FOURTH MEETING OF THE ST PETERSBURG INITIATIVE FOR EDUCATION AND TRAINING IN GENERAL PRACTICE AND FAMILY MEDICINE

Report on a WHO Meeting
Minsk, Belarus, 12-14 October 2000
**EUROPEAN HEALTH21 TARGET 15 - AN INTEGRATED HEALTH SECTOR**

By the year 2010, people in the Region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system.

*Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998.*

**ABSTRACT**

This was the fourth meeting of the St Petersburg Initiative, bringing together academics and decision makers from eastern European countries. Participants reviewed current developments within primary health care, especially with regard to training and multidisciplinary collaboration. Following presentations and discussions on the present level of training and education, and a review of specific experiences in several countries – including a site visit to Minsk, the participants concluded that specialists working in a primary health care team should be given the opportunity to undertake postgraduate and postgraduate education and training with other disciplines; it would equally be important to outline the roles of specialists regularly participating in such teams. The meeting inter alia recommended that examples of positive experiences of collaboration between doctors and nurses within the area of family medicine should be collected and disseminated.

**KEYWORDS**

EDUCATION, MEDICAL - trends
FAMILY PRACTICE - education - trends
PRIMARY HEALTH CARE
INTERPROFESSIONAL RELATIONS
HEALTH CARE REFORM
COMMONWEALTH OF INDEPENDENT STATES
RUSSIAN FEDERATION
EUROPE

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Introduction

1. The fourth Meeting on technical training and education in general practice/family medicine within the framework of the St Petersburg Initiative network took place in Minsk, Belarus, from 12 to 14 October 2000. The meeting was jointly organized by the WHO Regional Office for Europe and the Ministry of Health of Belarus. Among the 34 participants were representatives from nine newly independent states (NIS), specialists in the field of medical education, health care management and training of general practitioners/family physicians, international organizations and WHO Collaborating Centres (Annex 2).

2. Dr Mårten Kvist, Technical Adviser, Primary Health Care, WHO Regional Office for Europe, welcomed the participants on behalf of the Regional Director of WHO and reviewed the issues which had been considered at the previous meetings. A welcome address was delivered by Professor Svetlana Petrovna Vinokurova, Chief Advisor for Health in the Presidential Administration of the Republic of Belarus. Dr Larisa A. Sokolovskaya, Deputy Minister, Belarus, greeted the participants on behalf of the Minister of Health.

3. Dr Sergei Denisov, Minsk State Medical Institute, Belarus, was elected Chairperson and Dr Samvel Hovhannisyan, Armenia, was elected Rapporteur.

4. The aims of the meeting were:

- to discuss ways and means of setting up multidisciplinary groups and organizing training in this specific area in relation to primary health care requirements
- to learn about the participating countries’ latest achievements in the training of primary health care professionals, and
- to become familiar with the current situation of the primary health care system in the host country (Belarus) by means of site visits.

Presentations on multidisciplinary collaboration in primary health care

Ms Fedelma Winkler, Department of Post-Graduate General Practice Education

5. In her statement, Ms Fedelma Winkler, Department of Post-Graduate General Practice Education, London, United Kingdom, spoke about multidisciplinary collaboration, using the example of the United Kingdom.

6. Multidisciplinary collaboration in primary health care is very important if the quality of health care is to be improved and good results are to be achieved with minimum financial expenditure, which determines economic efficiency in the health system. Her report covered the following topics:

⇒ Issues and obstacles
⇒ UK experience
⇒ Components of collaboration.
7. There is no alternative to collaboration in a multidisciplinary team providing comprehensive and horizontally integrated primary health care, since all members of the team share the same aims and tasks. There is no “right” or “wrong” way to achieve this collaboration, which is a prerequisite of the principles of respect, support and participation in the process of work. Close collaboration with colleagues from different disciplines is an important part of professional activity and should be largely covered by codes of professional ethics. For this reason, independent action without regular exchanges of experience and mutual updating of skills can no longer be regarded as adequate from a professional point of view. In the same way, all workers in primary health care (nurses, pharmacists, dentists, social workers, etc.) must work as a single team and be fully aware of the need for collaboration in the resolution of the many complex health care problems which cannot be solved by workers from any one health profession alone. In their professional training, members of all health professions must accept the need to respect human dignity and obey the principles of professional ethics and solidarity. They must also acknowledge that the members of each profession have their own sphere of competence and that, since they all have to work together, they must respect the sphere of competence of their colleagues. Working together, complementing one another’s work and constantly exchanging information can make collaboration considerably easier and give the participants a full understanding of the prevailing social and cultural conditions in the society concerned.

