

Jørn Holm-Hansen

# Introduction Occupational Theraphy in Russia

Swedish efforts evaluated



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# Introduction Occupational Therapy in Russia



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Jørn Holm-Hansen

# Introduction Occupational Therapy in Russia

Swedish efforts evaluated

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# Preface

This Evaluation has been carried out for the The East Europe Committee of the Swedish Health Care Community (SEEC). The Report documents the efforts made by the Swedish Association of Occupational Therapists (FSA) and the St. Petersburg State Medical Academy named after I. I. Mechnikov (the Mechnikov Academy) to introduce occupational therapy in Russia. In accordance with the Terms-of-Reference the Review has aimed at identifying results, and it presents a set of recommendations. The report aims at facilitating learning for future use.

The preparations, field studies and writing up have taken place within the framework of 175 man hours. The Norwegian Institute for Urban and Regional Research (NIBR) would like to thank all those having shared their time, information and insights with the Evaluator. Everybody has been very helpful.

The Evaluator is particularly grateful to Annica Larsson and Birgitta Jansson at SEEC, who provided all necessary documents, neatly organised chronologically in binders. This saved much time for the Evaluator.

The Evaluator has drawn on discussions with senior researcher Marte Feiring at the Norwegian Institute for Urban and Regional Research. She is a sociologist with a background as an ergotherapist. Inger Balberg at NIBR deserves thanks for her technical finish on the final version of the report.

Oslo, March 2009

Marit Haug

Research Director

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# Summary

*Jørn Holm-Hansen*

## **Introducing Occupational Therapy in Russia:**

Swedish efforts evaluated

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Russia has a strong tradition of rehabilitation and recovery, which among others manifests itself in a fine-meshed net of sanatoriums all over the federation. The professional subdivisions within Russian rehabilitation does not coincide with those of, say, Sweden. For instance, occupational therapy as a profession does not exist in Russia. Introducing occupational therapy was the main objective of the project evaluated in this Report, and the main intervention to reach this goal consisted in establishing education in occupational therapy.

The project was carried out by the Swedish Association of Occupational Therapists (FSA) and the Mechnikov State Medical Academy in St. Petersburg in four consecutive phases between 1998 and 2008.

The main objective of the project was not reached despite efforts throughout ten years and grants amounting to almost ten million SEK. Occupational therapy has not been introduced during the project period.

Nonetheless, as a result of the project, a small group of medical doctors have received the basic training recommended by the World Association of Occupational Therapy. Some of them are qualified as trainers. A number of medical institutions function as model units where students can practice. In other words, in case Russian authorities in the near future decide to introduce occupational therapy, there is a certain critical mass of skilled personnel in St. Petersburg.

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The project suffered from a weak programme theory (assumed links between the project activities and the results). From carrying out training to introducing a new profession there is a long way to go, and the project owner hardly looked beyond the training stage. In fact, at times the project owner referred to training as the projects main goal.

The project might have gained from distinguishing between varieties of introducing occupational therapy. The aim was to introduce it as a standardised *specialisation* for medical doctors, but it could also have been based on nurses, physiotherapists or other health professions. Introducing it as a profession is but one among several varieties. Alternatively, occupational therapy could be established not as a fully-fledged profession, but rather as *a field of activity* applicable for specialists within various medical professions.

The project met serious problems at an early stage. The Russian partner clearly showed signs of loosing interest as the project periods passed by. The Russian project partner seems to have got second thoughts already during the first project period, but was apparently not ready to discontinue the project formally.

Since the project started on the initiative of a superior decision-maker in St. Petersburg's health system at the time, the FSA made little further investigation into the actual need and wish for occupational therapy in Russia. The Swedish partner was not very attentive to – or knowledgeable about – the set-up of the medical sector, and worse, they do not seem to have got much help from the Russian side in acquiring such insight. The project had very few links to the recent reform of recovery medicine in Russia that took place during the project. In fact, the reform went unnoticed by the Swedish partner. The lacking links to an overall reform strategy explains some of the difficulties in securing Russian funding of project activities (refurbishing training premises; paying Russian lectures among others).

Apart from small technical and pedagogical adaptations, the project methodology and approach were not changed. In stead the project owner repeatedly applied for funds to replicate the previous project. In fact, there is reason to ask why the project was not discontinued at the end of project 2 or 3.

