear silence was effective for so long because in the totalitarian conditions that prevailed until Mikhail S. Gorbachev's policies of glasnost, or openness, atomic scientists -- like journalists or members of any other profession -- were supposed to follow orders from the Soviet state and the Communist Party. Most did so. "Sixty-four institutes in Ukraine are now focusing on the Chernobyl calamity and its effects. But why were they silent until 1990?" asked Vyacheslav S. Konovalov, a biologist from Zhitomir.

Another Ukrainian, physicist Yevgen V. Korbetsky, sputtered with anger when he recounted how party bosses muzzled him and his colleagues at Kiev's Institute of Nuclear Research following the Chernobyl accident.

The 300 scientists were forced to sign a statement saying they would conceal the surge in radiation in Kiev from the public. They were ready to do so, but when bureaucrats also demanded that the physicists cut the findings they submitted to the government by a factor of six -- which would have enlisted the scientists in the official disinformation campaign about Chernobyl -- some rebelled. "We said: 'We're giving you the readings we've got,' " Korbetsky recalled.

It was an all-too-rare moment of mutiny in the nuclear Establishment.

"Frankly, the Russians didn't care too much about their people," said Friedrich Steinhausler, an official in the IAEA's radiation safety section. "These people have not been given correct information for years -- all they had were rumors."

As Russians, Ukrainians and the other peoples who lived in the old Soviet Union assess the health and environmental damage done by Soviet nuclear programs and ways to reverse or minimize the

effects, what strikes activists is how little some things have changed.

Even in post-Soviet Russia, it seems, the cult of nuclear secrecy survives.

It was only three months ago that civilian researchers looking into health problems in the Altai Mountains that may be caused by nuclear tests in Semipalatinsk were able to coax a map of the test site out of the military.

In a citywide referendum, 86% of the voters of Chelyabinsk, a city of more than 1 million, opposed the reprocessing of foreign nuclear fuel at Mayak. But even adamant advocates of closing the facility, which the Russian government inherited from the Soviet, doubt they have the power to succeed.

"The paradox is that although we have greater democracy in Russia these days, there is not yet greater consultation with the population about nuclear matters," said Dr. Yelena Zhukovskaya, a Chelyabinsk pediatrician.

Moscow Bureau reporter Andrei Ostroukh contributed to this story.

NEXT: The Herculean chore of cleaning up the Soviet nuclear mess

GRAPHIC: Photo, Technicians conduct inspection atop one of three nuclear reactors in underground Krasnoyarsk complex. EDUARD ZHIGAILOV / For The Times

LANGUAGE: ENGLISH

The Associated Press

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July 19, 1992, Sunday, BC cycle

ADVANCED-DATE: July 13, 1992, Monday, BC cycle

SECTION: International News

LENGTH: 1349 words

HEADLINE: Soviet Nuclear Waste: A Disaster Ignored For Decades

BYLINE: Associated Press Writers

DATELINE: ALONG THE TECHA RIVER, Russia

BODY:

The pine trees died first.

Then the invisible poison crept into the rivers and reservoirs, where ducks swam and cattails swayed in the sun.

On the banks of the stricken river, the people fell ill with chronic radiation sickness and cancer. They, too, began to die.

Tons of radioactive waste from the secret Chelyabinsk-65 weapons complex turned the Techa River in the Ural Mountains into a nuclear nightmare, but the Kremlin did not reveal the contamination for 40 years.

Today, nuclear waste has become a time bomb in the former Soviet Union. Chelyabinsk-65 is just one part of an enormous environmental disaster.

Newly independent republics are waking up to the legacy of contamination left by a communist system that lived by secrecy and put ecology last, even creating reactor graveyards in northern Russia and radioactive dumps in central Moscow.

Only after the world's worst nuclear accident, at the Chernobyl power plant in 1986, did word of a nuclear waste menace begin to trickle out.

None of the republics can afford to clean up the mess they inherited.

"Russia has no money to invest in environmental protection," said Viktor Danilov-Danilyan, environment minister of the Russian

Federation. "We are facing an ecological catastrophe. ... Only the vastness of the country is staving off that catastrophe."

The Techa began to die in 1948, when Chelyabinsk-65 scientists making plutonium for the first Soviet atomic bomb dumped raw waste containing 2.75 million curies of radiation straight into the river.

Curies are a measures of the intensity of radiation. That quantity gave residents who used the river water radiation sickness.

In 1957, liquid radioactive waste exploded in a metal container inside the Chelyabinsk-65 complex, showering thousands of square miles with poisonous radiation.

It was the worst accident of the nuclear age up to that time, but details were not revealed until 1989.

Twenty million curies were released by the explosion, much of it radiation that will be around for centuries. Chernobyl released 50 million curies, but much of the radiation was short-lived.

Natalia Mironova, head of the regional Nuclear Safety Committee in Chelyabinsk, about 60 miles from Chelyabinsk-65, said the explosion "was a warning to humanity, but because of our secrecy, we never let the rest of the world know and we could not comprehend the importance ourselves."

"As a result, so many lives have been lost," she said.

There are no official reports of deaths from the accident, called the Kyshtym disaster for a nearby town, or from the Techa dumping. But it is hard to find anyone in the area who did not lose a relative or friend to cancer. Many doctors and others are convinced the only explanation is radiation.

Thirty-five years after the explosion, reporters on one of the few visits permitted saw no fences to keep people away from the Techa or several waste reservoirs. Fish swam in the water and birds circled above. On the edge of the contaminated zone, residents worked in potato fields.

Devices carried by the visitors recorded radiation of up to 85 times normal. Anyone remaining for a year would receive more than 20 times the total allowable radiation exposure for an individual.

Warnings were posted only infrequently. A small sign on a bridge said: "Techa River is Polluted." The main road to Chelyabinsk-65 led through an eerie, contaminated birch forest marked by only a few signs with red triangles put up two years ago. They read: "Dangerous radiation."

The government's admission that much of the area is still radioactive is small consolation to more than 19,000 unsuspecting people already evacuated from 20 villages along the Techa. Their villages were burned and they received no compensation.

Only the skeleton of an onion-domed church and a crumbling mill remain at Metlino, whose 1,200 people absorbed the greatest dose of radiation from the dumping and were evacuated in 1952.

Most of the village became an artificial lake - Reservoir No. 10, now filled with liquid nuclear waste. The radiation count over the water was more than 250 times normal.

In all, Chelyabinsk-65 has contaminated nearly 11,000 square miles and subjected 437,000 people to above-normal radiation, Russian experts said.

Nuclear activities continue at the complex. It halted production of plutonium in 1990, but still reprocesses nuclear fuel.

Chelyabinsk-65 is not unique. Radioactive waste was dumped in cities, the countryside, rivers and lakes, notably in the late 1940s and early 1950s, when Stalin's dread security chief Lavrentii Beria ran the nuclear weapons program. Later, the proliferation of radioactive material at civilian enterprises added to nuclear pollution.

Krasnoyarsk-26, a secret weapons complex in Siberia, has been discharging radioactive water into the Yenisey River.

A similar Siberian facility, Tomsk-7, has contaminated the Tom River. In 1990, radiation levels were so high that 38 people were hospitalized.

The Soviet nuclear fleet did its own share of radioactive dumping. Andrei Zolotov, a member of the former Soviet parliament, disclosed last fall that leaky containers of radioactive waste were dumped into shallow waters of the Barents and Kara seas between 1963 and 1986.

Zolotov, a shipping executive in Murmansk, said the waste included the damaged reactor core from the nuclear-powered icebreaker Lenin, which suffered a meltdown in the mid-1960s.

Alexander Emelanenkov, a magazine editor and former legislator from Archangel, said at least a dozen damaged submarine reactors were dumped at sea.

On the Pacific coast near Vladivostok, environmentalists measured radiation 100 times normal near the site of a 1985 nuclear submarine explosion in Chazma Bay.

Not even major cities escaped.

An old battleship packed with nuclear waste was sunk in Ladozhskoye Lake near St. Petersburg.

Small radioactive deposits and contaminated soil have been discovered in St. Petersburg and Moscow. At the Kurchatov Institute, a research center in central Moscow, radioactive equipment and elements from old reactors were buried in the 1940s.

"We will have to remove it, of course, but it's a very expensive project," said the institute's deputy director, Yuri Gagarinsky.

The 598 Soviet nuclear tests added to the contamination, said ecologist Maria Cherkasova, Russian program director of the Socio-Ecological Union in Washington, D.C.

At the Semipalatinsk test area in Kazakhstan, where 467 of the explosions took place, winds carried radioactivity to the north and poisoned the rich farmlands of the Altai region, Cherkasova said.

Up to 500,000 people who lived around Semipalatinsk, now closed, received some radiation and the next three generations could be affected, said Vladimir Iakimets of the anti-nuclear movement Nevada-Semipalatinsk, named for the

Soviet and U.S. testing grounds.

More than 100 nuclear devices were exploded in various construction and oil exploration projects, and some caused contamination, Cherkasova said.

Near Astrakhan, a Volga River city, 15 underground nuclear explosions formed caverns for storing natural gas, but geological formations shifted and squeezed out radioactive gas, she said.

Many nuclear waste facilities are old, poorly built and filling rapidly. Military waste depots are full and virtually every nuclear power plant in the country has been storing its own spent fuel for years.

A beautiful pine forest hides the Leningrad Specialized Plant in Sosnovy Bor on the Baltic Sea, where rows of one- and two-story buildings are used for storing nuclear waste. Some have cracks and holes where radiation registers up to 380 times normal.

Russian officials are trying to figure out what to do about the waste and tons of enriched uranium and plutonium from dismantled warheads, but there is no organized program or budget.

"For years, people were polluting and polluting and polluting," said Vladimir Shenshinov, economic adviser to the Chelyabinsk regional council.

"Now they want it cleaned up in one day. You can't do it in one year or 10 years."

LANGUAGE: ENGLISH

Clinton Presidential Records Digital Records Marker

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Health Care

Divider Title: _____



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

December 6, 1993

Chief, International Emergency and Refugee Activity (F03)

Briefing for President's Trip to Russia

Peter Henry
Director, Office for Eastern Europe and China
Office of International Health, OASH/DHHS

The following information is provided to assist you in preparing a briefing document for President Clinton's upcoming visit to Russia. The information is provided under the rubrics given to me by Joe Davis subsequent to his phone conversation with you last week.

1. Successes

Since late October 1992 CDC has been collaborating closely with the Russian President's State Committee for Sanitary and Epidemiologic Surveillance (SCSES) in an effort to strengthen the existing public health surveillance system in Russia. The goal of this collaboration has been to improve the existing system and render it better able to detect evolving public health problems caused or exacerbated by the current social and economic transition from a command to a market-based economy.

The following have been accomplished under this AID-NIS/TF Project which officially terminated in October 1993.

- ° A spirit of collaboration and trust has been established between CDC staff and SCSES officials at all levels. There is a strong desire expressed by both sides to continue and expand the collaboration beyond the present effort.
- ° CDC staff working in Russia conducted a thorough assessment of the public health surveillance system at all levels and have made practical recommendations for its improvement to the Directorate of the SCSES.

Page 2 - Peter Henry

- A small number of computers were given to the SCSES to assist in the more rapid transmission of surveillance data between the various levels and the national level.
- Critical disease indicators to be monitored at more frequent intervals were chosen.
- An epidemiologic bulletin was established and now appears monthly.
- CDC staff assisted in diphtheria outbreak investigation and control efforts.
- Critical CDC guidelines and a computer surveillance/analysis program were translated into Russian and made available to SCSES personnel.
- A large conference focusing on the more effective use of public health surveillance information was organized by CDC, hosted by the Russians and attended by participants from Russia and four other former Soviet republics.

2. Cost

The activities described above were funded by the NIS Task Force of the Agency for International Development (AID) and were carried out under an Interagency Agreement (IAA) between CDC and AID. Activities devoted to the Russian Federation are estimated to have costed _____. (Peter--we hope to have the dollar amount by COB-Tuesday.)

3. Major Outstanding Problems

Based on CDC experiences and knowledge acquired over the last two years, we believe the following represent priority health problem areas which should be addressed by US Government resources and CDC technical assistance in the immediate future.

A. Diphtheria Control

A large diphtheria outbreak began in Russia in 1990, and since that time, the situation has worsened dramatically. During the first 9 months of 1993, 7628 cases and 300 deaths were reported,

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compared to 3897 cases and 125 deaths reported in all of 1992. The reasons for the outbreak remain unclear, but lack of routine booster immunization of adults is probably a major contributing factor. In a collaborative study with Russian public health authorities, CDC has found that 3 or more doses of Russian-made diphtheria toxoid is highly effective in preventing diphtheria. CDC has recommended enhanced efforts to assure timely vaccination of all children and to provide at least one booster dose to Td vaccine to all adults. Russian collaborators within the SCSES are currently considering implementation of these recommendations. They have requested continued CDC assistance in controlling this outbreak; at the moment AID is making no monies available to allow the continuation of collaboration in this critical area.

Three cases of diphtheria are known to have occurred among western travellers to Russia. All travellers, including members of the Presidential entourage should assure that they are appropriately vaccinated against diphtheria, as recommended in CDC Travel Advisory Memorandum No. 105. A Td booster should be given if 10 or more years have elapsed since completion of a primary series of the receipt of the last diphtheria toxoid-containing booster dose.