8. In the United Kingdom, the following approaches are being adopted to all these issues:

⇒ Substitution
⇒ Breaking down hierarchies
⇒ Skill development
⇒ Inter-professional training.

9. In this area, there is a tendency towards greater autonomy for nurses, who are moving to the heart of health reform. Fifty per cent of nurses in the United Kingdom are now permitted to issue prescriptions on their own authority. Changes in the functions of physicians and nurses are needed, and this has led to opposition from physicians, who are afraid that they will lose part of their job as a result of this potential overlap in functions and activities. Suggested educational priorities include the pre-eminence of patients’ interests over the interests of the health professions. Physicians and nurses need to define their functions and activities precisely in the interests of the patient, which necessarily entails taking the patient’s opinion into account. In order to achieve all this, we must change the curricula studied by both physicians and nurses and include courses where the two groups train together.

10. National strategies for development of the approaches outlined above should take the following form:

*Whole system method components are:*

National Strategy

- supported by educational philosophy
- recognized by institutional arrangements
- sustained by economic incentives
- enabled by psychological preparedness
- assured by accountability structures
11. This is the only way to introduce this wide-ranging and important reform programme, involving changes in the functions, responsibilities and actions of two of the most important and fundamental members of the team which provides medical and social care to patients within the primary health care service — general practitioners/family physicians and family nurses.

**Ainna Fawcett-Henesy, Regional Adviser, Nursing and Midwifery, WHO Regional Office for Europe**

12. In her statement, Mrs Ainna Fawcett-Henesy, Regional Adviser Nursing and Midwifery, WHO Regional Office for Europe, spoke about collaboration between all the members of the multidisciplinary primary health care team, based on the HEALTH21 policy framework.

13. WHO believes that nurses and midwives play a central part in the strategy for improving health and health care throughout Europe. The question of responsibility in nursing is a crucial one, and its importance is increasing, owing to the ever-greater professional role played by nurses in European countries. The need to take a more careful look at what this responsibility means in both theory and practice has become particularly acute in recent years. The health system is becoming increasingly complex in structure, and a growing number of different health workers are operating within it, which begs the question: who is responsible for what?

14. The multidisciplinary team of health workers in primary health care includes physicians, nurses, midwives, paramedics, dentists, pharmacists, physiotherapists, social workers, etc. In the present case, particular emphasis has been placed on the qualifications of physicians and nurses working in primary health care, since these professions are central to the whole network of services. The diagram below shows the main care providers in the primary health care service.

![Diagram of care providers in primary health care service]

15. According to the recommendations of the First WHO Conference on Nursing and Midwifery (Vienna, 1988), well trained family nurses form another very important group of primary health care professionals, who can make a considerable contribution to health improvement and disease prevention, as well as providing necessary care. Family nurses can support individuals and families facing disease or chronic illness, as well as in stressful situations: they spend much of their time in patients’ homes or with their families. These nurses must be capable of advising patients on lifestyle issues and behavioural risk factors and giving families general assistance.
with health issues. In view of the rapid development of certain conditions, they can create a situation where any of the family’s health problems can be resolved at an early stage.

16. The main tasks of the multidisciplinary team should be as follows:

⇒ Sharing a common purpose
⇒ A clear understanding of one’s own functions and recognition of common interests
⇒ Pooling knowledge, skills and resources; responsibility for the outcome shared by all members
⇒ Effectiveness — the ability to carry out one’s own work and to change as an independent group.