The report contains a set of recommendations of a general character for use in ongoing or future projects. These are:

1. *Be ready for normalcy.* Prepare for project implementation in stable, well-structured countries, and link up with reform agendas in the target country.
2. *Do not underestimate the knowledge-intensity of the project.* Carry out an in-depth appraisal or pre-feasibility study before starting up the project.
3. *Use Russian in Russia.* Translate basic literature into Russian as early in the process as possible, and make use of Russian-speaking trainers as much as possible.

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## Краткое резюме отчета

*Jørn Holm-Hansen*

**Внедрение эрготерапии в России: оценка работы шведской стороны**  
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В России существуют устойчивые традиции в сфере реабилитации и восстановления, что выражается, помимо прочего, в наличии хорошо развитой сети санаториев на всей территории федерации. Профессиональное разделение внутри российской системы реабилитации не совпадает, скажем, со шведской моделью. Так, к примеру, в России не существует эрготерапия как самостоятельная специальность. Представление и внедрение эрготерапии было основной целью проекта, который подвергается оценке в данном Отчете, и основное воздействие проекта, направленное на достижение этой цели, заключалось в организации обучения эрготерапии.

Проект выполнялся Шведской Ассоциацией Эрготерапевтов (FSA) и Санкт-Петербургской государственной академией им. И.И. Мечникова. Проект состоял из четырех последовательных этапов и длился с 1998 по 2008 год.

Основная цель проекта не была достигнута, несмотря на усилия, прилагавшиеся в течение 10 лет, и гранты, составившие почти десять миллионов шведских крон. Эрготерапия не была внедрена за время действия проекта.

Тем не менее, в результате проекта немногочисленная группа врачей получила базовое образование, рекомендованное Всемирной Ассоциацией Эрготерапии. Некоторое из них

получили право преподавать. Ряд медицинских учреждений располагают показательными отделениями, где студенты могут практиковаться. Другими словами, если в ближайшем будущем российское руководство решат внедрить эрготерапию, в Санкт-Петербурге в наличии уже будет некая критическая масса квалифицированного персонала.

Проект пострадал от слабой программной теории (предполагаемые связи между мероприятиями, задействованными в ходе проекта, и результатами). От организации обучения до внедрения новой специализации – долгий путь, а держатели проекта едва ли смотрели вперед дальше, чем стадия обучения. Фактически, держатели проекта периодически упоминали обучение как главную цель проекта.

Проект мог бы выиграть, если бы рассматривались разные варианты внедрения эрготерапии. Целью было ввести эрготерапию как стандартизированную *специализацию* для врачей, но можно было бы привлечь и медсестер, и физиотерапевтов и других специалистов. Введение её как специальности было всего лишь одним из нескольких вариантов. И наоборот, эрготерапия могла бы быть учреждена не как полноценная специальность, а скорее как *область деятельности*, применяемая специалистами других медицинских специализаций.

Проект столкнулся с серьезными проблемами на ранней стадии. Российский партнер демонстрировал явные признаки смены интересов на разных стадиях проекта. Российский партнер по проекту, похоже, был склонен к пересмотру своего решения уже на первом этапе проекта, но явно был не готов к формальному прекращению проекта.

Поскольку проект стартовал по инициативе тогдашнего высшего руководства системы здравоохранения Санкт-Петербурга, FSA приложил недостаточно усилий к проведению дальнейшего исследования на предмет того, нужна ли эрготерапия в России и хотят ли её там. Шведский партнер был не очень внимателен к – или мало знал - об организации медицины в России, и, что еще хуже, похоже, что российская сторона не оказала значительной помощи в приобретении таких знаний. Проект был мало связан с

недавней реформой медицины реконвалесценции, которая имела место в России во время проекта.

Практически, реформа прошла незамеченной шведским партнером. Недостаток связей с общей стратегией реформы объясняет некоторые трудности в получении российского финансирования деятельности по проекту (среди прочего ремонт помещений для занятий; оплата российских преподавателей )

Помимо незначительных доработок технического и педагогического характера, методология и концепция проекта не менялись. Вместо этого, держатель проекта неоднократно обращался за финансированием для того, чтобы продублировать предыдущий проект. В сущности, можно было бы задать вопрос, почему проект не был остановлен в конце проекта 2 или проекта 3.

Отчет содержит ряд рекомендаций общего характера, которые могут быть использованы в текущих или будущих проектах:

1. *Готовьтесь к нормальной работе.* Подготовьтесь к реализации проекта в стабильной, хорошо структурированной стране и увяжите свою заготовку с программой проведения реформ в конкретной стране, где вы будете работать.
2. *Не следует недооценивать важность предварительной информации о проекте.* Проведите всесторонний предварительный анализ или предпроектное технико-экономическое исследование до начала проекта.
3. *В России пользуйтесь русским языком.* Как можно раньше переведите основную литературу на русский язык, как можно чаще используйте русскоговорящих преподавателей.