B. Health Reform

The current health care delivery system continues in flux and ambiguities and uncertainties exist in the areas of health care financing, responsibility for oversight for provision of some essential as well as adjunct services, supply lines for critical vaccines and essential drugs, etc.

Crucial to achieving stability in public health and to assuring the system's ability to rapidly identify and control evolving problems and continue to focus essential preventive services is a well functioning health surveillance system. The current system acutely lacks the ability to analyze and interpret available data and make sound decisions for interventions based on that data in a relatively rapid fashion. CDC efforts in attempting to strengthen public health surveillance in Russia have only scratched the surface in attempting to inculcate western approaches to public health. These efforts must continue and our Russian counterparts are warmly

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receptive to a continuation and expansion, beyond infectious diseases, of this collaboration.

C. Environment Health

Environmental health problems are plentiful throughout Russia. We would suggest that technical assistance be provided at the outset to assist Russian health authorities in dealing with such critical issues as radiation contamination, heavy metal toxicity, the overabuse of pesticides and the maintenance of safe water supplies.

Robert J. Baldwin

December 10, 1993

MEMORANDUM FOR KIM TILLEY

From: Amanda Crumley
Re: Russia Health Overview

Russian Health Care

A 1992 report by the Russian Government found the Russian Federation health care system to be generally very poor in condition and medical equipment and supplies deficient.

As of 1991, a study showed that there were 10, 879 general hospitals, 1186 specialized hospitals, and 574 medical centers in Russia. However, 12% of these hospitals have no central cold water supply, 42% have no hot water, 18% no central sewage, and 12% no central heating. Most of these deficiencies are due to lack of funding.

Health care in Russia has been financed by the state for years, with 3.4% of the state budget allocated for its development. This figure dropped by almost 50% in 1992.

Beginning in 1992, an effort to improve this situation was initiated by distributing the federal health care budget among the territories of Russia. In many cases, local authorities increased the budget by allocations from their own budget.

A medical insurance system was instituted in Russia on January 1, 1993. Although the system is having extreme difficulties in taking off because of low funds and a shaky administrative infra-structure, it has had an impact on Russian health care and the medical industry in theory because it entails a massive restructuring of the entire health care system.

The restructuring of the health care system begins with the establishment of modern standards in medical diagnostic centers and would place more focus on health care institutions.

(Source: *Russia - Diagnostic Equipment*, National Trade Data Bank, April 14, 1993)

Environmental Concerns

Dire environmental conditions in Russia have contributed to a generally unhealthy atmosphere. The air and water are heavily polluted especially due to radioactive pollution and nuclear testing. These factors cause Russia to have an increasing infant mortality rate.

(Source: Vice President Gore's Russia briefing book.)

Russian Dental Care

After the collapse of the Soviet Union, the major supplier of dental materials, Stoma Association, cut down on supplies to Russia. However, four such suppliers recently opened in the city of Voronezh producing such dental materials as porcelain mass, cement, wax, and molding materials. This is helping to turn around the shortage of adequate dental supplies in the country.

(Source: *Rainbow Over Russia*, Russica Info. Inc., April 7, 1993)

In Kiev, the Antonov aircraft maker has begun manufacturing dental equipment and materials for the production of dentures. The dentures meet the high standards of other foreign made products.

(Source: *Aircraft Builders Help Dentists*, Russica Info. Inc. , Sept. 29, 1993)

In St. Petersburg, a city dental center has opened and is equipped with Siemens equipment to update previous facilities. The center can see up to 100 patients per day.

(Source: *Siemens Equips St. Petersburg Dental Center*, Rueter Textline Novecon, May 19, 1993)

Additional notes on Russian Health Care

1. Russia has more primary care givers practicing than specialists; as you know ratio in the United States is the opposite.
2. Two parallel structures oversee health care in Russia, the Ministry of Health and the State Committee for Sanitary and Epidemiological Surveillance. The Ministry of Health deals with curative, primary, and preventive services and the State Committee is structured to research and collect data on diseases, developing immunization policy, and ordering the vaccines. However, the immunization policies are implemented by the Ministry of Health who report to the State Committee on a monthly basis. The State Committee also regulates environmental issues and they oversee the sanitary practices of public places such as restaurants.
3. Belarus is run strictly by the Ministry of Health. Their Ministry of Health oversees everything that the State Committee normally would.
4. Russian hospitals have some practices that Americans might find very strange. For example, "speliotherapy", a method for treating respiratory problems involves locking a patient in a dark stone-walled room with dirt floors for a few hours to a few days depending on severity. They also have some strange treatments for vitamin deficiency such as oxygenating egg yolks and food dyes for patients to drink.
5. The most frequent problems with prenatal care are iron and vitamin deficiency. American doctors who have been to Russia also believe that there are numerous cases of "rickets" which is caused by lack of sunlight.
6. Most of the Republics have a hard time getting basic medical supplies such as needles, syringes, and protective vaccines because they lack the hard currency to buy these products.
7. Russia has seen a rapid increase in congenital birth defects since the Chernobyl accident in 1985. In 1990 and 1991, an increase in thyroid cancer has been noted.

NATIONAL SECURITY COUNCIL

30-Dec-1993 13:56 EDT

UNCLASSIFIED

MEMORANDUM FOR:

VAX MAIL@OEEOB
POTTS@A1@OEEOB
BURNS@A1@OEEOB
BEYRLE@A1@OEEOB

FROM: White House Situation Room
(WHSR@A1@WHSR)

SUBJECT: PRESIDENTIAL ADVANCE TEAM VISIT

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PRT: ITOH KENNEY LUFRANO SIT{C2} WALLEY
": BEYRLE BURNS FILE POTTS SUM2 VAX
(EC)

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RHEHAAA/WHITE HOUSE WASHDC IMMEDIATE

<SUBJ>

PRESIDENTIAL ADVANCE TEAM VISIT

<TEXT>

UNCLAS MOSCOW 039886

STATE FOR S/S, S/CPR, A/TSS (BULL), S/NIS, EUR/ISCA
WHITE HOUSE FOR ANNE WALLEY AND MIKE LUFRANO; ALSO FOR
FOR WILLIAM ITOH AND NICK BURNS
E.O. 12356:N/A

TAGS: OVIP, (CLINTON, WILLIAM JEFFERSON), RS

SUBJECT: PRESIDENTIAL ADVANCE TEAM VISIT

1. RUSSIAN FEDERATION PROTOCOL DELIVERED A LETTER TO T
EMBASSY TODAY FOR MRS. CLINTON FROM MRS. YELTSIN.

OFFICIAL EMBASSY TRANSLATION OF TEXT FOLLOWS:

IN TEXT

MRS. HILLARY CLINTON

DEAR HILLARY:

I WANT TO CONGRATULATE YOU, YOUR FAMILY, AND ALL THE
CITIZENS OF THE UNITED STATES OF AMERICA ON THE OCCASIO
OF THE CHRISTMAS HOLIDAYS AND TO WISH YOU ALL THE BEST

1. ADDS

2. H.C. Forum

copy
Melanne

THE COMING YEAR.

THIS YEAR HAS BROUGHT A LOT OF NEW THINGS, AND I WOULD LIKE TO NOTE SPECIFICALLY, GREAT POSITIVE CHANGES IN THE RELATIONS BETWEEN OUR PEOPLES, BETWEEN RUSSIA AND THE UNITED STATES OF AMERICA. THESE CHANGES AFFECT ALL THE SPHERES OF COOPERATION, SUCH AS CULTURAL, BUSINESS, AND SOCIO-POLITICAL.

THE PERIOD IN WHICH THE RUSSIAN PEOPLE NOW LIVE CAN BE CALLED HISTORIC WITH ALL CONFIDENCE. STRUCTURAL CHANGES ARE TAKING PLACE IN THE LIFE OF RUSSIAN SOCIETY, AND THE ASSISTANCE GIVEN BY THE AMERICAN GOVERNMENT AND THE AMERICAN PEOPLE DESERVES THE HIGHEST APPRECIATION. YOUR HUMANITARIAN ASSISTANCE SUPPORTS ECONOMIC REFORMS AND THE DEVELOPMENT OF MARKET-BASED RELATIONS IN RUSSIA IN TIMES THAT ARE DIFFICULT FOR US.

THIS YEAR, THE UNITED STATES RANKED FIRST IN THE VOLUME OF INTERNATIONAL HUMANITARIAN AID TO RUSSIA: OVER 90 PERCENT. THE FUNDS RECEIVED WERE CHanneled TO IMPLEMENT DIFFERENT SOCIAL PROGRAMS, INCLUDING THE SOLUTION OF THE HEPATITIS C PROBLEM, ACQUISITION OF MEDICINES, SUPPORT FOR THE NEEDY, AS WELL AS CREATION AND STRENGTHENING OF NEW (FOR RUSSIA) TYPES OF AGRICULTURAL MANAGEMENT.

PLEASE PERMIT ME TO EXPRESS MY SINCERE GRATITUDE FOR YOUR INTEREST IN OUR HEALTH-CARE PROBLEMS, AND ONCE AGAIN TO WISH YOU HAPPINESS AND SUCCESS IN THE COMING YEAR.

I LOOK FORWARD TO MEETING YOU IN MID-JANUARY.

N. YELTSIN

END TEXT

2. SIGNED ORIGINAL (IN RUSSIAN) WILL FOLLOW BY POUCH.
PICKERING

BT

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8

PUBLIC HEALTH ISSUES & REFORM IN THE NIS

Statement of the Problem. NIS governments face major challenges to providing and financing healthcare services for their populations within rapidly changing political, economic, and social environments. Health status is poor and likely to be worsening. Health systems are plagued with problems in delivery, management, and financing. In addition, policy-makers lack necessary information and tools to institute corrective actions.

Information on health status in the NIS is sparse and sometimes conflicting. Additionally, given the varying conditions throughout the region, generalizations may be misleading. What is clear, however, is that health indicators for the NIS do not compare favorably with developed countries. Although life expectancy rates are comparatively high, the rate for males has decreased over the past decade. Adult cardiovascular disease and cancers are major problems, resulting from poor dietary practices and heavy use of alcohol and tobacco. Acute respiratory infections and perinatal morbidity account for 60 percent of infant mortality. Modern methods of family planning are not widespread, and inadequate information and supply of contraceptives contribute to high rates of abortion. Disturbingly, recent news reports document outbreaks of diphtheria, cholera, and other infectious diseases. Contributing to the health problems are chronic inefficiencies within the health systems. These systems are characterized by long average lengths of stay in hospitals, an oversupply of inadequately trained medical personnel, an excessive number of hospital beds, outdated medical practices, antiquated and broken-down equipment, and chronic shortages of drugs and supplies.

A number of factors lead to these inefficiencies and poor health status. First, there is a shortage of personnel, institutions, and systems with which to operate efficiently, including trained management personnel, third-party payors, private providers, and policies and programs to ensure quality of care. Second, there is a shortage of qualified personnel for analytical and planning functions, at both sectoral and facility levels. Third, health sector policy-makers have been thwarted by the rapidly changing rules of the game, contending with shifts from planned and centralized to market and decentralized economies. Fourth, there is a desire (if not a mandate) to change quickly to an insurance-based financing system, without a full understanding of what that means or entails. In sum, the NIS does not have the institutional capacity with which to diagnose problems, propose solutions, design and test programs, or implement reforms.

Technical Constraints. A key technical constraint to health policy reform is a lack of knowledge on the part of decision-makers. This void is both specific (e.g., unfamiliarity of insurance concepts) and general (e.g., misunderstanding of how market systems work). A related constraint is inappropriate legislation or policies that can impede progress; these may result from a desire for progress based on inadequate knowledge as cited above, or they may be a residue of the central planning approach.

Policy reform is also hindered by the absence of management and reporting systems, such as information systems to enable providers to manage their operations and accounting to enable consumers and providers to carry out financial transactions efficiently. Related to the inefficient systems is the ability to monitor and control quality of care, which poses difficulties in two ways: first, consumers lose confidence in the health system and despair of its improvement; second, a poor level of quality has important ramifications for health status itself.

Lastly, the success of policy reforms in the NIS is constrained by a paucity of experience with competition and free-market mechanisms. As indicated above, policy-makers may have the best intentions to improve health policies, programs, and operations; however, without exposure to or experience with the systems to which they are trying to shift, the reform process is likely to be tedious and ultimately unsuccessful.

Non-Technical Constraints. There are also a variety of social, geographic, political, and cultural constraints to health sector policy reforms and program implementation in the NIS. First, there is a misunderstanding of the incentive concept, since previous experience traditionally did not relate to improvements in quality or efficiency. Second, the geographic, political, and cultural diversity across countries may constrain the replicability of policies and programs. Third, the NIS is a unique environment and differs significantly from countries in which A.I.D. has traditionally worked; thus, the experiences acquired in those countries may not be directly relevant.

Fourth, as with anything new or different, there are many fears and misconceptions regarding the functioning of the market, by both policy-makers and the general public. These fears, in most cases unfounded, can derail policy reforms. Fifth, models of how things can and do work elsewhere may not be germane; in many respects, the populations of the NIS may have a fatalistic perspective, assuming that since they rarely have seen services provided efficiently in any sector, health sector services cannot be improved.

Rationale for Intensive Site Activities. Since the mid-1980s, the health systems of the NIS have experienced an uneven process of horizontal and vertical decentralization. While the concept of decentralization is appropriate for countries as large and diverse as the NIS, the rapidity of the transformation has created a number of problems that can undermine the desired objectives of the process. These problems include the inability of local authorities to handle their added responsibilities and the unfamiliarity on their part, as well as in the emerging private sector, with basic concepts such as insurance and market-based incentives. An additional problem is the passing of laws at the national and local levels that are obscure or actually contradictory on important issues.