17. All these aspects should be included in the undergraduate and postgraduate curricula of both family physicians and family nurses. To do this, the functions, rights and obligations of both professions must be changed, and new qualifications must be developed and approved. It is considered that education must be both multidisciplinary and interdisciplinary. Multidisciplinary education and practice is when all members of the team study an activity in parallel, often with different aims, but always in the interests of the patient. Interdisciplinary education is when all members are working towards the same goal (joint planning and decision-making and, naturally, joint definition of goals). The family nurse’s functions must include care both for the individual and for families and groups in all areas on which their health depends. She must participate actively in the resolution of crises in people’s lives, not waiting but working proactively within the family and providing a “bridge” between the family and the physician.

18. The most crucial times in a person’s life are the following:

- birth
- the change from primary to secondary school
- school examinations
- leaving the parental home
- finding one’s own home
- beginning work
- the birth of one’s first child
- job insecurity, changing jobs or losing a job
- developing a chronic illness
• retiring from employment
• losing one’s spouse and close friends.

19. Chronic diseases will prove to be a scourge and the greatest problem of the twenty-first century. The role of the nurse will increase, not in diagnosis, but in explaining to the individual or family how to live with a given illness (diet, physical activity, etc.). The nurse is not usurping the role and functions of the physician, but complementing them.

20. The multidisciplinary primary health care team must respect the following criteria:

• Authority
• Responsibility
• Accountability.

21. To achieve this, there must be changes in the following areas:

• Legislation
• Education
• Regulation.

22. Medical care is a multi-level and collective activity. One positive aspect for patient care is that the expert team represents a collective source of specialist knowledge and skills in all relevant areas. Another positive factor in collective activity is that the members of the team are agreed on the common aim shared by all. This shared aim becomes a task which the group of experts commits itself to tackling, thus assuming a collective responsibility. The distribution of responsibilities within the group must also be the subject of general agreement; each member of the group must understand and observe this distribution of responsibilities, which affects both himself/herself and other members of the team.

23. Nurses are the largest group of health workers and, in most cases, it is they who provide people with direct medical care. The quality and effectiveness of medical care are thus primarily dependent on the quality and effectiveness of the nurse’s work. “HEALTH21: the health for all policy framework for the WHO European Region” calls for education and professional training for all health workers, including nurses, which will give them the skills they need to participate actively in the process of permanent quality improvement; in this task, they must make use of well-documented data on the results of treatment, as well as their practical experience. The World Health Organization has published its European strategy for training nurses and midwives in the context of the health for all policy”, which will assist them in the achievement of that aim.

Valery E. Tcherniavski, Adviser, Country Strategic Cooperation (NIS), WHO Regional Office for Europe

Training together — working together

24. In his statement, Dr Valery E. Tcherniavski, Adviser, Country Strategic Cooperation (NIS), WHO Regional Office for Europe, discussed shared training for physicians and nurses, using the example of a pilot project conducted in St Petersburg in the 1990s.
25. The main aim of this pilot project was to train senior physicians and senior nurses from city polyclinics in shared training courses. The design of the course was in line with the following basic principles:

⇒ Form a clear idea of the respective functions of physicians and nurses
⇒ Identify points of contact and areas of shared responsibility
⇒ Choose appropriate teaching methods.

26. In order to obtain a clear idea of the functions of physicians and nurses, the first task of the pilot project was to study the official Ministry of Health documentation relating to the duties of certain categories of health worker. The next step was to conduct specialized research on the work actually done by these groups of health workers in practice. From this research, the project identified points of contact and areas of shared responsibility, and subsequently:

• drew up job profiles for health workers, in the light of health system reforms in the Russian Federation
• identified areas of activity in which there are constant, regular or occasional contacts between members of various health professions

27. After this preparatory stage, the project went on to select the teaching methods, including

• traditional lectures
• active seminar method
• group dynamics
• pre-course preparation
• full-time training
• evaluating the effectiveness of training.

28. The actual process of teaching this course for physicians and nurses involved both separate and shared blocks of teaching. The teaching cycle began with a separate one-week block of classes for each group, in which the physicians and nurses studied the new job profiles for their own profession. The next one-week block was a shared one, in which the participants identified and discussed areas of activity where contacts and shared responsibilities arose in practice. In the last week, the two groups were again taught separately, with further discussion of ways and means of working together in areas of shared responsibility, which enabled each group to achieve a better understanding of the other’s role and function in group work.