# 1 Introduction

## 1.1 Brief information on the project activities evaluated

### 1.1.1 The project in brief

**Objective:** To establish occupational therapy as a profession in Russia.

**Partners:** Swedish Association of Occupational Therapists (FSA) and the St. Petersburg State Medical Academy named after I. I. Mechnikov (the Mechnikov Academy).

**Methods:** To train medical doctors in occupational therapy. The trained doctors then have been supposed to build up education in occupational therapy as well as introducing occupational therapy in to the health system in St. Petersburg.

**Scope:** 1998 – 2008. The projects have received the following grants:

	Duration	Total sum (in SEK)
1 <sup>st</sup> project	1998 – 2001	2,400,000
2 <sup>nd</sup> project	2001 – 2004	3,453,230
3 <sup>rd</sup> project	2003 – 2006	1,715,000
4 <sup>th</sup> project	2005 – 2007*	1,442,900

(Source: *Final Activity Reports*)

\* Sums spent in 2008 were negligible.

### 1.1.2 Background of the project

The project started out in the unstable and economically miserable Russian context of the late 1990's, but Russia soon entered into a period of stability and increased public and private spending. Like many other projects initiating from the chaotic years of the late 1990's, the occupational therapy project has had to face the challenges of re-explaining its role in a well-organised, controlled country.

During a meeting with top leaders of St. Petersburg's health authorities, organised by the East European Committee of the The East Europe Committee of the Swedish Health Care Community (SEEC) in 1997, the president of the Swedish Association of Occupational Therapists (FSA) clearly got the impression that there was a great interest on the Russian side for occupational therapy, which did not exist as a profession in Russia. A project proposal to the SEEC was approved in 1998. At the time FSA was quite convinced introducing occupational therapy into Russia would be possible, not least on the background of the fact that the initiative for the project came from the Russian side. FSA felt confident there would not be major obstacles to project implementation, and no objections came up from the Russian partner as to the feasibility of the project.

Throughout the ten years of co-operation the project has changed little, although of course various pedagogical arrangements have been tried out, like having lectures at relevant clinics at different times of the day, sometimes in the week-ends to cater for students working full-time, or making use of an interpreter when lectures have been given by Swedish occupational therapists. However, in their basic structures, the four stages (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> projects) are almost identical despite the fact that the contextual factors changed considerably between 1998 and 2007, and despite the difficulties encountered.

### 1.1.3 The actors

The project on occupational therapy has been carried out between SEEC's member organisation, the Swedish Association of Ergotherapists (FSA) on one hand and the St. Petersburg State



Medical Academy named after I. I. Mechnikov (SSMA) on the other.

The project has been marked by stability regarding the actors involved. For instance, on the Swedish side the project manager all the way through the project has been the same person.

The Occupational Therapy Programme is administratively under the Department of Recovery Medicine Faculty of Postgraduate Education.

The project has had a local, full-time administrator (a graduate from the 1<sup>st</sup> project), and the Swedish project manager has lived in St. Petersburg for longer periods during the projects. The local administrator was to learn how to set up training courses, make a choice of relevant literature, select examination methods, as well as how to carry out courses.

The institutions where occupational therapy is being applied (see chapter 3.3.2) are among FSA's local cooperation partners.

#### 1.1.4 Purpose and scope of the evaluation

The main purpose of the evaluation, as described in the Terms-of-Reference, is to enable *a learning process*. The evaluation provides an external look at methods, outcomes and impacts. Target groups for the learning are SIDA and the Board and Secretariat of SEEC and the Russian and Swedish project owners and managers. Learning is important to avoid duplicating mistakes within the project itself, and to provide a better starting point for future project activities, notably the future project staff of similar projects in Belarus.

The knowledge-base for the learning process will be *the evaluation's detailed scrutiny* of how the projects (phases 1-4) have been carried out. What are their designs? What are the assumed links between the project activities and the results aimed at? What mechanisms did the projects set in motion? How were the projects implemented and not least what are their results? What were the working methods applied? Have the partners involved been able to learn lessons during the project period? On a more fundamental level, it is also necessary to check the relevance of the project in the Russian context.

Although the evaluation's focus will be on the ergotherapy projects, it will also make conclusions with relevance to social and health project with Russia in general, as recommended by Ramböll Management in 2004.

The evaluation has been carried out within the framework of 175 man-hours.