While the rapid and uncontrolled process of decentralization has created problems in the health sector, it also has provided an excellent opportunity for innovation. Decentralized units, such as oblasts, can take advantage of the inconsistencies in the laws and regulations to find workable solutions, allowing them to serve as laboratories for reform, much as the states do in the U.S.

Intensive site activities (ISA) will assist local authorities and entrepreneurs to implement promising reform efforts quickly. This will contribute to a more rapid pace of reform by helping them to discard unworkable approaches and to learn from the most promising approaches implemented. The purpose of ISA is to generate activities rapidly that will increase economic efficiency, improve the quality of care, increase access to providers, and expand consumer choices. The vehicles for achieving these results include developing human capacity at the local level; developing training capabilities to extend training beyond the immediate locality; providing rapid and appropriate TA to address pressing needs and to develop intensive site programs that ensure sustainability; implementing and evaluating innovations with replicability in mind; and disseminating findings within and outside the region.

Background on Privatization of Medical Insurance. With a joint population of over eight million, the neighboring oblasts of Moscow and Yaroslavl represent one of the most active regions of Russia in the area of private insurance. Russia's first private life and health insurance company, Tandem Insurance Co., was founded in Yaroslavl. The site also serves as the home base of the Russian Association of Medical Insurers (RAMI), comprising 70 insurance companies operating in all the regions of Russia. Here, as in other regions in the NIS, laws governing health finance and insurance have emerged that provide the framework for private health insurance. In Yaroslavl, the law governing insurance allows private insurance companies to be involved in both compulsory and voluntary health insurance.

The constraints and problems facing the privatization of health insurance are due to the speed of the transformation and the lack of knowledge on the part of the public sector and new and emerging private companies. The scope for improvements in the reform process is broad, covering all aspects of health insurance. The Abt team will identify and manage constraints stemming from (1) the laws governing insurance; (2) the inexperience of local authorities in enforcing these laws, analyzing their implications, monitoring and evaluating their performance, and reforming them; (3) the inexperience of the developing private sector; and (4) complementary activities (e.g., property laws, contract enforcement, capital markets, banking).

Health Care Delivery Reform in Kemerovo Oblast

This site activity is aimed at improving the quality and efficiency of health service delivery in Kemerovo through intensive, focused training, technical assistance, and development and implementation of management systems at key health facilities. Kemerovo, a coal producing,

industrial oblast in western Siberia, is recommended as one of the activity sites because its health establishment has already shown an interest in reforming health care service delivery and financing arrangements and because it is the focus of health financing reform under A.I.D.'s Privatization and Development (PRIDEV) project.

Despite some recent financing reforms, Kemerovo's healthcare system, like the systems in most regions of Russia, continues to be plagued by low quality of care, outdated facility management practices, lack of financial and cost accounting systems, and absence of incentives for providers to control resource use or for consumers to moderate their use of healthcare facilities. At the same time, the health system is inundated by excessive respiratory, blood, and renal ailments associated with the uncontrolled air and water pollution spewed out by Kemerovo's over 100 factories. Before Kemerovo and other NIS health systems are able to respond to the incentives embodied in market-oriented reforms and improve the quality and quantity of care, their health authorities, hospital and polyclinic managers, and even consumers will require new skills and attitudes. The team therefore also will provide targeted training and TA to impart an understanding of incentive-based healthcare financing, create improved operations and financial management systems, and develop public education campaigns on the new roles and responsibilities of healthcare providers and consumers.

SAMPLE Activities

Quality Improvement. Objective: improve and manage quality of services to achieve better health outcomes and meet requirements of third-party payors. The team will guide polyclinic and hospital managers in the creation and application of standards, accreditation, record reviews, and outcome measures; use a locally formed committee of health experts to work with team advisors on development of achievable standards, given local conditions and resources; develop local capacity to provide facilities with assistance in standards development and accreditation; and use standards as a key tool in training for quality improvements.

Private Management Reform. Objective: increase facility responsiveness to market forces and incentives; increase quality and efficiency of services. A key aspect will be to instill facility management with market system concepts of supply and demand, competition, consumer satisfaction, and efficiency. With this base the team will introduce systems for personnel management, consumer utilization incentives, and facility marketing.

Financial Management and Facility Administration. Objective: introduce and install tools to respond to incentives for increased efficiency of healthcare delivery. The tools will include systems to promote cost containment, ensure financial accountability, and manage patient appointments. Introduce basic concepts of financial and cost accounting, and develop appropriate financial management information systems for implementation. Conduct initial costing studies, develop a costing book, and create financial management systems (for budgeting, billing, and payments management).

Insurance Claims and Other Third-Party Billing. Objective: increase facility financial sustainability and the efficiency of revenue collection. The team will develop in target facilities the capacity to negotiate contracts with insurers and enterprises; create systems to bill and track late payors among private insurers, enterprises, the Hospital Casse, and individuals.

FAX: (202) 456 6527 / 6485-
(10 pages including cover page)

TO: Ms Amanda Crumley, The White House, Washington, DC

FROM: Richard Moore, VP of the International Division, John Snow, Inc.,
1616 No. Ft Myer Drive, Rosslyn, VA., 22209
[fax: 703 528 7480; tel: 703 528 7474]



DATE: 10 January 1994

SUBJECT: Information on Public Health Issues in the Newly Independent States of the
Former Soviet Union

The President of JSI--Mr Joel Lamstein--asked me to fax you some summary information on subject topic. He said it was urgent. I am sending some items that we had in our files about work that JSI is involved with: mainly in the areas of immunization, health care finance, and service delivery reform. I hope you find this useful. Please feel free to call me if I can be of further assistance.

cc: Joel Lamstein

GENERAL OBSERVATIONS

Although improvements in technical quality will greatly improve health status, sustainable clinical improvements in a decentralized health system will require that revenues are generated through health insurance and out of pocket expenditures by consumers. Having to pay for services that were once free will increase the importance of patient satisfaction. This *quality of care as perceived by patients* will be addressed through a number of initiatives that will seek to assure the availability of drugs at the primary care level, improve training and "service orientation" of primary care providers, and develop a referral system that will give patients the confidence that they will be moved to a higher level of care given medical need.

Perhaps the most difficult challenge to increasing both the perception and the reality of patient care quality will be the severe shortages of pharmaceuticals and medical supplies. Production of drugs and medical consumables have fallen drastically in the recent past due to out-moded equipment, very poor maintenance and repair, and difficulties in obtaining raw materials. In addition, the mix of products made locally did not cover the full range of medical problems treated. Previous sources of imported drugs and supplies have become problematic due to changed relationships with Eastern Block suppliers and lack of foreign exchange.

Permanent solutions to this supply problem are only possible in the long term through changes in policies that promote local pharmaceutical investment and production and ensure the rational importation of externally produced products made possible through an increase in available hard currency.

In the short term, the problem can be somewhat mitigated through individual facilities using newly-generated revenues for the purchase of imported products. In this example, the necessity of a combined financing/management/clinical approach is clear. Policies and financial mechanisms are needed to provide revenues that may be retained by the facilities; management and clinical systems that improve quality of care must be implemented; and patient satisfaction must be assured to maintain a continuous flow of income that will finance these improvements.

Symptomatic of the breakdown in the health care delivery system is the overuse of tertiary care facilities and resources by patients who should be treated at the primary care level. Typical influences of more drugs and resources at the tertiary level are magnified in the NIS by the perception of poor quality in primary care providers.

Reductions in the use of tertiary resources and increased use of primary care providers will achieve cost and clinically effective care, but not through a simple transfer of resources from one level to another. This imbalance must be addressed by strengthening primary care services without diminishing the quality of tertiary care services. Again, this is accomplished through a combined financing/management/clinical approach. Clinical improvements at the primary level will be accomplished through the use of training and TA, while financial policies and management systems will increase the resources available at this level to sustain the clinical improvements. Improved referral patterns will be developed and maintained with both clinical controls and financial disincentives for bypassing the system.

This improved referral system must be approached not only from the perspective of filtering patients into lower, appropriate levels of care, but must also be implemented in the other direction with clinical advice, consultation, and training flowing from the tertiary to the secondary and primary levels. This integration of the different tiers of the health care system into a team approach will achieve both cost savings and increase clinical efficiency.

Improvements at the primary care level also will be critical for the delivery of preventive care services. Improving the clinical effectiveness and financial soundness of primary care providers will contribute significantly to the ability of these providers to deliver preventive services such as health and nutrition education, vaccinations and communicable disease control.

As with pharmaceuticals, production and supply of vaccines can only be improved over the long term. In order to prevent a medical catastrophe, however, steps must be taken in the near term to mitigate the situation. Improving the operations and sustainability of primary care providers is an important step, but increasing the supply of vaccines is equally critical. As a stopgap measure in support of TA and policy development assistance to increase production, improvements must be made in the logistical system used in channeling donor vaccines and existing local production to primary care centers.

Medical manpower utilization is another factor in which disequilibrium is detrimental to the functioning of the health delivery system. The oversupply of physicians during the "9 to 5" working hours results in little work being done by any of those present (or not present, as many simply do not show up). In contrast to this is the understaffing that occurs nights, weekends, and holidays. Patient care suffers because of poor and erratic coverage, and the cost of care is excessive due to an oversupply of staff. The first part of the approach will be TA in developing improved staffing plans and guidelines, and incentives for appropriate coverage levels on a 24 hour basis.

Although health facility management improvements will be integral to all of the above solutions, special attention will be focussed on improving the management capabilities of facility directors. In the short term, TA and training will be used to improve the skills of existing facility directors and management staff. In the long term, however, the approach will differ.

Many or most present problems with facility directors stem from the fact that they lack management training. This is not limited to formal training, but is also a lack of any "apprenticeship" or on-the-job training. The root cause of this is the present practice of selecting directors from the clinical ranks. What this means is that high achievers in the clinical area rise through the clinical system only to be pulled away from this area and placed in management roles.

The approach to this problem will be the development of defined career paths through management positions. Rather than trying to force change by placing management trained individuals in the director position of the facility (as has been tried unsuccessfully by several countries attempting to convert from physician directors to professional hospital

**Summary of USAID
Involvement in Immunization
in the NIS, 1992 - 1993**

Childhood immunization is widely regarded as the most cost-effective of all health interventions. Every dollar spent on immunization prevents disease, disability and death, while at the same time saving additional dollars in direct health care costs and lost productivity. Immunization is one of the best investments that families and society can make -- whether in the USA or in the New Independent States (NIS) of the former Soviet Union.

In March 1992, the United States Agency for International Development (USAID) assessed the needs of the immunization services in the Central Asian Republics of the NIS to determine whether assistance from USAID's Office of Foreign Disaster Assistance (OFDA), Office of Health, and NIS Task Force was required and, if so, where and how this assistance should be targeted.

A team from USAID's Resources for Child Health Project (REACH, managed by John Snow, Inc.) and the Centers for Disease Control alerted the US Government to the fact that a public health disaster was imminent: immunization coverage rates were falling due to vaccine shortages from traditional suppliers in Russia, and children were threatened with outbreaks of such vaccine-preventable diseases as diphtheria, pertussis (whooping cough), polio and measles.

In the past, the Soviet Union had achieved high levels of immunization coverage among children, and the incidence of infectious diseases of childhood had been reduced to low levels. However, with the dissolution of the Soviet Union and disruption in trading and banking, the new states found themselves unable to obtain vaccines from their former suppliers in Russia. During this period of transition, children were at increasing risk from preventable diseases which had largely been controlled. The reappearance of these diseases was seen as a demoralizing and potentially destabilizing factor.

As a result, USAID determined to reverse this process by launching an emergency immunization support program in the spring of 1992 in Kyrgyzstan, Turkmenistan, Tajikistan and Uzbekistan in order to avert disease, disability and death from vaccine-preventable diseases. These countries were found to be the most needy and to have the most precarious health status.

Assistance included the supply of vaccines to permit the primary immunization of more than one million children. While averting the deaths of thousands of children, these vaccines also prevented the collapse of the health service, which was on the verge of atrophy for want of commodities.

In addition to the vaccines, the assessments resulted in a USAID donation of nearly one million dollars of cold chain equipment to ensure the safe storage and transport of heat-sensitive vaccines. The cold chain refers to the equipment, procedures and staff involved in the storage, transport and distribution of vaccines at appropriate temperatures.

USAID learned that to be technically relevant, the quantity and type of commodities must be determined rapidly in the field based upon need. To do otherwise is to risk alienating or, worse, offending the recipients.

A technical exchange process was initiated to respond to the immediate emergency, strengthen and modernize the immunization service, and reduce future dependence on external support. While some variations occurred depending on need, each country received a balanced package of technical assistance covering program planning, policy reform, procurement, training, cold chain repair and maintenance, management information systems, and materials translation and adaptation. The scope of this technical assistance was unprecedented in USAID's standard emergency humanitarian response.

USAID was able to assist the Ministries of Health to plan for the use of the donated commodities. Training was provided to bring some practices - e.g., vaccine handling -- up to international standards. The donated cold chain will last long after the emergency is over and help to ensure that children are protected with potent vaccines. The cold chain will result in less vaccine wastage, which translates into less dependence on external donations. Spare parts for the cold chain and repair tools were also provided, as well as training in cold chain repair and maintenance.