29. The main lessons learned from the pilot project for joint training of senior physicians and nurses from city polyclinics in St Petersburg in the 1990s were the following:

• the shift from suspicion to collaboration
• the shift from a lack of understanding to a better understanding of the other group’s role and the synergies between the two roles
• the need for preparation for shared training.

30. The organizers of the project concluded that training together and working together as a team is the only way for health workers to tackle the task of increasing the efficiency and quality of health services.
Igor N. Denisov, Vice-Rector and Head of the Family Medicine Department, Moscow Sechenov Medical Academy

31. In his statement, Professor Igor N. Denisov, Vice-Rector and Head of the Family Medicine Department, Moscow Sechenov Medical Academy, Russian Federation, discussed collaboration in primary health care, using the example of the Russian Federation.

32. People’s health status has deteriorated over recent years, and the operational crisis in medical facilities is approaching the point at which the entire health system may collapse. Physicians account for 37% of health workers in the Russian Federation, and nurses for 63%, while in the economically developed countries the corresponding figures are 14-25% and 75-86%, respectively. The number of health staff per 10 000 population in various countries, listed below, shows the proportion of physicians to nurses more clearly:

Number of health staff per 10 000 population in various countries

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<thead>
<tr>
<th>Country</th>
<th>Physicians</th>
<th>Nurses</th>
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<tr>
<td>England</td>
<td>14.0</td>
<td>28.0</td>
</tr>
<tr>
<td>Canada</td>
<td>22.2</td>
<td>104.3</td>
</tr>
<tr>
<td>Denmark</td>
<td>25.6</td>
<td>143.4</td>
</tr>
<tr>
<td>Norway</td>
<td>24.3</td>
<td>114.3</td>
</tr>
<tr>
<td>USA</td>
<td>23.8</td>
<td>66.6</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>46.9</td>
<td>79.7</td>
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33. With the increasing specialization of polyclinics, the physician working in each clinic has been unable to coordinate the treatment and prevention activities of his/her clinic, or constantly monitor the condition of patients and their families, and was not actually responsible for the quantity and quality of care provided. At the time of the changeover to the compulsory health insurance system, a social law was adopted introducing general practice — a system of treatment and prevention based on the principle of family medicine and with the general practitioner (family physician) as its main element.

34. Of polyclinic physicians in the Russian Federation:

- 8.5% are completely satisfied
- 15.9% are satisfied
- 57.3% are fairly unsatisfied
- 12.2% are unsatisfied
- 6.1% would like to change their job.

35. Only 40% of the urban population are satisfied with the work of polyclinics in the Russian Federation: 65.2% are satisfied with the work of their internist, 35.4% with the work of their paediatrician and 23.9-29% with the work of their specialist.

36. The aims and tasks of the primary health care development programme in the Russian Federation are as follows:
• to make primary health care stronger and more effective, with the leading role being given to general practice (family medicine)
• to improve the laws, standards, methodology and financial and economic conditions underlying the reform of the outpatient and polyclinic care system, to introduce and develop general practice (family medicine) as appropriate and to increase the amount of medical care provided before admission to hospital and after discharge
• to introduce rational forms and methods of primary health care, based on general practice and its interrelationship with specialized types of medical care, domiciliary care and urgent and emergency care, taking into account the problems of social infrastructure in some parts of the country and the ageing population
• to develop an integrated system of professional training and systematically improve the qualifications of staff in general practice
• to establish and certify an information system to resolve the problems of general practice (family medicine).

37. The main aims of the restructuring of the health system are as follows:

• to work actively on the development of alternatives to hospital treatment
• to increase the amount of outpatient and polyclinic care provided
• to introduce a general-practitioner system, particularly in rural areas
• to increase the prestige of nurses and give them more control over their work
• to create a single legal environment governing the entire health system
• to reform the nomenclature of medical specialties and health facilities
• to raise the status of health workers
• to create an ideal of the healthy individual.

38. The failings of the health system can be divided into the following categories:

• development which emphasizes quantity at the expense of quality
• underdevelopment of the health network and the potential of the staff
• the lack of equipment in treatment facilities
• the low pay of medical workers
• the lack of economic management
• the excessive centralization of health system management.