## 1.2 Design and methodology

The Terms-of-Reference presents a set of criteria and questions for the evaluation of process, relevance, results, effects, cost effectiveness and sustainability. The set of criteria and questions formed the basis of the Interview Guides.

The evaluation will stick to the general framework outlined by Side's evaluation manual "Looking Back – Moving Forward".

### **Programme theory**

The evaluation has not only identified and documented *results/impacts*. In addition, it has described and analysed *process/activities*. In order to link activities and results, the *programme theory* tool has been applied. A definition frequently referred to, defines programme theory as:

"... a specification of what must be done to achieve the desired goals, what other important impacts may also be anticipated, and how these goals and impacts would be generated" (Chen, Huey-Tsyh, *Theory-driven evaluations*, Newsbury Park CA, Sage Publications, 1990, p. 43).

Programme theory is a practical tool to help bring forth the assumed relations between the interventions (inputs) and their outputs and outcomes, and the relations between the outcomes and the solution of the problems that the intervention seeks to reduce or solve. Programme theory, like other theory, suggests links between causes and effects. One could also think in terms of configurations of context, mechanisms and outcome (CMO): What outcomes are results of what mechanisms under what preconditions?

### **Programme theory for the project on occupational therapy**

The following questions are helpful in structuring the analysis of the effects and impacts of the project on occupational therapy:

1) What is it that makes the intervention, measure or project lead to the anticipated output? Outputs are the direct results of the activity (the “input”), like for instance the number of people trained through seminars.

*In the case of the projects on ergotherapy in St. Petersburg, the question would be to what degree the training makes students capable ergotherapists.*

2) What is it that makes the output lead to the desired outcome? Will the participants of the training programme use their recently acquired skills for the purposes sought by the programme?

*What will make the participants of the training programme work as ergotherapists?*

3) Is there reason to believe that the outcome will lead to the wanted impact? To follow up the example: Will the activities carried out as a result of the 80 weeks training programme lead to – or contribute to – the impacts identified.

*In what ways will the fact that a certain number of people with a medical degree have been trained in ergotherapy contribute to the profession's establishment and survival in Russia?*

In other words, what mechanisms leading to the desired goal will the project bring into play? What makes A (the input) lead to B (the output)? What makes B lead to C (the outcome), and what is the link from C to D (the impact)?

### **Case study approach**

Much of the methodological approach is outlined above. The use of programme theory to clarify the expected links between interventions and results, outcomes and impacts will be combined with an open attitude to real-life complexities that will be accounted for in the report.

In real life, processes of change are less linear than envisaged in programme theory. Therefore, in order to account for change in an efficient way, the analysis will be based on attention to *actors* in the processes of change as well as their *activities*, and not least

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seeing these activities in their *institutional context*. Russia is a well-structured country, with an elaborated legal framework, strong and self-confident administrative institutions, financial mechanisms and professional traditions. Also, Russia has a distinct – and often problematic – administrative and decision-making culture. All this has to be accounted for in the investigation and the analysis. It requires going in-depth analysing the ergotherapy projects in their real-life context. Doing this, we will draw on *case study approaches*.

### **Interviews**

In evaluations the interview constitutes a major source of information. Good interviews, therefore, is of great importance. The interviews carried out as part of this evaluation have been semi-structured, meaning that they have proceeded according to a plan common for all interviews with similar interviewees.

Being semi-structured the interviews have allowed the interviewees to bring in aspects or issues other than those planned by the evaluator. Listening carefully to what the interviewee is actually saying and what he/she tells between the lines is fundamental for all research interviews because it is the source of follow-up questions that may lead the research further, and throw light on what other interviewees have told or what has been written in project or programme documents.

### **Documents**

The evaluator has had access to all relevant documentation (among them applications and reports). The SEEC provided a binder in which all relevant documents were placed chronologically. Also the FSA was very helpful in providing additional information and specialist literature on occupational therapy.

### **Ethics**

We have followed the standards of the Joint Committee on Standards for Educational Evaluation as well as the AEA Guiding Principles. Among others this implies making sure individuals and organisations evaluated as well as those directly involved in the evaluation have been treated with due respect during interviews and visits as well as in the report. Critical assessments and comments will be based on fairness and justification, and no uncalled for harm will be done.

## 2 Occupational therapy in the Russian context

### 2.1 Why place occupational therapy on the Russian agenda?

#### 2.1.1 Occupational therapy

Occupational therapy is one among several professions within rehabilitation and habilitation internationally. The profession is present to a varying degree from country to country, and is present in 26 of Europe's 44 countries.

