FACULTY FORUM

Public Health Nursing Education in Russia

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ABSTRACT

The collapse of the Soviet Union in 1990 brought many changes to Russia, including changes in nursing education. However, the changes did not include content in public health nursing. Most health care in Russia is provided at the tertiary level in hospitals. Health promotion and health education are new concepts in Russia and are not well understood. When health education does occur, it is at the individual level, taught by physicians, and in response to new diagnoses. Health promotion at the primary level and with aggregates is not often practiced. Russia currently is in a demographic crisis where health indicators continue to decline. Russian nurses trained in public health principles, such as health promotion, health education, and providing primary and secondary prevention services at the population and aggregate level, can positively affect the current demographic crisis.

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The former Soviet and current Russian health care systems can be classified as illness-focused systems. Minimal public health content is included in nursing or medical curricula. Most health care is conducted in hospitals at the tertiary level. Concepts such as health promotion, health education, and primary, secondary, and tertiary care are new. When health education does occur, it is at the individual, rather than aggregate, level.

Russia currently is in a demographic crisis in which the death rate exceeds the birth rate, the life span of men is 58 years, alcohol abuse is rampant, and the percentage of the population that smokes continues to increase (Alexeov, Yakyshev, Shoekova, & Maslakova, 2000; Demitriov, Onitsenko, Toropsev, & Gontsarenko, 2000; Office on Smoking and Health, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, World Health Organization, 1997; Ogurtsov, 1998). The number of cases of tuberculosis and hepatitis A and B are increasing, while the acknowledgment of AIDS as a health problem has only recently been made (Cmagina, 2000; Kracelnekov & Doropheev, 1999, 2000).

As of January 1999, the population in Russia was 146.3 million (Balgin & Bryee, 1999). If the current demographic crisis does not change, the population of Russia is predicted to decrease to approximately 55 million by 2075 (Cmagina, 2000). Public health initiatives are known to be effective in decreasing morbidity and to be cost saving for individuals and governments (Lantz et al., 1988). Including content related to primary and secondary prevention, such as identifying populations at high risk for disease, and health promotion in nursing curricula would begin to strengthen the public health infrastructure of Russia and address its demographic crisis.

History of Nursing Education in Russia

The collapse of the Soviet Union in 1990 brought many changes to the country, including changes in the education and preparation of nurses. Under the Soviet system, nursing education started after the 10th grade for 2 years or after the 8th grade for 3 years. The extra year after the 8th grade did not include nursing content but helped students adjust to higher education. Physicians taught nurses at medical education centers. According to Dr. Victor Lapotnikov, Dean of the Faculty of Advanced Nursing Education at the St. Petersburg State Medical Academy (personal commu-

nication, June 25, 1995), this accounted for a medical model of nursing education that included coursework in subjects such as ophthalmology, neurology, and gastroenterology. Little patient contact was included in nursing education because the places of employment were considered to be nurses' practicum. Any patient contact that did occur was at the end of the coursework, rather than integrated throughout the nursing program. Nurses primarily worked in hospitals or clinic settings (known as polyclinics), functioning under the direction of physicians and fulfilling basic tasks, such as obtaining vital signs and distributing medications.

The current Russian nursing education system continues to be highly bureaucratic and is regulated at the federal level. Any changes in nursing curricula must be approved by the Federal Education Board and implemented as Russian Federation law, making any changes a lengthy proposition. Nursing education was expanded to 3 years after the 11th grade in 1991 when it became mandatory for all Russian students to complete the 11th grade. However, nursing education continued to be taught by physicians at medical education centers, medical academies, or colleges using a medical model. No content in health education or health promotion was added to the curricula.

The third year of nursing education was added to provide students with specialization in an area such as family practice nursing. Family practice nursing was initiated in response to the 1992 movement in medical education to prepare family practice physicians (Denisov, 2000). The former Soviet medical system prepared highly specialized physicians with no preparation in general practice, family practice, or primary care (Denisov, 2000). The need for family practice physicians grew out of the recognition that Russia did not have physicians trained in primary health care who could provide holistic care to entire families at the primary and secondary levels (Denisov, 2000). Family practice nurses are trained to work specifically with family practice physicians in providing health care to families. Although family practice physicians and nurses have been undergoing training since 1992, Russian Federation law did not uphold their preparation until 1999 (Denisov, 2000). According to Denisov (2000), the law projected the movement toward primary health care as a

> continual movement of the health care system toward primary health care and the preparation of Family Practice Physicians, lifting the prestige of nurses working in Family Practice offices, the development of alternative places of practice for primary health care, and the active involvement of the Russian population in decisions related to health promotion. (p. 3)

As such, the law provided a mechanism for introducing public health principles into nursing curricula.

Nursing curricula began to change in 1996 with the introduction of the nursing process. However, according to Dr. Galina Perfiljeva, Dean and Professor of the Nursing Department at the Sechenov Moscow Medical Academy (personal communication, December 28, 2000), the nursing process was not accepted by Russian Federation Law and as a result was not taught consistently. Nursing theories also were taught sporadically, based on individual faculty members' knowledge of these theories. In 1996, the requirement for completing a course of continuing education every 5 years was begun. Such programs are offered at medical centers, academies, and colleges and include content on various topics that primarily focus on the disease process.