39. The emphasis on quantity rather than quality in resource acquisition in the health system in the twentieth century has disappeared, and we need to find ways of emerging from the current situation, based on the following two approaches:

1. **Concentrating on risk factors**
   • health depends not only on health care, but also on lifestyle and living conditions

2. **Concentrating on improving the efficiency of health services**
   • making results commensurate with expenditure
   • emphasizing prevention and the development of primary health care
   • improving the quality of medical care, both in hospitals and in the primary health care system.
40. Reform of the primary health care system will require solutions to a number of major problems, which can be listed as follows:

- the reforms have not been coordinated (some polyclinics work under the old system, while others have adopted the general practice system)
- there are no regulations governing the training of general practitioners and nurses
- there is no financing mechanism for general practitioners
- there is no regulatory documentation
- information provision for general practitioners is poor.

41. In order to resolve these problems, we must take the following action:

- psychological reorientation to deal with the new working conditions
- changes to the duties of general practitioners and specialists
- reorganization of inpatient, emergency and urgent care.

42. However, many problems have arisen in the primary health care system itself, requiring solutions which may be categorized as follows:

- the increasing burden on physicians
- the physicians’ work is no longer under their control
- physicians are not prepared for the growing number of cases of chronic illness and geriatric problems
- lack of feedback between hospitals and polyclinics
- the lack of an agreed approach to clinical problems (e.g. protocols and standards).

43. Considerable changes are needed in the training system. The present system is one of “supportive education”, based on fixed methods and rules designed to help the health worker deal with familiar, regularly recurring situations. The alternative to this is “innovative education”, which develops the student’s ability to design projects to deal with future tasks and requires radically different approaches. Innovative education requires the curriculum content to be organized on a multidisciplinary basis, which will create a culture of systemic thought of the form “people — society — nature”. The content and methods of teaching under this system are designed to promote the individual’s innovative capacity, the ability to create something even if the teacher has not already talked about it.

44. Medicine in the twentieth century was patient-centred, which made possible the sequence “illness — recovery — more illness — chronic illness” within the paradigm “sick person — physician”. Medicine in the twenty-first century, however, must be health-centred, making possible the sequence “citizen — physician — healthy society” within the paradigm “patient — physician”.

**Country reports**

**Armenia**

45. The reform of primary health care in Armenia began in 1997 with the creation of a programme and strategy for the transition to the principles of general practice/family medicine.
Also in 1997, the financing system for outpatient care and polyclinics was changed to the capitation principle and, at the same time, a number of strategies from the new programme (staff training and establishment of 70-80 rural outpatient clinics staffed by physicians) entered the planning stage with support from the World Bank. The training element of the World Bank project included the creation and provision of facilities for departments of family medicine at the Yerevan State Medical School, the National Institute of Health Care and the Basic Medicine School. Lecturers have been trained in countries with experience in the teaching of family medicine (United Kingdom, Norway, Netherlands). These departments of family medicine were established in June 1997, and the departments at the Yerevan State Medical School and the National Institute of Health Care began to train physicians in September 1999. In August 1999, the Ministry of Health adopted provisional regulations on family physicians in Armenia (the rights and duties of the family physician and the physician’s qualifications, including the knowledge and skills expected of him/her). However, the corresponding regulations for family nurses have not yet been prepared. Thirty-six graduates of the medical and paediatric faculties of the Yerevan State Medical School and the National Institute of Health Care are now going through the two-year course in the family medicine departments of those institutions. Twenty-eight practising physicians have completed a one-year course at the National Institute of Health Care.

46. Thus, training in family medicine in Armenia is provided not only for new graduates, but also for practising physicians, using the same curriculum, although the length of the course is different for the two groups, depending on the students’ basic knowledge and skills. The training programme for family nurses is at the stage of development of the curriculum and preparation of the regulations governing the profession.