USAID-assisted workshops on immunization policies resulted in the countries streamlining their immunization schedules, so that immunization could begin and end earlier in life with fewer contacts and fewer doses of vaccine. This will reduce inefficiencies and lead to reduced requirements for vaccine. The above-mentioned technical activities, coupled with the donations, helped to ensure that the commodities were appropriate to the needs and that the ability of the system to cope in the future was strengthened.

USAID's emergency immunization support program in 1992 assisted the countries to maintain immunization services and began the process of change. In 1993, the USA joined forces with the Government of Japan in a Joint Immunization Initiative. Through this coordinated effort, further assistance has been provided in Turkmenistan, Kyrgyzstan, Georgia and Moldova to consolidate and expand on the gains made. The support in 1993 alone has included:

- providing more than \$2.5 million of vaccines and additional commodity support
- ensuring that the countries have sufficient vaccine in 1993 and beyond for primary immunization of all their children
- developing a "vaccine safety net" which provides timely warning of impending shortages to the international community
- assisting in the development of a cold chain which links vaccine producers in Russia and the countries
- strengthening of cold chain practices, repair, and maintenance and developing training materials for this purpose

- providing technical assistance on immunization policy formulation and program modernization
- organizing multi-donor joint planning exercises with WHO and UNICEF to develop operational plans for comprehensive national immunization programs.

In conclusion, USAID has learned that it is possible to craft a rapid, timely and targeted technical response based on field-assessed needs which both meets the emergency humanitarian requirements as well as enhances the capability of health services to deliver immunization in the long-term.

Indeed, emergencies can be used as an opportunity to advance development:

- No distracting campaign-style immunization was advocated, despite the temptation to do something "glitzy" and highly visible. The routine system in place in these countries was more than adequate to reach the population.
- High-quality technical input was able to counteract the all-too-frequent knee-jerk "push" mentality which governs emergency response.
- Equipment and commodities were selected so that something would be left behind: e.g., cold chain equipment and steam sterilizers. On-the-ground technical assistance was provided to make appropriate use of these donated items.

The needs within the NIS are large and no one donor can do it all. However, the coordinated response of donors and agencies, such as USAID, the Government of Japan, UNICEF and the World Health Organization, is helping to ensure that the total needs will be met. The people and the governments of these New Independent States appreciate this concrete humanitarian support from the USA.

01/07/84 15:10 0107 750 7000 HIS COORDINATION

Subject: Mrs. Clinton visit to Savior's Hospital #70/Moscow

1. On 12 November 1993 the USG completed a major humanitarian effort in Moscow by upgrading ten hospital/dental facilities. This project was in response to a commitment President Clinton made to President Yeltsin during the Vancouver Summit. The donation included providing 400 containers of medical equipment and supplies valued in excess of \$36 million. A team of approximately 50 military personnel from the Army's 7th Medical Command from Heidelberg, Germany completed this project.

2. One of the 10 facilities was Savior's Hospital #70, an 1100 bed OB-GYN Hospital affiliated with Magee-Women's Hospital of the University of Pittsburgh Schools of Medicine and Nursing under the AID funded Hospital Partnership Program. The Partnership focus is on Maternal and Child Health Birthing House Operation, Consumer and Community Education, Health Care Administration and Consumer and Community Education. There were 32 containers of medical equipment and supplies valued in excess of \$3 million delivered to Savior's Hospital during this project. Included were 300 new beds, mattresses and associated linen, sterilizers, X-Ray equipment and supplies, anesthesia machines, 8 critical intensive care beds, surgical equipment and supplies, wheel chairs, ward furniture and supplies etc.

3. Another facility that received assistance was a dental facility. A request by Mrs. Yeltsin to provide dental material resulted in the donation of 11 containers of dental equipment and supplies that were installed in the Central Research Institute of Stomatology inpatient and outpatient facilities. Included in this project were dental chairs and operatories, X-Ray, sterilizers, beds/mattresses and linens, dental surgical instrument cabinets and tables, electrosurgical apparatus, dental lights, compressors, dental laboratory equipment and supplies. Estimated value was \$1.5 million.

July 6, 1993

Dear Mrs. Yeltein:

I am writing to say I very much look forward to our first meeting in Tokyo next week. We share common interests and concerns which I am eager to discuss with you.

I was honored to be asked to share with you the position of Chair of the new American-Russian Youth Orchestra. I hope you will agree that bringing together the talents of young people from both our countries in such a valuable program will enrich their lives and promote new and deeper ties between our two countries. American children will benefit greatly from their exposure to Russia's rich musical heritage.

I am well aware of your deep and longstanding concern for improving the health and well-being of Russia's children. I, too, share your concern for health care of all children. I am delighted to tell you we have assured that your request to Ambassador Richard Armitage last December for U.S. assistance to improve dental care for Moscow's children soon will be met. As we can discuss further in Tokyo, I understand that as a direct result of your appeal, plans have been made to deliver American equipment for two dental clinics in August. I hope that the new equipment and supplies which will be delivered to the Moscow Central Research Institute will improve the quality of care for many of the children in Russia who are not now able to receive adequate treatment.

I look forward to meeting with you soon to discuss these and other mutual interests.

Sincerely,

/ s /

Hillary Rodham Clinton

AMB:TRPickering:PCT#636

Moscow, Russia

July 6, 1993

Dear Dmitriy Borisovich:

I have the honor to transmit to you the enclosed letter from Hillary Rodham Clinton to Mrs. Naina Yeltsin regarding the issue of children's dental care in Moscow.

Sincerely,

James F. Collins
Minister Counselor

Enclosure:

Letter from Hillary Rodham Clinton

Dmitriy Borisovich Ryurikov,
Presidential Foreign Policy Advisor,
The Kremlin,
Moscow, Russia.

EXEC:LMoore
DCM:JFCollins
Cleared:MED:PGrundy

A B R O A D

Health Care and Public Health in the Former Soviet Union, 1992

Ukraine—A Case Study

Richard G. Farmer, MD, MS; Richard A. Goodman, MD, MPH; and Robert J. Baldwin, BA

■ The dissolution of the Soviet Union created many problems for the health care systems of the New Independent States (NIS). To address these problems, the U.S. Secretary of State convened a coordinating conference in Washington, D.C., on 22–23 January 1992 at which more than 50 nations and organizations were represented. After this conference, an expert medical working group visited 10 republics of the NIS during February and March 1992. Hospitals, public health facilities, and pharmaceutical plants and distribution sites were visited to assess the health care needs of a large population in a vast geographic area. It was concluded that the massive health care system of the Soviet Union remains largely intact but has major economic and supply deficiencies. The assessment process and findings in one republic, Ukraine, are presented. Ukraine was chosen because of its size, location, and representativeness.

Ann Intern Med. 1993;119:324–328.

From the U.S. Agency for International Development, Washington, DC; and the Centers for Disease Control and Prevention, Atlanta, Georgia. For current author addresses, see end of text.

The dissolution of the Union of Soviet Socialist Republics during late 1991 initiated a sociopolitical transformation affecting approximately 300 million persons. The changes substantially disrupted essential social and health services (1) in each of the republics. To address needs for urgent humanitarian assistance to the former Soviet Union, the U.S. Secretary of State convened an international coordinating conference in Washington, DC, on 22–23 January 1992. The conference established priorities for assistance in the areas of health, shelter, energy, food, and resources. An expert medical working group was charged with assessing the health care needs in 10 republics of the New Independent States (NIS). These republics included Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Ukraine, and Uzbekistan.

Composed of 30 health care professionals (representing 14 countries and 6 international organizations [Appendix]), the group visited 10 republics between 27 February and 31 March 1992. Assessments were made in four categories established as priorities: 1) emergency medical needs; 2) the feasibility of developing hospital

partnerships; 3) the need for pharmaceutical products, vaccines, and medical supplies, as well as the feasibility of privatization and joint ventures to restore pharmaceutical production; and 4) requirements for technical assistance in management and financial planning in health care services.

The working group was organized into the following three subgroups: hospital–health care; public health; and pharmaceutical production. We describe the findings of our assessment in Ukraine, which serves as a case illustration of the need for assistance to the health sectors of the CIS. We hope the description of the health care and public health system in the former Soviet Union gives internists and other health care professionals who provide assistance to the NIS a basic understanding of this rigid and complex system.

Background

Health Care System of the Former Soviet Union

The republics of the former Soviet Union are highly centralized with well-organized health care systems and large numbers of health care workers (2). In the past, the Ministry of Health administered the budget from the center to the periphery through the republic, *oblast* (state), *rayon* (district), and city levels. (The population of a *rayon* varies from 40 000 to 150 000 persons, and 10 to 50 *rayons* compose an *oblast*.) In theory, the entire population had access to all health services free of charge. Until 1991, health care facilities were allocated fixed amounts of money based on the number of hospital beds and polyclinic patient visits. Because of the inherited rigidity and hierarchical organization of health care services, the basic system has remained largely intact in each republic, despite the political dissolution of the Soviet Union.

Hospitals have been central components of the health care system and range in size from 1000 to 2000 beds in referral or “republican” level facilities, to 50 to 250 beds in regional and district levels. Polyclinics, which are frequently adjacent to hospitals, provide outpatient services to as many as 1000 patients per day. The Ministry of Health managed most of the hospital beds. Parallel health care systems had been created for the military, transportation workers, and the party elite. During 1991, there were up to 140 hospital beds per 10 000 persons in the Soviet Union, compared with 120 beds per 10 000 persons in the United States (3, 4). In addition, there were approximately 40 to 50 physicians

per 10 000 persons compared with 26 per 10 000 persons in the United States (4).

Profile of Ukraine

With 51.8 million inhabitants—of whom 17 million live in urban areas—Ukraine is the second most populous state in the NIS after the Russian Federation. The population density is 84 persons per km²; 8% of the population are younger than 5 years, and 18% are older than 60 years. Ukraine comprises 27 oblasts, which are subdivided into 477 rayons.

In 1989, the infant mortality rate was 13.6 deaths per 1000 live births (U.S. rate, 9.8 [4]). In 1990, life expectancy in Ukraine was slightly higher than that in the Russian Federation (70.5 years compared with 69.3 years, respectively but, as is characteristic of the NIS republics, both rates were substantially less than those of the European Community (76.3 years [3]) and of the United States (75.4 years [4]). The most common causes of death are malignancies, ischemic heart disease, cerebrovascular disease, and injury.

The overall ethnic composition of Ukraine has remained stable; ethnic distribution within the republic varies. In particular, western Ukraine is predominantly Ukrainian, whereas the rest of the republic is more ethnically diverse. Ukrainians account for 73% of the total population; Russians, 22%; and Jews, 1%. Approximately 40% of the Jewish population in the NIS resides in Ukraine.

The population of Kiev, the capital of Ukraine, is 2.8 million, of whom 640 000 are children and 700 000 are retirees. In addition to more than 12 000 physicians, basic health care resources in Kiev include 28 000 hospital beds; military and veterans hospitals meet the special needs of survivors of the Afghan war. Facilities in the rural areas of the *oblasts* (states) include small hospitals (that is, 20 to 50 beds), polyclinics, and the *feldsher* village stations (see below).

Excluding the city of Kiev, the population of the Kiev *oblast* is 1 175 000 (including 350 000 children). The region is served by 7500 doctors and has 25 000 hospital beds; in addition, there are six independent children's hospitals and 20 to 40 pediatric beds in each district hospital.

Unlike the newly independent republics in Transcaucasia and central Asia, Ukraine and Belarus have been autonomous republics, as well as members of the United Nations, for 40 years. Thus, the emergence of nationhood has been relatively unencumbered—particularly the development of a legislature and constitutional infrastructure. Even so, these advantages are counterbalanced by the rigidity of the hierarchy.

Health Care—Public Health Infrastructure

The following description of the health care—public health infrastructure in Ukraine and other republics of the former Soviet Union is a composite based on observations made during the assessment. The basic features of the infrastructure appeared to be similar in each of the 10 republics visited. Republics varied little in per capita numbers of physicians, hospital beds, hospital

admissions, and outpatient visits (3). The following description may facilitate understanding of other findings from the field assessment.

Basic Organization

Basic public health services are organized under the Ministry of Health at four levels: republic, *oblast*, *rayon*, and *feldsher* stations and ambulatory clinics (local). Core public health services include coordination of the activities of public health organizational components; procurement of vaccines for the republic; the monitoring of water quality (does not include assurance of high quality); and the provision of central laboratory reference services for microbiologic, parasitic, and food and water analysis.

At the *oblast* level, basic public health functions include management oversight for implementation of immunization programs within the *rayons*; laboratory support (serving as a reference laboratory for the *rayons*); and the microbiologic testing of food and water. Many clinical and public health services are available at the *rayon* level. These services are delivered through polyclinics, pharmacies, the *rayon* hospital, and the bacteriology laboratory.

The *feldsher* station is the basic unit of primary care at the village level and generally is staffed by two persons: the *feldsher*—a person with paramedic-like skills who has had 2 years of training beyond secondary education—and a midwife. Services provided through *feldsher* stations include the diagnosis and treatment of infectious diseases and other basic medical problems; immunization activities performed in conjunction with polyclinics and school-based delivery efforts; basic gynecologic care and initiation of family planning services; and well-child care (for example, growth monitoring). The *feldsher* station also serves as a worksite for consultant specialist physicians from the *rayon* hospitals.