In 1994, a higher education program was introduced for nurses who had been working for several years. This program was begun to prepare nurse managers for working in hospitals and polyclinics. The 4-year program (i.e., 4,600 hours) included course content in nurse management, marketing, social services and health care, psychology, nursing education, organization of hospital food services, health care economics, health care law, and biomedical ethics (Krasnova, 1998). According to Dr. Galina Perfiljeva (personal communication, December 28, 2000), by the end of December 2000, there were a total of 25 programs throughout the Russian Federation that prepared nurse managers. However, the current economic crisis has made it difficult for these nurses to find appropriate positions in hospitals and polyclinics. Some have gone into nursing education as the need for nurse educators has been recognized.

Although changes in nursing education have occurred, they have failed to include content in public health for nursing students in the "generic" 3-year programs. A basic understanding of primary and secondary health care is provided in family practice and nurse management programs. However, even in these programs, minimal content in health promotion and health education is provided inconsistently and remains at the individual or family levels, rather than the community or aggregate levels (Denisov, 2000).

Nursing Employment

Changes in nursing education have occurred. However, nursing tasks have not changed since the Soviet health care system was in place. Nurses do not practice independently, and their tasks primarily involve implementing physicians' orders. Nurses are state employees, and the current economic condition in Russia has affected their salaries. Starting salaries for new graduate nurses working in hospitals are abysmal and ranged from 232 rubles (St. Petersburg) to 650 rubles (Moscow) in December 2000, which are the equivalent of $9 and $24 per month in the United States. Nurses working in polyclinics receive even lower salaries. In December 2000, the living minimum (i.e., minimum amount on which one person can live) was determined to be 1,600 rubles for women, 1,800 for men, and 1,400 for school-age children and adolescents. Although this amount varies by city and region, most Russians consider these unrealistic estimates of the

amount of money required to live. To compensate their salaries, some nurses have agreed to take on housekeeping tasks, such as cleaning patient rooms and washing floors, while others work as masseuses.

The majority of Russian hospital nurses work a 24-hour shift, followed by 3 days off, and then another 24-hour shift. Few Russian hospital settings have personnel similar to nurse assistants in the United States. As a result, nurses bathe and feed patients, as well as perform nursing duties. Physical assessments are not conducted because they are considered to involve medical, rather than nursing, skills, and no health education is provided by nurses.

Nurses working in polyclinics work day shifts. Their salaries are lower than those of hospital nurses because they cannot compensate their salaries by working 24-hour shifts. At polyclinics, nurses and physicians make home visits when requested by patients. Nurses' home visits include obtaining patient histories prior to hospital admission, changing dressings, and performing basic treatments, such as using heat lamps for skin ulcers. Polyclinic physicians conduct physical assessments and any patient health education.

Nurses working in family practice offices also work day shifts. Their three main activities are "independent practice, working professionally together with the Family Practice physicians, and involvement in medical-social assistance to populations" (Denisov, 2000, p. 4). However, their ability to practice independently is limited by the physicians, and their involvement in medical-social assistance is limited by their knowledge base. Similar to nurses working in other settings, family practice nurses primarily implement physicians' orders. Home visits are made to obtain blood analyses, conduct procedures such as dressing changes, start intravenous lines, and administer pain medications to oncology patients.

Family practice nurses do not consistently conduct health education, but when they do, it is at the individual, rather than aggregate, level (Denisov, 2000). Family practice physicians are minimally involved in health education activities in their practice. For example, only 20% of family practice physicians included health promotion or education activities in their practices (Denisov, 2000). A recent study conducted in Russia asked patients who visited family practice offices to identify their main source of health information. Sixty-two percent of patients considered physicians or nurses their main source of health information (Denisov, 2000).

Screening activities for noninfectious diseases and illnesses (e.g., high blood pressure) rarely are conducted by nurses or physicians (Denisov, 2000). Secondary prevention activities (e.g., flu shots) are provided for the population but only at patients' request and by their physicians. Because the incidence of tuberculosis has continued to increase, physicians do conduct tuberculosis screening of all health care workers and children annually. Any other aggregate level screening occurs only when physicians consider the population to be "of low culture," meaning unable to understand illness symptoms. For example, according to Dr. Pavel Krotin, Director of Youventa Youth Center (personal communication, November June 13, 2000), physicians screen all female students at age 15 for sexually transmitted diseases.

Conclusion

Public health initiatives are known to be effective in decreasing morbidity and improving quality of life. Nurses have always been considered an integral part of any health care system. Educational content in public health principles, such as health promotion, health education, and providing primary and secondary prevention services at the population and aggregate levels, are needed to help resolve the current demographic crisis in Russia. The educational preparation of family practice nurses and nurse managers is a start in upgrading nursing education in Russia toward a wellness focus. Russian nurse leaders are aware of the demographic crisis and the potential of nurses to positively influence this crisis. They are eager to collaborate with nurses from various countries to help them improve nursing curricula to include primary care and public health principles. More international cooperation and collaboration among nurses and nursing organizations is needed as nurses worldwide cope with new and diverse global health issues.

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