**Azerbaijan**

47. The State Commission on Health Reform has operated in Azerbaijan since 1998. At present, it is the information system which is undergoing reform, although changes are also under way in the education system to prepare for the introduction of general practice/family medicine. There are plans to set up a department of family medicine, on the same basis as the department of polyclinic medicine at the State Medical University. This new department will train family physicians at both undergraduate and postgraduate level. There are five medical schools in Azerbaijan, and in future these will also train family nurses. An association of family physicians is to be established, on the model of the alternative emergency care service in Baku, and this will coordinate all issues connected with the introduction of the family physician system and training of physicians in their new discipline.

**Belarus**

48. Health care reform in the Republic of Belarus, involving a change of priorities in favour of primary health care, began in 1992 and was partly due to the need to acknowledge the general practitioner as a key figure in the health system.

49. Firstly, as an experiment, we gained experience of organizing health care according to general practitioner/family medicine principles at the Krupitsa rural physician-led outpatients’ clinic. The Ministry of Health issued a number of orders intended to resolve the organizational, staffing, financial and technical problems associated with development of the general practitioner system. The 10 physician-led outpatients’ clinics in rural areas of Minsk oblast have been particularly successful, and the general practitioner model is continuing to be developed here
with the support of the Netherlands Institute of Primary Health Care, as part of the MATRA programme.

50. The training of students in higher education is changing. At the undergraduate level, family medicine forms part of the basic curriculum for all students, whatever their future specialization. A curriculum has been developed for a two-year on-the-job training course for general practitioners. Preparations have also been made for general practitioners to be trained at the Belarusian Medical Academy for Postgraduate Education. Sixteen departments are contributing to the training of general practitioners, under the coordination of the department of general practice.

51. A programme of skills updating for nurses and paramedics for work in health facilities using the general practitioner system has been developed and approved in Belarus. Teaching is based at the republican centre for postgraduate education for specialists with intermediate-level specialist and pharmaceutical education. A working group has been established to draw up a State Programme for Nursing Development in the Republic of Belarus, which is also intended to include a reform of nursing training.

**Georgia**

52. Georgia began to train general practitioners in 1997. Eight physicians from five major polyclinics in Tbilisi took a one-year course at London University (United Kingdom) and studied for one month at the University of Essex. A Department of Primary Health Care was set up within the Ministry of Health to coordinate efforts and oversee the introduction of the family medicine system.

53. From September 2000, we have begun to implement a joint project with the British Know-How fund, which includes the establishment of a national centre for training in primary health care, pilot family medicine centres and training for family physicians and nurses. As part of this project, eight nursing lecturers and 10 general-practice managers will begin their training in November 2000. These workers will provide a sound foundation for the provision of multidisciplinary education based at the above-mentioned national centre. At the same time, lecturers will be trained for the regional family medicine centres, and they will then train the general practice team in each region.

**Kazakhstan**

54. Reform of the primary health care system in Kazakhstan began in 1992, when family physicians began to be trained at the Postgraduate Institute. In the period 1996-98, as part of our programme of collaboration with Bristol University (United Kingdom), four two-month training courses were held for 30 physicians from two polyclinics in Almaty.

55. In 1997, the first specialist programme in family medicine began, and some 20 physicians have been trained. At present, the Ministry of Health is re-evaluating the reforms which have taken place in primary health care.

**Kyrgyzstan**

56. Restructuring of the outpatient care and polyclinic network in Kyrgyzstan and training of medical staff for the requirements of primary health care are continuing under the national MANAS programme of health reform, with the support of the World Bank.
57. Family medicine specialists are trained at both undergraduate and postgraduate levels. A family medicine department has been established within the medical faculty of the Kyrgyz State Medical Academy. It has an annual intake of 80-85 students, whose training is financed from regular budget resources. Postgraduate training (specialization) in family medicine, in the form of a two-year clinical studies course, is carried out both at the State Medical Academy and at the Republican Centre for Continuing Education of Medical and Pharmaceutical Workers. The noteworthy feature of the courses for clinical trainees at the Republican Centre is that the second year of the course is completely devoted to family medicine. The Republican Centre incorporates a family medicine centre, whose main task is to work towards the introduction of family medicine and train family medicine specialists. With the assistance of foreign consultants, the family medicine centre has developed curricula and training plans for physician lecturers and nurse lecturers in family medicine and for retraining of practising physicians and nurses.