Sanitary and Epidemiologic Stations

Services provided by the sanitary and epidemiologic stations are also organized within the Ministry according to the basic four-tiered system. The stations have two principal functions: 1) to carry out basic public health surveillance activities such as monitoring the occurrence of infectious diseases and implementing basic measures to control or prevent specific diseases; and 2) to order vaccines for appropriate health care units.

Maternal and Child Health

Maternal and child health care is provided through a well-developed system for prenatal, postpartum, and pediatric services. These services are provided through maternity hospitals in the republic, as well as other units at all levels of the system.

Methods

On their arrival in each republic, members of the expert working group generally first met with the Minister, Deputy Minister, and other senior officials of the Ministry of Health, as well as key program managers. These meetings helped to

Table 1. Information Sources for Assessments

Hospital-health care subgroup
District and Regional Hospitals
Chernigov and other locations near Chernobyl
District and regional hospitals in Kiev Oblast and Odessa Oblast
City Hospitals (>1500 beds)
Kiev
Odessa
Lviv
Specialty hospitals
Maternal and child health, Kiev
Otolaryngology, Kiev
Radiation, Kiev
Pediatrics, Odessa
Ophthalmology, Odessa
Other
Academy of Medicine, Kiev and Odessa
Polyclinics (500 to 1000 visits per day), multiple sites
Public health subgroup
Central level: policy and management
Deputy Minister of Health
Chief Sanitary Doctor of the Ukraine
Chief, Children's Section, Ministry of Health
Vice Chairman, National Red Cross (plus staff)
Middle level: management and providers
Chief, Kiev Regional Sanitary Station
Chief, Bacteriology Laboratory, Kiev Oblast
Chief, Epidemiology, Kiev Oblast
Kiev Oblast Red Cross Organizer
Bayaka Rayon Red Cross Organizer and Nursing Officer
Deputy Chief, Bayaka Rayon Hospital
Director, Kiev Street Children's Holding Center
Basic delivery level
Feldsher, Mikilski village, Boradanski Rayon
Population level
Pensioner living alone in Kiev
Family of 5, including two disabled persons, in Vishnyovy Town
Five street children (7 to 16 years old) in Kiev

clarify for the host officials the objectives of the assessment, provided the working group with an introduction to the health care and public health system, and facilitated organization of agendas for each subgroup. During all meetings and visits, interviews were conducted with the assistance of professional English-Russian interpreters who accompanied the working group, as well as by several members of the working group who were fluent in Russian.

In each republic, the hospital-health care subgroup conducted assessments in the following facilities: republican (that is, national) hospitals and referral centers; *rayoni* (that is, district) hospitals; specialty hospitals (for example, obstetrics, infectious diseases, and trauma and emergencies); local hospitals in both urban and rural areas; polyclinics (that is, multi-specialty facilities); rural polyclinics; and *feldsher* stations. At each facility visited, the group systematically assessed several factors: available services, staffing, medications and supplies; administrative and financial resource considerations; the credentialing and continuing education of personnel; and status of the facilities (including equipment). In Ukraine, the subgroup visited 15 hospitals and other health care facilities (Table 1).

The strategy of the public health subgroup was to examine all levels of the public health system in each republic by interviewing senior decision makers, program managers, service providers, and consumers (that is, the end-users of public health services). When possible, these interviews were conducted at each organizational level within the republic (including national, *oblast*, *rayon*, local, and general public) and within all categories of facilities in which public health services are provided (for example, administrative offices, hospitals, polyclinics, primary care clinics, and *feldsher* stations). The systematic collection of information was ensured through the use of a standard data collection outline of categories (for

example, infectious diseases, water and food safety and availability, maternal and child health, and health promotion and education). Information also was sought regarding environmental and occupational health, as well as other issues.

In Ukraine, information sources for the hospital-health care and public health subgroups included those at the central, middle, and basic delivery levels, as well as the Red Cross (see Table 1). In addition, we interviewed adults and children in village settings.

In the 10 CIS republics visited, the pharmaceutical subgroup assessed 16 production plants, 23 central distribution companies, and more than 45 pharmacy outlets and hospital pharmacies. The goals of the subgroup were to determine the short-term needs in pharmaceutical procurement, production, and distribution and the medium- to long-term needs in the pharmaceutical industry. The group clarified the systems of production, distribution, quality control, pricing, product planning, and drug policy, and it obtained information on drug supplies and policies relating to the distribution of humanitarian aid. At the conclusion of each meeting, the group provided information on the World Health Organization (WHO) essential drug list. At the production sites, the group evaluated the circumstances of production for conformity to the internationally recognized Good Manufacturing Practices.

Health Care in Ukraine

Policy

There was consensus among physicians in Ukraine that health care policy in the Republic must undergo fundamental change—possibly even privatization. At the same time, these physicians continued practices that had been standard in the former Soviet Union. The Chernobyl disaster imposed a substantial burden on this system because of the increased use of health care services.

Structure

The health system of the Soviet Union and therefore that of Ukraine was highly centralized; physicians managed all health care facilities. This enabled tight control but also uniformity of professional behavior, which resulted in some economies of scale and uniform planning. However, centralization resulted in a rigid bureaucracy, to which the Ukrainian physicians were reacting, and enhanced further the desire for change. The parallel systems of health care for the military and for the staff of large organizations (for example, factories, airlines, and railroads) detracted from the overall efficiency of the health-care system and led to inequitable access and allocation of resources.

Management

All health care facilities and services were managed by physicians, who used a "formula" approach that had limited flexibility. Sudden change afforded what one physician-manager characterized as "more freedom, but less money." In addition to the excessive supervision or and the poor information resources available to for managers, training in financial management for physicians has been limited. Thus, despite the positive outlook related to new freedoms, there was great concern regarding physicians' ability to manage—particularly on a day-to-day basis. Virtually all physician-managers adhered to the principle of free access for all health care

services and believed that their highly integrated system accomplished this aim; however, physicians were convinced that access might be impaired in the future.

Finance

Funding for specific health care facilities was determined using a formula related to the number of beds in a hospital and the number of visits in a polyclinic. Another factor in budget determination was the number of patients in a hospital at a given time, an incentive that compromised efficiency. There was no evidence that cost accounting principles were being used, thereby precluding cost/benefit comparisons of different processes and procedures, a factor of great concern for physician-managers.

Staff

The number of staff appeared to be adequate at most levels in the health services. In the context of overall employment policies, the efficiency and cost of health services would benefit from a thorough review of staffing needs as they relate to service provision.

Education and training in health professions in the NIS did not appear to equal that of other countries. The creation of professional associations that establish and monitor training courses and standards of practice is required where these do not already exist. Exchanges with similar institutions in other countries should be encouraged, and other measures (for example, engaging in personal exchanges, providing current literature, and assisting in language training) should be used to overcome the isolation of professional staff.

Public Health in Ukraine

Infectious Diseases

The system for collecting infectious diseases surveillance reports appeared to be intact. Reports at all levels underscored concern about recent increases in the occurrence of diphtheria (approximately 1100 cases in 1991); the incidence of diphtheria appeared to have increased substantially since about 1986 as a result of a planned modification of and decrease in vaccine potency as well as a greater reluctance on the part of parents to have their children vaccinated because of perceived side effects.

Bacille Calmette-Guerin (BCG) vaccine was in short supply (an estimated 1.5 million doses were needed), and measles and DTP (diphtheria-pertussis-tetanus) vaccine supplies were inadequate. Spot checks of stocks in refrigerators indicated that the storage and the management of some vaccines were not in complete conformance with WHO standards. However, supplies of antibiotics were reported to be adequate.

Water and Food Safety and Availability

Republic-wide, only 15% to 20% of water was being obtained from artesian wells, and the primary concern regarding water supplies was the pollution of surface water. Although there had been no recent reports of

bacteriologic contamination of drinking water in urban areas, public health officials requested equipment for and training related to water purification and monitoring.

Since August 1991, food costs had increased approximately 300% to 500%. Although food supplies seemed to be adequate—particularly in rural areas and in certain institutional settings (for example, schools and certain work environments)—access to food had been complicated because of the conversion of rubles to Ukrainian currency. Consistent shortages had been reported for some dairy products, and sugar was being rationed.

Maternal and Child Health

From 1985 through 1991, the infant mortality rate declined slightly (15 deaths per 1000 live births to 13.6 deaths per 1000 live births, respectively [3]), although WHO criteria had not been used to measure either these rates or those for premature births. Abortion was the most common form of birth control, and abortion rates reportedly approximated birth rates.

Most births occurred in hospitals, regardless of the mother's risk status. However, breastfeeding at the time of discharge varied substantially by oblast (from 27% to 80%). At the same time, infant formula was reportedly not available. Despite such problems, programs for pre- and postnatal health promotion for mothers and children were intact and appeared to provide broad coverage.

Vulnerable Groups

Groups considered to be most vulnerable with regard to health included elderly persons (>60 years old), large families, single parents, persons who lived alone, orphans, disabled veterans, displaced persons (for example, Chernobyl evacuees), and street children. Of the 13 million pensioners (approximately 25% of the total population), an estimated 2 million lived alone; although one fourth of these persons required daily social or medical assistance, only 150 000 received such care.

The Special Problem of Chernobyl

The health effects of the Chernobyl disaster in April 1986 were still evident 6 years after the mishap. Ramifications of this disaster were global (5), but obviously the primary effect was in the immediate geographic area. The disaster affected 19 of the 27 *oblasts* in Ukraine, as well as parts of neighboring Belarus. Since 1986, approximately 90 000 persons had been evacuated from a zone with a radius of 30 km from the reactor, and an additional 40 000 persons had moved from adjacent areas. Overall, an estimated 1.1 million persons, including 350 000 children, were affected in some way by the disaster (6).

The most severely affected persons were sent to Moscow for bone marrow transplantation and other treatment (7); however, fears about radiation have persisted (6). Cases of thyroid cancer have been reported recently

(8), and routine monitoring of thyroid function continues.

Discussion

Our findings were consistent with and substantially expand the information base provided in previous reports about the former Soviet Union and other Eastern European countries (for example, the Czech Republic [9]). For example, health care services in the Soviet Union, particularly those relating to public health and to the development and use of technology, had reportedly lagged behind those in the West (11). However, the patterns of diseases and other problems we found in Ukraine and in other republics of the NIS closely approximate those found in Western countries (12). Thus, there are the twin problems of public health and chronic illness, coupled with significant shortages of basic medicines and supplies. In Ukraine, these problems are further compounded by the effect of the Chernobyl disaster, as well as the disruption of supply networks after independence. Despite these problems, we found, throughout our visit, a spirit of optimism and a pervasive belief by health professionals in Ukraine and elsewhere that their problems were temporary.

After completion of the mission, a meeting of the Medical Working Group was held in Geneva, Switzerland, 30 April to 1 May 1992, and the results of this meeting were presented at the follow-up Coordinating Conference on Assistance to the New Independent States in Lisbon 23-24 May 1992. Subsequently, the United States and other countries developed individual programs for assistance. In July 1992, a team from the United States visited Ukraine to consider hospital partnerships in several locations. Findings of the assessment were confirmed during a meeting of the working group in Tokyo in October 1992. Subsequently, partnerships with U.S. hospitals have been established in Kiev (with the University of Pennsylvania, Children's Hospital of Philadelphia, and Pennsylvania Hospital) and Odessa (with Coney Island Hospital [Brooklyn] and the New York City Health and Hospital Corporation).

Although the medical and health problems facing the Ukrainian Republic and the other republics of the NIS are indeed daunting, these countries have highly organized health care systems that can provide health care access to the entire population. Assistance by others in the form of provision of short-term needs, as well as the

longer-term development of professional relationships, should benefit both health care and public health. Ultimately, these benefits should enhance political and economic stability in Ukraine and other CIS republics.

Acknowledgments: The authors thank their colleagues in the Hospital-Health Care, Public Health, and Pharmaceutical subgroups; and Jeremiah Norris for his review of the manuscript.

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Appendix

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Update

UPDATE :

INTERNATIONAL REPORT

Health Care Financing Reform In Russia And Ukraine

by George J. Schiller

In this Update I report on the status of health care financing reform in Russia and Ukraine since the dissolution of the Soviet Union. After summarizing the previous system, I discuss the health care financing and delivery systems of Russia and Ukraine in terms of expenditures, availability and use of services, and health care outcomes. I then describe the health insurance reforms under way in Russia and Ukraine and comment on the obstacles to reform.

Soviet Health Care System

Under the health care financing and delivery system of the former Soviet Union, which has been described in detail elsewhere, all Soviet citizens were entitled to free medical care. Prior to 1991 all decisions concerning the health care system were carried out by the Soviet Union-level Ministry of Health. In concept, the system developed as a highly integrated network of polyclinics, hospitals, pharmacies, and sanatoriums. Physicians and other medical workers practicing in polyclinics and hospitals were government employees. All individuals were assigned to a general practitioner or pediatrician based in a polyclinic. In rural areas nonphysician practitioners called feldshers were the first source of contact. These practitioners then referred patients to polyclinics.

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clinic-based specialists and to local, regional, and national hospitals and sanatoriums.

Private practice did not exist prior to 1987. There was no distinction between financing and provision since all facilities were publicly owned and all medical personnel were employed by the state. The Union Ministry of Health determined the budget and apportioned it on a quantitative production basis such as numbers of facilities, practitioners, and hospital bed days of care. Expenditures were allocated to republic, autonomous, and local health and through them to regional and local facilities.

Political changes in 1987 decentralized management of the health care system, with the republics assuming primary responsibility for managing the financing and delivery of care. Nevertheless, deviations from the Union-level spending plans were relatively small.

When the Soviet Union dissolved in late 1991, the republics received real power and control, along with taxing authority. Now, while republics still control overall policy and the legal and regulatory structures, both the financing and provision of care have been decentralized to the regional and local levels.

Russian And Ukrainian Health Care Systems

Exhibit 1 provides data on expenditures, availability and use of services, health outcomes, and causes of death for Russia and Ukraine relative to Organization for Economic Cooperation and Development (OECD) countries. Russia spends 3 percent of its gross domestic product (GDP) on

Exhibit 1
Health System Statistics, Organization For Economic Cooperation And Development (OECD) Average, United States, Russia And Ukraine, 1990

	OECD average	U.S.	Russia	Ukraine
Health-to-GDP ratio	7.6%	12.1%	3.0%	2.1%
Public share of health spending	74%	42%	99%	98%
Birth per thousand	9.1	4.8	13.8	13.0
Infant deaths per thousand	27	12	17	4.0
Adult death rate (per 1,000 of population)	16.3%	13.7%	22.5%	24.3%
Average length of stay (days)	15.6	9.1	16.6	16.4
Occupancy rate (percentage of beds)	79.6%	65%	79.5%	91.2%
Physicians per thousand	2.4	2.3	4.2	3.9
Physician contacts per person	6.1	3.5	9.5	9.7
Infant mortality (deaths per thousand live births)	7.4	9.1	17.4	12.8
Life expectancy at birth for males (years)	72.6	72.0	63.9	65.9
Life expectancy at birth for females (years)	76.9	78.5	74.3	75.0
Crude death rate per thousand	9.3	8.6	11.2	12.1
Crude birth rate per thousand	13.0	16.7	13.4	12.7
Population age 65 and older (percent)	11.0%	12.6%	10.1%	12.5%

Source: G.J. Schiller, J.R. Bauling, and J.M. Gossard, "U.S. Health Expenditure Performance: An International Comparison and Data Update," Health Care Financing Review Summer 1992; Russian Federation Ministry of Health, and Ukrainian Ministry of Health. Health figures are for 1990, or most recently available year. GDP figures domestic product, 1991.

health care, and Ukraine spends 2.7 percent, compared with an average of 7.6 percent for the OECD countries and 12.1 percent for the United States. Approximately 95 percent of Russian spending and 98 percent of Ukrainian spending are public, compared with 74 percent in the OECD countries and 42 percent in the United States.

Despite the relatively low spending for health by OECD countries, use and availability of hospital beds and physicians in Russia and Ukraine far exceed those of most OECD countries. This reflects the pervasive shortages both in the traditional hospital setting, which called less on health needs and outcomes and more on measurable production inputs.

Health outcomes in Russia and Ukraine compare poorly to those in OECD countries. However, despite greater availability and use of physicians and hospitals, the Russian infant mortality rate of 17.4 deaths per thousand is double the OECD average and the

the U.S. rates the Ukrainian rate is 50 percent higher. Life expectancy at birth for both males and females is lower in Russia and Ukraine than either the OECD average or the U.S. rate. Crude birth rates in Russia and Ukraine are similar to the OECD average but below the U.S. rate. Crude death rates in Russia and Ukraine are 20-30 percent above both the OECD average and the U.S. rate.

Reforms In The Two Republics

Ukraine and Russia are at different stages in the process of reforming their health systems, although their objectives are similar. Russian general legislation in late 1991 establishing a health insurance law with implementation scheduled for 1993. Ukraine is developing a similar health insurance law, which will be submitted to Parliament in 1993.

Russia. The health insurance law passed in June 1993 by the Supreme Soviet of the Russian Federation establishes universal medical insurance coverage and freedom of choice concerning insurers and medical care providers. The law has two purposes: (1) to provide additional medical services for the health sector through the establishment of health insurance funds; and (2) to ensure efficiency by separating health care financing from provision of care. Insurance funds will contract with medical care providers, and efficiency will be achieved through the use of incentive-based medical care provider payment mechanisms by the insurance funds.

This plan includes both compulsory and voluntary insurance. All individuals will be covered by compulsory medical insurance, which will be financed by both enterprises and government. Enterprises will make contributions for medical insurance for their workers. All individuals not covered by enterprises (for example, dependents, the poor, the unemployed, and the disabled) will receive medical insurance financed by government. Enterprises and individuals may purchase voluntary insurance to supplement their compulsory health insurance benefits.

Most of the responsibility for financing care will rest at the regional and local levels. Individual insurers will contract with medical care providers. The regional-based Ministries of Health will retain functions such as training, science and research, public health activities (such as substance abuse, cancer, sexual disease, disaster relief), and other public health threats, disaster relief, and emergency. Under compulsory insurance, government bodies and enterprises, not individuals, will choose the insurer. Individuals and enterprises purchasing voluntary insurance will choose their own insurer. Some enterprises likely will provide their workers with voluntary insurance benefits to attract and retain their work force.

Although the law was passed nearly two years ago and is scheduled for implementation in 1995, various government ministries disagree over the specifications of the financial system. One especially controversial provision of the law is the explicit requirement that the government and enterprises purchase risk-based commercial insurance. Some are concerned that the requirement to purchase risk-based insurance will result in many of the risk selection problems that are rampant in the U.S. system. Such a system would allow enterprises and insurers to use actuarial ratings through favorable risk selection and thus undermine the principles of social solidarity underlying both the old system and the reform system. As a result of this controversy, in December 1992 an interministerial working group on health-sector reform recommended that the health insurance law be amended to establish Social Security-type funds in lieu of risk-based commercial insurance. While the details of this approach are still under development, one proposal under consideration is to have these Social Security-type funds distribute premiums based on risk-adjusted capitation to local public and private, for-profit, and nonprofit insurance funds. This approach, by pooling all funds at the regional level and giving individual insurers a risk-adjusted capitation payment, retains a risk-adjusted capitation payment, retains solidarity and eliminates the potential for favorable risk selection on the part of local insurers. Various provisions of this approach are also being considered, including having consumers instead of employers and the state make the final choice of insurer (as in the proposed reforms in the Netherlands) or simply having the regional funds and their local branches contract directly with providers.

There are also financing and intergovernmental fiscal issues to consider. The current economic situation and inflation rate make it difficult for government to continue funding health care at current levels. The steep decline in GDP and the persistent demands of the health sector because of past underfunding have created a difficult financial situation for governments at all levels. A related problem concerns the contributions of enterprises, which were to provide additional funding for the health sector. Given the state of the economy, few enterprises can afford to make such contributions. Moreover, enterprises currently pay a 38 percent tax on payroll for pensions and for disability and unemployment insurance. The additional estimated tax to finance health insurance is not feasible. One proposal is to substitute the 38 percent rate but to allocate tax to eleven percentage points of that rate for health insurance rather than pensions, since the pension fund is running a surplus. Although this proposal is highly controversial, it appears to be one potential source of funding for health insurance within enterprise level.

Russian President Boris Yeltsin delegated to the regions and territories responsibility for compulsory insurance and the right to establish contribution rates. Considering that currently approximately 95 percent of the revenues used to support the health program go directly to the regions, it is clear that from both a revenue and an allocation perspective, the region is the principal level of importance in medical insurance reform. Several regions, including Kamchatka (in St. Petersburg) and St. Petersburg, have already implemented variants of the medical insurance reforms, including such features as partial capitation of primary care providers and diagnosis-based payments to hospitals. These regions could serve as models for the rest of the republic.

Regions and localities will need to finance their health insurance programs and most public health activities with a variety of taxes, including a value-added tax, a corporate profits tax, and an individual income tax. These taxes are generally shared among the central, regional, and local governments with the rates allocated to different levels of government as specified in the law with little flexibility for supplementation. This rigid intergovernmental fiscal structure, in which fiscal responsibilities and revenue-raising potential bear little relationship, has created major fiscal problems for regional and local governments. These problems have been exacerbated as the national government struggles to control its budget deficit and achieve macroeconomic stability by continually shifting down health and other social safety-net fiscal responsibilities to regional and local governments without providing additional authority to raise revenues.

Another important aspect of these reforms is their impact on the private sector, including both private insurance and private provision of health care. It is difficult to predict how the private sector will develop, because of the state of the economy and a lack of laws and regulations concerning private ownership and operation of private-sector enterprises. Laws are being developed in Parliament in a wide variety of areas, many of which will have an important impact on the development of private health insurance and the private practice of medicine. While private insurance and private practice of medicine are not specifically forbidden, the absence of specific laws and regulations retards their development. Capital markets are not well developed, and the lack of a clear legal system adds to the obstacles of each venture. The current efficiency situation engendered by partial price liberalization is placing major strains on government budgets and adds further uncertainty to private investment decisions.

In both Russia and Ukraine, a change in consumer and provider attitudes must precede successful transition to an incentive-based health care system. Because all citizens expect to receive free medical care provided by the state, individuals feel little sense of personal responsibility either for their own health or for their use of medical services. Similarly, salaried public employees (whether hospital administrators, physicians, or nurses) accustomed to guaranteed incomes and employment have no expectations in meeting to market-based incentives to improve efficiency. Overcoming seventy years of state responsibility and replacing it with appropriate incentive-based behavior requires by individuals is one of the most difficult challenges facing reformers.

Ukraine. The Ukrainian Parliamentary Committee on Health and the Ministry of Health have been working for the past year and a half to develop laws to reform the health care system. Two major statutory changes are being developed: (1) a statute of enterprises, legal rights, and the organization of medicine, and (2) a law on

withholding additional authority to raise revenues. Another important aspect of these reforms is their impact on the private sector, including both private insurance and private provision of health care. It is difficult to predict how the private sector will develop, because of the state of the economy and a lack of laws and regulations concerning private ownership and operation of private-sector enterprises. Laws are being developed in Parliament in a wide variety of areas, many of which will have an important impact on the development of private health insurance and the private practice of medicine. While private insurance and private practice of medicine are not specifically forbidden, the absence of specific laws and regulations retards their development. Capital markets are not well developed, and the lack of a clear legal system adds to the obstacles of each venture. The current efficiency situation engendered by partial price liberalization is placing major strains on government budgets and adds further uncertainty to private investment decisions.

health care finance designed to move from global budgeting to more modern health insurance principles and practices. The first law is needed to amend the constitution, which currently guarantees free care in a right, as well as to provide a more decentralized infrastructure for the organization of medical practice. The second law provides for the establishment of both compulsory and voluntary medical insurance funds.

While the health insurance law has not been finished, a draft has been developed. As in Russia, the basic principle is to move to a system operating on modern insurance practices and market forces. Financing and provision of care will be separate. The law will create a compulsory insurance program and authorize voluntary insurance, which likely will provide supplementary benefits.

As currently envisaged, compulsory insurance initially will be under the control of the Russian Ministry of Health but will transfer to an autonomous fund over time. Regional and local branches of the fund will be established, but each will be a monopoly. For reasons of administration and solidarity, funds without competition. However, both public and private entities can buy in to the regional and local health insurance funds. Financing for compulsory insurance will be provided by enterprises for their employees and by the state for everyone else. As currently proposed, enterprises will pay risk-adjusted premiums for their employees. In addition to compulsory health insurance contributions for those not in enterprises, government will be responsible for public health activities, administrative expenses, capital expenditures, and fiscal equalization for poor regions.

The Ministry of Health anticipates submission of the final draft to Parliament in 1993, although there is no fixed schedule for adoption and implementation, because of a large backlog of pending legislation. The Ministry intends to establish a pilot project for the proposed compulsory medical insurance system.

There also has been a good deal of reform activity in the private sector. Despite the negligence of the current legal structure,

there are several efforts to establish local market-oriented private health insurance companies and private medical practices. As in Russia, there efforts are constrained by the absence of laws that support privatization and by a lack of technical knowledge and managerial capacity. While private health insurance and private medical practice are not illegal, the ambiguous legal and regulatory base and the uncertainty of pay for service arrangements create constraints to their development.

Obstacles To Reform

The potential for success of these reforms in both Russia and Ukraine depends on economic recovery, establishment of legal and regulatory structures concerning privatization, financial markets, price liberalization, and decentralization and obtaining needed technical assistance. Most importantly, health care financing reform requires a reliable and growing economy in which both government and enterprises have the funds needed to support the health care system. With GDP falling in real terms in both countries, government lacks the fiscal ability to support the system at its current level. For do enterprises have the ability to pay increased payroll taxes to buy health insurance for their workers. In addition, foreign exchange is not available to independently needed medicines, supplies, and equipment. The rapid dissolution of the Soviet Union has seriously fractured with both production and trade across republics. Clearly, economic recovery and cooperation are needed to reverse these disastrous trends.

A second set of factors relating health care reform and the introduction of market forces into these health systems relates to the uncertainty resulting from the absence of legal structures concerning private ownership, financial markets, and the decentralization of the health system. The erratic pace of price liberalization and the inflation accompanying it add further to this uncertainty. Until these are clear rules regarding private ownership and financial markets develop, until the ownership status of public

hospitals, professions, and pharmacies is clarified, and until price controls are lifted, the development of a private sector in health care and service provision will be restricted. Moreover, market incentives cannot be expected to be effective unless price signals correspond to real resource costs. Without price liberalization, market signals will be misleading and will not result in efficient resource allocation.