58. The institutions above have adopted a modular approach to the subjects involved in family medicine. During the teaching process, considerable attention is paid not only to improving the health workers’ level of theoretical knowledge, but also to giving them the necessary practical skills in diagnosis, treatment and prevention of the most common diseases and pathological conditions, as well as health promotion and education.

**Moldova**

59. The reform of the primary health care system in the Republic of Moldova began immediately after the WHO Ljubljana Conference. Now family medicine centres have been established, based at existing polyclinics. Legally, they are subdivided into health centres and surgeries for family physicians outside the cities (the former outpatients’ clinics and paramedic/midwife units). Health services are provided at 2 500 health facilities, each employing one general practitioner and serving 1 500 people.

60. Since 1997, we have provided a three-year specialized training programme in general practice. Since 1998, retraining has been provided for internists and paediatricians. Over the past few years, approximately 1 300 physicians have undergone training in family medicine. In 1998, a department of general practice was set up at the Medical University in Chisinau.

61. In the family medicine centres, where not all physicians have yet received specialist training in general practice, a team approach to care is used (2 internists + 2 paediatricians + 1 obstetrician/gynaecologist per 6 000 population).

62. Retraining for general practice consists of training courses for internists, paediatricians and, to a lesser extent, other specialists, followed by three years of on-the-job training. In 2000, 40 physicians who had completed the three-year training were certified as general practitioners. The best candidates from the first set of graduates will be recruited to train others. However, in order to train family physicians, university-level training facilities — pilot teaching centres for family medicine — will be required. These issues, as well as the training of instructors, will be addressed as part of the partnership between Norfolk/Portsmouth (USA) and Chisinau, supported by USAID and other sponsors.

**Russian Federation**

63. The development of primary health care in the Russian Federation is regulated by an order issued in 1992. At present, the implementation of tasks in this area is at a transitional stage, but the entire health system will be covered by 2003.
64. Health care is one of the country’s vital systems, and its cornerstone is staff training, which must be guaranteed by the State Educational Standards. The basic principles of these revised standards are: the maintenance of a unified training environment, improving the quality of training and increasing the range of possibilities for obtaining a sound education. Each course must include a federal component, a regional (university) component comprising up to 15% of the total and subjects chosen by the student and taught by the university, also comprising up to 15% of the total. The training curriculum for a family physician (2550 hours) should comprise: 36% of the total time on internal medicine, 15% on surgery and trauma medicine, 11% on paediatrics, 10% on the socioeconomic foundations of family medicine, 9% on obstetrics and gynaecology and 19% on other clinical subjects.

65. The educational standards lay down the following length of courses: initial specialization for graduates in internal medicine and paediatrics — 2 years (3456 hours); professional training for experienced physicians — six months (864 hours); certified (approved) courses for general practitioners/family physicians — two months (288 hours); training in individual subjects — 72-100 hours. It is proposed to use both the existing regional universities and the newly established oblast-level general practitioner training centres for the training of general practitioners/family physicians and physicians practising in polyclinics, district hospitals, physician-led outpatients’ clinics and private practice. All the training courses have been designed to cover the main activities of the general practitioner/family physician, including: prevention, diagnosis, treatment and rehabilitation of the most common diseases, emergency and urgent treatment, medical manipulation and organization of the physician’s work.

**Tajikistan**


67. The department of general practice (family medicine) at the Tajikistan State Medical University has been open since November 1999, following a reorganization of the department of polyclinic medicine.

68. The transition to family medicine calls for a review of medical education, based on the “New Educational Concept”. Shortly after its establishment, the clinical base of the family medicine department was extended and the staff studied systems of training in family medicine, both in countries of the Commonwealth of Independent States and in countries with many years of experience of teaching this subject. “Family medicine” has now been introduced as a subject in the training of all students in years 4, 5 and 6 at the Medical University. A training programme in family medicine for specialists has been prepared. The qualification of family physician will be awarded on completion of a two-year postgraduate course. The first intake of students on this course will be in 2001. Family physicians are also trained at the Institute for Postgraduate Training of Medical Workers: 60 physicians have retrained to date. At present, 111 physicians from rural areas are undergoing retraining. A faculty of nursing has been established at the Institute: 61 nurses have so far taken courses to improve their qualifications, and 35 nurses have been trained in the family nurse programme.