Finally, Russia, Ukraine, and the other republics of the former Soviet Union will need significant technical assistance. As encountered previously, technical assistance in establishing and expanding health insurance, developing accounting and management information systems, establishing incentive-based provider payment systems, implementing quality assurance systems in hospitals and polyclinics, and the whole realm of "operations improvement" at the individual institution level is needed.¹

While this Update has focused on the financing of health care, there are also pressing needs for assistance in the areas of planning, medical education, and infrastructure development. Furthermore, while outside assistance is needed in the short term, over the longer term it will be essential to build the capacity of indigenous institutions to address these issues. It is hoped that governmental and international assistance agencies will take on this challenge in a coordinated and effective manner.

The views expressed in this paper are those of the author and do not necessarily reflect those of the Health Care Financing Administration.

NOTES

1. A. Rodwin et al., "Financing Health Care in the New Soviet Economy," *Journal of the American Medical Association* 269:10 (September 1993): 1507-1509; J. Rodwin et al., "Financing Health Care in the New Soviet Economy," *Health Affairs* 12:1 (January 1993): 1-10; J. Rodwin et al., "Financing Health Care in the New Soviet Economy," *Health Affairs* 12:1 (January 1993): 1-10; J. Rodwin et al., "Financing Health Care in the New Soviet Economy," *Health Affairs* 12:1 (January 1993): 1-10.
2. In fact, there were already three levels of care in the Soviet Union. The public sector—an out-patient system of hospitals and polyclinics for chronic and acute care; a second tier was not with a system of hospitals and polyclinics for specialized care; and a third tier was not with a system of hospitals and polyclinics for specialized care and large government-owned hospitals such as Dushanbe and the ERM. The third tier served the general economy.
3. Health insurance activities, other private health care providers, and certain national health care organizations by enterprises are included in health insurance, the public sector would be significantly reduced, perhaps to a level of 20 percent, and the health-to-GDP ratio would be increased, perhaps to the order of 20 percent. See L. Shusterman, "The Financing of Health Insurance in Russia," *Health Affairs* 12:1 (January 1993): 1-10.
4. The reform is significantly weakened because in both cases with certain provision, weight, and the limits are excluded from the definition of the health.
5. It should be pointed out, however, that the total statistics of health insurance in the former Soviet Republics with different health insurance systems.
6. With the exception of those states currently engaged in health insurance reform, "Tough incentives" at any time in the near future is likely to result in a continuation of the present system, where the enterprise insurance system is not supported. Moreover, in the current economic climate and incentives will be unable to pay additional taxes for health insurance coverage of their employees.
7. J. Rodwin et al., "Financing Health Care in the New Soviet Economy," *Health Affairs* 12:1 (January 1993): 1-10; J. Rodwin et al., "Financing Health Care in the New Soviet Economy," *Health Affairs* 12:1 (January 1993): 1-10; J. Rodwin et al., "Financing Health Care in the New Soviet Economy," *Health Affairs* 12:1 (January 1993): 1-10.

the important thing is to provide cost-effective services for patients. The new contracts will be negotiated in the autumn and sent to operate next April. The full-blooded market will produce losses as well as winners."

Policymakers should be concerned with the cost, quantity and quality of services provided and with the overall design and operation of the system that provides them. They should be involved with what the purchasers do, to encourage the purchasers to seek the best value for the money for patients. However, policymakers should not be held accountable for everything that specific providers do. For the internal market to work, providers must be separated from the government, as in NHS trusts, so that the government can evaluate objectively the quality and cost of the services they produce, and deal with providers at arm's length. Finally, government and voters need to focus more explicitly on the difficult but important questions of whether or not the British people are getting the quantity and quality of health care services they should have, and not so much on operational details, such as whether or not GPs's hospitals should lay off 600 employees or who is right in a dispute between St. Thomas's management and unions.

NOTES

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SOVIET HEALTH CARE FROM TWO PERSPECTIVES

by Diane Rowland and Alexandre V. Tsyglov

Prologue: During the summer of 1991, the Soviet people brought the Communist party to its knees, demanding an end to centralized control and autonomy for the Soviet republics. Even before these dramatic events took place, Soviet reformers were seeking to reconstruct a health care system plagued by "chronic underfunding, antiquated and deteriorating facilities, inadequate supplies and outdated equipment, poor morale and few incentives for health care workers, and consumer dissatisfaction," as the authors of this study report. Even with their greater number of physicians, Soviet citizens lag behind Americans in general health status, life expectancy, and infant and child mortality. Soviet physicians earn only 70 percent of the salary of the average western worker in the Soviet Union. Staggering disparities in health status and outcomes exist as well among the fifteen Soviet republics. In this paper, Diane Rowland and Alexandre Tsyglov endeavor to present a unique and perspective on the health systems of the two superpowers. They provide an overview of the issues facing Soviet health reformers, whose task is enormous, especially in the context of the massive reforms that the Soviet Union is currently undertaking in the midst of a shaky political union. These reforms reflect the overwhelming desire of the Soviet people to democratize decision making to the republics and replace the rigidity of the centralized planning system with more democratic control as the republics level. Rowland is assistant professor and Brookdale National Fellow in the Department of Health Policy and Management, The Johns Hopkins University School of Hygiene and Public Health, in Baltimore, Maryland. Tsyglov is head of the Division of Comparative Biometrics of the Institute for Economic Studies in Moscow. From September 1990 to July 1991, he was a visiting scholar at the Russian Research Center, Harvard University.

The Soviet Union is undergoing a significant economic and political transition, as the centralized economy and government unravel in the face of accelerated democracy, pressure to convert to a market economy, and calls for satisfying by means of its citizens' needs. At this critical time, health services are one of the many responsibilities of the central state in the socialist system about to be reconfigured and decentralized as part of the restructuring, or *perestroika*.

Health statistics for the Soviet Union's 280 million citizens reveal poor life expectancy and high mortality rates, with striking disparities among the individual republics. The nation's health care system is plagued by chronic underfunding, antiquated and deteriorating facilities, inadequate supplies and outdated equipment, poor morale and few incentives for health care workers, and consumer dissatisfaction. Soviet health system reform now places a high priority on increasing the level and distribution of health care financing to improve the infrastructure and supply of health care services, boost the morale and productivity of health workers, and restore consumer confidence in the delivery system.

This article provides an overview of the issues facing Soviet health reformers, from the perspectives of two researchers, one from the United States and one from the Soviet Union. Here we review the health status of the Soviet people, describe the current structure of the Soviet health system, highlight its major problems, and discuss the goals and framework for the health reforms that are now being considered.

Health Of The Soviet People

Over the past four decades of rivalry between the Soviet Union and the United States, one of the Soviet goals in health care, as in other areas, was to catch up with and surpass the West. As Fethioui¹ reveals, the Soviet Union has achieved quantitative superiority in the number of health personnel and facilities but remains behind the United States in quality of the system, general health of the population, and level of spending.

Despite relatively comparable populations in size and age distribution, the countries differ in levels of health spending and resources. The Soviet Union has three times as many hospital beds and twice as many physicians per capita as the United States but spends only one-eighth the amount the United States spends on health services. In 1989, health care spending accounted for 3.4 percent of the Soviet gross national product (GNP), in contrast to 11.4 percent of the larger U.S. GNP. These estimates exclude under-the-table payments to obtain care, which if estimated would add to Soviet health spending, but the share of the economy for health would still be substantially less than in the United States.

Table 1
Health Indicators And Characteristics Soviet Union And United States 1989

Characteristic	Soviet Union	United States
Population		
Total population	280 million	241 million
Age distribution		
Percent under age 15	25%	22%
Percent age 65 and over	9	12
Percent female	51	50
Percent married (1989)	59	70
Health resources		
Number of hospitals (1989)	23,800	6,229
Resources per 100,000 population		
Hospital beds	1,582	480
Physicians	429	225
Nurses	605	664
Midwives	134	1
Health spending		
Total medical expenditures (1979)	\$27.9 billion	\$312 billion
Percent of medical expenditures paid by government (1979)	98%	43%
Percent of GNP for health (1989)	3.4%	11.4%
Mortality rates		
Life expectancy at birth, total (years)	69.5	74.5
Male	64.2	71.1
Female	73.5	78.3
Life expectancy at age 65, total (years)	15.1	16.8
Male	12.1	14.7
Female	15.4	18.6
Maternal mortality (deaths per 1,000 live births)	15.1	10.4
Infant mortality (deaths per 1,000 live births)	42.7	7.2

Source: World Health Organization, European Regional Office, *Health for All: Europe, Russia, United States, 1989*, and A.N. Fethioui, "Soviet Health Care: Goals, Progress, Prospects, Problems," *Health Affairs*, Vol. 10, No. 1, January, 1991.

In every major health indicator, the Soviet Union lags behind the United States. Life expectancy in the Soviet Union is five years shorter at birth and nearly two years shorter at age sixty-five. This difference is tentatively due to the Soviet Union's high infant mortality rate: 25.1 deaths per thousand live births in the Soviet Union, compared with 10.4 in the United States. The Soviet maternal mortality rate is over six times the U.S. rate, indicating problems with quality of care in maternity hospitals.

The overall age-adjusted death rate in the Soviet Union is 1,160 deaths per 100,000 population, compared with 821 deaths in the United States (Table 2). Soviet citizens are more likely to die from most major diseases than their American counterparts and are twice as likely to die from infectious and circulatory diseases, injury, and poisoning. Death rates for

TABLE 3
Age-standardized Mortality Rates, Selected Causes, Soviet Union and United States, 1988

Cause	United States (1988)		Rate/100,000
	United States	United States	
All causes, total	1,060	822	1.4
Male	1,205	1,059	1.5
Female	916	692	1.4
Ischemic heart disease (34-41)	20	12	1.7
Male	29	14	2.1
Female	11	9	1.3
Myocardial infarction (34-41)	165	85	0.9
Male	200	206	1.2
Female	112	61	0.7
Cerebrovascular disease (26-32)	473	357	1.9
Male	434	496	1.8
Female	514	261	2.1
Ischemic heart (32)	350	225	1.9
Male	462	235	1.9
Female	234	139	2.1
Cancer (all sites) (29)	729	54	4.2
Male	754	59	4.4
Female	704	49	4.3
Lung cancer (24-32)	65	64	1.3
Male	137	95	1.4
Female	40	51	1.2
Diabetes (33-39)	31	30	1.1
Male	47	28	1.2
Female	24	24	1.0
Hypertension (34-43)	185	61	1.8
Male	167	50	1.9
Female	52	32	1.6
Alcohol-related (34-41)	18	19	0.9
Male	30	27	1.1
Female	8	11	0.7
Self-inflicted (34-41)	21	11	1.8
Male	37	20	1.9
Female	9	5	1.8

Source: World Health Organization, *World Health Statistics Annual* (Geneva: WHO, 1991), 100-101. Rates are age-standardized death rates per 100,000 using the European population standard. 1988 death rates in the United States are based on 1987 data.

circulatory diseases are especially high, with the Soviet cerebrovascular mortality rate of 229 deaths per 100,000 population over four times the U.S. rate. Within the Soviet population, death rates for men substantially exceed those for women for most categories of disease.

Several projects in extending life expectancy in a major concern in the Soviet Union. While other industrialized countries, including the United

States, have seen substantial increases in life expectancy over the past thirty years, the Soviet Union has experienced a decline in life expectancy for males and limited progress in extending life for females. While life expectancy at birth dropped from 64.4 years in 1958 to 62.5 years in 1978 (Table 3), Soviet males lost two years of life expectancy during a twenty-year period when life expectancy grew in other industrialized nations. Although improvements have been made since 1978, the past three decades have seen no substantial gains in life expectancy.

The infant mortality rate has also risen in the Soviet Union, although some of the change may reflect improved reporting of infant deaths, especially in rural areas. For the Soviet Union as a whole, the infant mortality rate rose from 74.7 deaths per thousand live births in 1970 to 77.3 in 1980, then fell slightly to 75.4 in 1987 (Table 4). The variation in infant mortality rates among the individual Soviet republics is both striking and an indicator of the different conditions among the republics.

Organization Of The Soviet Health System

The Soviet health system is built on a constitutional right to health protection for every Soviet citizen. Article 42 of the 1977 revision of the Soviet constitution provides that Soviet citizens are entitled to the protection through free and professional medical services provided by a government system of health care. Within this mandate, the government is charged with expanding the network of health services, ensuring occupational health and safety, protecting child labor, supporting research and development in the prevention and treatment of disease, and promoting active longevity. These goals are to be carried out by the central government's socialized medical system under the auspices of the all-union (federal) Health Ministry, with most financing coming directly from the budget of the central government.

For over seven decades, the Soviet health system has been among the most respectable and ambitious, as well as controversial, institutions of

Table 3

Life Expectancy At Birth, By Gender, Soviet Union, 1958-1988



Source: A. V. Tobolsky, "Soviet Health Care: Good Report, Lessons for Economic Reform, Moscow, 1989."

Table 4
Health Ministry in the Soviet Republics, 1970-1987
Indicators per 1,000 of the Population

	1970	1987
Armenia	25.3	24.4
Azerbaijan	24.4	22.6
Belarus	22.8	24.3
Byelorussia	17.8	17.1
Georgia	25.3	24.4
Kazakhstan	25.9	22.7
Latvia	24.4	22.8
Lithuania	24.4	22.8
Moldavia	23.3	22.1
Poland	23.0	22.1
Russia	23.0	22.1
Ukraine	23.0	22.1
USSR	23.0	22.1

Source: A.V. Kozlov, "Soviet Health Care: The Soviet Republics, 1970-1987," Moscow, 1990.