**Uzbekistan**

69. A decree on reform of the health system was adopted in 1998. One of the main aims of the reform is to shift the emphasis in the provision of health care from costly hospital-based care to
cost-effective primary health care, as well as to establish rural medical posts within the primary health care network and to effect a gradual transition to a general practitioner system. There are now 1,200 rural medical posts in operation. A two-level training system has been introduced in the country’s medical schools, comprising a seven-year undergraduate course leading to the qualification of general practitioner and postgraduate training, in subjects including family medicine, lasting 2-4 years. As regards intermediate-level medical training, our medical schools are gradually being converted to professional medical colleges and preparing to train general practice nurses. Since 1999, new faculties for training nurses with higher educational qualifications have been opened at medical institutes. As well as initial training for physicians and nurses in the medical institutes, between 1996 and 1999 specialists were retrained at the Tashkent Institute for Continuing Education of Physicians in four-month courses for physicians with some practical experience. In 2000, the second phase of retraining began, consisting mainly of blocks of teaching spread over 10 months—a combination of short blocks (two weeks) of theoretical training and practical training in the workplace, with a certification examination at the end of the course.

70. Thirty-eight lecturers/trainers from seven medical institutes have been trained to date, and they are now training 123 physicians from rural medical posts throughout Uzbekistan.

**Site visit to Minsk District**

71. The group paid a visit to the Minsk District, 223014, Health Care Centre Krupitsa and were welcomed by Dr Anatoly Sklyarov, Director, and Dr Valentin Rousovitch, General Practitioner, Minsk District, 223014. Dr Wienke Boerma from the WHO Collaborating Centre in Utrecht, The Netherlands, is supporting the project, together with other donors.

**Conclusions**

72. The St Petersburg Initiative is dedicated to the principle of provision by family physicians of the highest possible quality of care for families. At the fourth meeting of the St Petersburg Initiative in Minsk, Belarus, from 12 to 14 October 2000, the participants came to the following conclusions, aimed at the realization of this goal:

⇒ Specialists who will be working in a team must have the opportunity to undertake undergraduate and postgraduate education and training with other disciplines.

⇒ There is a need to specify the roles and responsibilities of all key specialists who regularly work in a team in primary health care.

**Recommendations**

(1.) A working group, including both nurses and physicians, should be established to achieve a mutual understanding of the respective roles of physicians and nurses, as well as their respective responsibilities (obligations).

(2.) The skills necessary for the discharge of these obligations and the development and modification of the required legislative base are essential if these aims are to be achieved.

(3.) Curricula must be developed in each participating country to respond to the obligations which have been determined.
(4.) Examples of positive and effective collaboration between physicians and nurses in the area of family medicine should be selected and accumulated, and this experience should be widely disseminated in the countries participating in the St Petersburg Initiative. Collaborating centres should be established for this task.

(5.) Seminars should be held in each participating country in order to establish teams or groups of health workers. Criteria should be defined for evaluating the advantages of creating a new environment in the area of health services.
Annex 1: Working papers and background material

Working papers

5020876 2000/1 Provisional list of working papers and background material

5020876 2000/2 Scope and purpose

5020876 2000/3 Provisional agenda

5020876 2000/4 Provisional programme

5020876 2000/5 Provisional list of participants

5020876 2000/6 Multidisciplinary collaboration in primary health care - 
Ms Fedelma Winkler, Department of Post-Graduate General 
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5020876 2000/7 Multidisciplinary collaboration in primary health care - 
Mrs Ainna Fawcett-Henesy, Regional Adviser, WHO Regional 
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Background material

EUR/ICP/DLVR 040202 Report Third meeting of the St Petersburg Initiative for education 
and training in general practice/family medicine, Bishkek, 
Kyrgyzstan, 18-20 November 1999

- Overview of conclusions and recommendations from St Petersburg 
Initiative Network meetings, 1997-99
Annex 2: List of participants

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