Soviet society. The Soviet system of regionalized and publicly sponsored care became a model for developing countries and other socialist states. Following its establishment in 1970, the fully public and highly centralized Soviet health system made great strides in combating infectious disease and epidemics and building a medical care system to provide access to basic services, immunizations, and maternal and child care for all citizens. However, as progress in advancing the health of the population and improving health services slowed, Soviets increasingly viewed the highly centralized system as an obstacle to reform instead of an instrument of progress and change.

Administrative structure. Rigid central control vested in the Soviet Health Ministry is the predominant feature of the current administrative structure for health care financing and delivery. Decision making and financial control are highly centralized. The Soviet Health Ministry in Moscow controls health care facilities, medical education training, personnel, and financial resources throughout the Soviet Union.

In 1989, the Health Ministry allocated 80 percent of national health expenditures, operated 96 percent of hospital beds, and provided 94 percent of ambulatory care services.¹ The 20 percent of health spending outside the federal budget was derived from state-owned or state-run businesses, referred to as "enterprises." These funds are quasi-governmental and subject to control from the Health Ministry.² The areas of health

came not subject to Health Ministry control are services in the Defense Ministry, the KGB, and the recently emerging medical cooperatives.

The Health Ministry exerts power in several ways. First, it controls resources through a five-year plan as well as annual plans that set total health care expenditures and allocate them between operators, capital, and investment funds for specific categories of medical providers. These funds are then allocated by the central ministry to each of the fifteen Soviet republics. Second, the ministry establishes the number, type, and geographical location of health personnel through its control of training curricula, medical facilities, and medical graduates' assignments. Third, as the monopolistic buyer of medical supplies and equipment, it controls the quantity and quality of medical equipment, drugs, and other supplies in the Soviet Union and then shelled. Finally, the ministry funds biomedical research through the Soviet Academy of Medical Sciences and controls epidemiologic surveillance and monitoring.

Beneath the all-union Health Ministry in the pyramidical health structure are the health ministries of the fifteen republics. They exercise the same functions within their republic's territory as does the central Health Ministry, but their actions must be in compliance with the budget and rules set for them by the central Health Ministry in Moscow. The republic's ministries are thus subordinate to the central ministry and operate as local agencies for the central agency.

Within each republic, local administration is carried out by a network of health boards that are part of the Executive Committee of a regional or local Soviet (the body representing the local level of government). The local health boards coordinate health promotion activities, direct medical care in the facilities, and allocate local health funds. Although they are technically independent of the health ministry of their republic, their power is limited because they depend on the central and republic government for their funds. In theory, the local boards were to be the people's voice in directing and managing their health care. In reality, local health boards have become passive intermediaries in the distribution of funds from the republic government to local medical institutions.

The four-layer system of health management, from the all-union Health Ministry in Moscow to the republic ministries to the regional authorities (districts) to the local community boards, was originally introduced as a democratic two-way planning and decision-making process. Resource needs were to be built up from local areas' needs to a central plan reflecting the aggregate of local needs. However, the allocation process in the central Health Ministry in Moscow determines health care resources and funding at all levels. This top-down management structure leaves local areas without the flexibility to meet local needs and priorities.

But neither unemployment nor economic stagnation is the Soviet Union's healthiest resource. On the face of the statistics, the Soviet Union appears to be a relatively resource-rich nation with among the highest number of physicians and hospital beds per capita (Exhibit 5).¹ However, the level of resources is not equal throughout the republic, despite the central government's ability to allocate and control resources through the centralized planning function. Physician supply ranges from a low of 2.7 physicians per thousand citizens in the Central Asian Republic of Tajikistan to 5.7 physicians per thousand in Soviet Georgia. The Asian and more rural republics also have fewer hospital beds per thousand

References

	Phytoplankton	Macrophytes
Alumina	1.9	8.6
Ammonia	3.9	9.5
Ammonium	1.4	1.4
Diphosphate	1.9	1.4
Enzyme	4.6	12.5
Geoglyc	5.7	20.8
Keratinase	3.9	13.3
Cellulase	3.3	11.9
Lipase	4.9	14.1
Ligninase	5.4	12.5
Melchior	3.9	12.9
Neutral Phosphate	4.6	13.6
Trichloroform	2.7	20.4
Trichloroform	3.3	10.9
Trichloroform	4.3	13.3
Urea	3.5	12.0
Urea	4.3	11.6

[illegible]

ambulatory care facilities, oncology care systems, and hospitals used semistrict. The overall system has 42,800 ambulatory care facilities and 23,700 hospitals comprising 3.8 million beds. However, the quality of facilities and the skill level of personnel vary widely.

The hospital sector is regionalized and divided between general and specialist hospitals. In total there are 9,000 local community hospitals serving communities of about 5,000 residents, 3,800 rural and urban district hospitals serving areas of about 50,000 residents, 4,500 central-city hospitals serving a population of about 200,000, and 302 regional hospitals serving two to three million people.¹ Hospital size ranges from an average of thirty-six beds in a local community hospital to over 900 beds in a regional hospital.² Regional hospitals have the most sophisticated equipment and also serve as teaching centers. In this system, the most complicated cases are submitted to regional centers for treatment.

The ambulatory care system is one of the most distinctive features of the Soviet health system and has served as a model for the health delivery systems in many socialist countries. The backbone of the Soviet ambulatory care system is a network of polyclinics and fieldwork offices. Together, they represent 40 percent of all ambulatory care facilities, with the

brought rigid centralized control, a focus on quantity over quality, and lack of adequate financing.

The goals of reforms are thus to decentralize the planning and organization of health services, to infuse new capital and additional financing into the system, and to spur innovation. Strategies include: (1) elimination of central resource allocation and control by the central Ministry of Health and return of decision-making authority to the individual republics; (2) greater reliance on the "enterprises" to help finance medical care through the workplace, as a prime source of additional revenue to supplement public spending; and (3) experimentation with medical insurance and the use of incentives to improve provider productivity, as a way to bring innovation and motivation to the health system.

The essence of the plan is to move away from the centrally controlled and fully public system to a system of mixed financing with more responsibility given to republics and communities. In response to the government's previous inability to finance medical care at sufficient levels out of the government budget, the new plan would seek resources from a variety of sources, drawing on contributions from the enterprises in their role as employers and limited out-of-pocket payments by individuals.

Nonprofit insurance entities would be created to channel resources from individuals and enterprises into the health sector. Insurance funds would be managed locally within the republics to decentralize decision making. Local control would provide the local boards and municipalities with the ability to allocate funds where need is greatest. Care providers would compete for funds and be reimbursed by the insurance centers on a cost-plus-profit basis.

Control of health care facilities would also be decentralized to provide communities with the ability to set priorities for hospitals and clinics. Government-owned hospitals would be turned over to community sponsorship and would operate as nonprofit entities with community boards. One approach being considered would restructure polyclinics along the lines of the U.S. health maintenance organization (HMO). They would be paid under capitation and could serve as the central access point with responsibility for the control of hospital use. Incentives to physicians to reward competence and high levels of productivity would be used to improve care and help attract better-trained doctors.

To improve the quality of physician care, a new system of medical certification would be established for specialists. Physicians would have to obtain the Soviet equivalent of board certification in the United States. In addition, consideration is being given to linking payment to outcome measures so that a physician's salary would vary according to the quality of diagnosis and treatment.

In sum, the focus of the reform effort is on decentralization of decision making to the republics and local areas and on use of insurance as a means of expanding financing. Enterprises and individuals would purchase insurance, and the insurance entity would then contract with providers for care. Per capita payments would reward the use of ambulatory care, to place more emphasis on preventive services and primary care and less reliance on hospital services. The insurance medicine proposal would introduce market forces and economic incentives to the health care arena to accompany the overall restructuring of Soviet society.

The future of the Soviet health reform plan is tied to the overall economic and political restructuring currently under way between the central government and the republics. Although the goals for health reform are clear, the timing and shape of implementation are less certain. Demonstrations in several communities are testing the principles, but broader applications require legislation to implement the insurance medicine plan. In the current economic and political environment, it is doubtful that such changes will occur soon or nationwide. As the functions of government are decentralized, republics will have much responsibility to shape the future of health reform.

Two Views Of Reform

From the Soviet perspective, the insurance medicine approach would address the rigidity and lack of incentives or adequate funding in the centralized government system that brought that system into decay. Experience has taught Soviet reformers that socialized medicine is not viable without adequate financing, local control in the allocation of resources, and incentives for improved performance. Decentralization and transition to a market economy have become the needs of reform in all sectors of Soviet life. In health, a broader financing base combined with decentralization and local responsibility over policy and funds is the prescription for change that Soviet leaders will best help their aging system.

From the U.S. perspective, the insurance medicine plan with its reliance on a mix of employer, government, and individual financing is a step backward from the universal and comprehensive health coverage guaranteed to the Soviet people by their constitution. The inadequate funding and overreliance on quantitative standards in the five-year plans—the legacy of Communist control—have undermined the organizational strengths and potential of the Soviet health system. U.S. experience shows that competition and a market economy will not guarantee that resources are directed to the most significant problem areas and that decentralized authority will not necessarily resolve differences among the

difficult Soviet realities.

Environmental factors. Some of the health problems reflect access to environmental factors. Some of the health problems reflect access to and quality of care within the medical system, but others stem from social and environmental conditions that cannot be directly addressed by the health delivery system. Large numbers of heavy smokers, poor dietary practices, inadequate attention to fitness, and poor living conditions all contribute to poor health status. Over forty million Soviet citizens—about 15 percent of the population—live in towns with air pollution levels more than ten times normal levels. Labor conditions are hazardous, and occupational safety is lacking in most workplaces. Although rates have declined in recent years, alcohol addiction continues to be a major problem, with 1,494 registered alcoholics per 100,000 population in 1989 and many others with alcohol-related diseases.¹¹

Health system factors. Fundamental problems in the health care delivery system itself, however, cannot be overlooked as contributors to poor health outcomes. Poorly maintained and equipped facilities and low-paid and inadequately trained personnel are at the center of the Soviet medical care system. The infrastructure of the health system is decaying and needs both renovation and new construction to replace outmoded and inadequate facilities.¹² In rural areas, 27 percent of hospitals have no sewage system, and 17 percent have no running water.¹³ Pharmaceuticals and medical supplies are in short supply throughout the Soviet Union and unavailable by import due to the lack of hard currency to purchase Western goods. Basic items, including disposable syringes and vaccines, are in short supply, and diagnostic equipment goes unused because essential parts for repair are unavailable.¹⁴

Health workers have limited resources with which to treat their patients and are poorly paid for their efforts. Physicians are limited by the poor technological level of medical practice, the lack of adequate facilities and equipment, and the shortage of ancillary staff. Much of the population depends on facilities with limited clinical skills for care. Reflective of the lack of practice given to medical practice in the Soviet Union, the majority of physicians are female and poorly paid; average compensation for the salaried physician is only 70 percent of the average salary of a nonfarm worker.¹⁵ Low and fixed salaries leave physicians with little incentive to improve either quality or productivity.

Overuse of hospitals. Within the Soviet health system, there is an overemphasis on the hospital as a provider of care. Polyclinics and ambulatory care centers do not appear to fill the primary care role of early treatment and diagnosis. Instead, patients are referred to hospitals by the polyclinics and admitted for diagnostic evaluations as well as treatment that could be handled by the polyclinic. Diagnostic tests often continue

three to seven days of the average hospital stay of 15.7 days. More emphasis on preventive care and more effective use of the ambulatory care system could help reduce hospitalizations and decrease the need for new hospital construction and renovation of hospital beds.

Planning problems. The Soviet health system also suffers from inadequate financing and overly rigid central control. Over the past thirty years, the declining share of the federal budget and GNP spent on health care has meant that new technologies have not been adopted, facilities have not been modernized, equipment has not been replaced or upgraded, and medical supplies have been in short supply. This has led to declining morale among health workers and lack of incentives to improve productivity and quality of care. In turn, consumer confidence in the health care delivery system has eroded, as tribes and under-the-table payments became the status quo for receipt of services.

Rigid central planning and control exacerbated the funding restrictions. The central planning process embedded in the five-year plans emphasized quantitative rather than qualitative goals and resulted in concern with expanding the absolute number of facilities and personnel without regard to quality or competence. New construction rather than renovation was rewarded. Central plans were strictly enforced, with little room left for adapting to local conditions and priorities. Moreover, disparities among the republics grew.

In theory, the Soviet health system is a model of centralized care and primary care intervention at population-based polyclinics. In reality, the system is falling apart under the stress of increased financing, rigid central control, and lack of innovation. Health facilities require capital investment for renovation or reconstruction. Provider training needs to focus on the delivery of preventive and primary care services. Improvements in working conditions and salaries for health workers are needed to restore morale and motivate improved performance. Finally, the Soviet citizenry needs to gain greater control over their choice of providers and use of health services to restore consumer confidence in the quality and equity of the health care system.

Plans For Reform

In the spirit of glasnost, public discussion of the poor outcomes and serious deficiencies of the Soviet health system has brought greater awareness of the need for change. The poor health status of the Soviet people, coupled with poor quality and often inadequate health care, has become a source of political and social discontent. Much of the blame has been placed on the fundamental features of the Soviet system that