Occupational therapy is multi-disciplinary and draws on medical, social, psychological, and biological sciences.

The core idea of occupational therapy is to assist patients with reduced capacities for activity in achieving well-being and life quality. The goal is to assist the patient master everyday activities (occupational behaviour) in the patient's social, domestic and personal environments.

Occupational therapy focuses on the linkage between activity and health. The activities of the patient are what cure him/her. Occupational therapists focus not only on the patient, but also on his/her surroundings.

Occupational therapy is marked by its approach to the patient. Occupational therapy focuses on the patient's talents, possibilities and resources rather than his/her non-existing or lost functions.

### 2.1.2 The position of occupational therapy in Russia

Russia's elaborate legal framework, strong administrative institutions, financial mechanisms and professional traditions all form the background for the project's attempts at paving the way for the introduction of occupational therapy as a new specialisation.

Among others through is fine-meshed network of sanatoriums and health resorts Russia has a strong tradition for rehabilitation broadly defined. There are several professions that have official recognition within the well-developed sector of medical rehabilitation and habilitation. Occupational therapy, however, is not among them.

In 1996 the Mechnikov Academy started the process of registering physiotherapy (in the "Western" sense of the word) in Russia. At the first Russian Congress in Rehabilitation (Vosstanovitel'naia meditsina) the Academy tabled a resolution to include occupational therapy on the official list of specialities in the health care system. This, however, did not happen.

The profession of *work therapy (trudoterapiia)* was developed by the well-known Soviet psychologist Solomon G. Gellerstein. Work therapy today is applied mainly within social work with psychiatric patients, among blind people, and within neurological and post-stroke rehabilitation. Work therapy contains elements of occupational therapy. According to the occupational therapy group in St. Petersburg it is not a good idea to introduce occupational therapy through work therapy. The reason is the low educational level of the work therapists.

The fact that the ministries of health care and social protection were merged in the early 2000's, was expected to make the introduction of occupational therapy easier, but it turned out not to be the case. In a document the Ministry of Health and Social Development says that occupational therapy should be used in post-stroke treatment, but the ministry provides no further specification.

The certificate and the Diploma in Therapia handed out after completion of the course offered through the project evaluated in this report has no formal meaning in the Russian system. It is

nevertheless a confirmation of having acquired the required skills through a capacity-building training course. The fact that the training fulfils the requirements of the World Federation of Occupational Therapists, of course, is an asset.

Rather than being a profession listed in the nomenclatura, in Russia occupational therapy is set of techniques and approaches that can be applied by medical doctors within recovery medicine. Occupational therapy is being actively promoted by the Russian Association of Occupational Therapist (raet.spb.ru), established as part of the project.

In order to register a new professional specialisation within the Russian health care system an approval is needed from the Ministry of Education and the Ministry of Health and Social Development.

If introduced in Russia, occupational therapy would have to find its place among already existing professional traditions. Within Russian rehabilitation a version of physiotherapy is widely applied. This is physiotherapy based on electro-treatment, treatment with water, mud and magnets. A Russian physiotherapist differs from a Scandinavian “sjukgymnast” or “fysioterapeut” (which in Russian is called *fizicheskaia terapiia*) by not primarily making use of massage.

What Scandinavians call physiotherapy is called physical therapy (*fizicheskaia terapiia*) in Russia, and is closer to the Russian “*lechebnaia fizkul'tura*” (LFK), or medical exercises. LFK is a specialisation at middle as well as higher medical level. In other words, LFK is practiced by doctors as well as nurses, who, within the field of LFK are called instructors. Usually, the division of labour is like this: The medical doctor examines the patient, the instructor trains him/her, and the doctor re-examines the patient.

In 1997 recovery medicine was introduced as an officially recognised scientific specialisation (the specialisation no. 140051), which allowed PhD students to take a doctor's degree in the recovery medicine, but not work with patients. In 2003 s specialisation for doctors (no. 040132) was introduced and merged with LFK, *kurortology* and physiotherapy (in its Russian version). The new specialisation integrated elements from several medical branches.

The practice is that the doctor investigates the patient, the instructor (middle medical education) carries out the therapy, and the doctor investigates the patient again.

In 2003, the rehabilitation services were reorganised and subsumed under the epithet of *recovery medicine* (vosstanovitel'naia meditsina). Order (prikaz) no. 297 from the Minister of Health defined the tasks of medical doctors of recovery medicine. They were to be drawn from the ranks of doctors from the basic medical education ("lechebnoe delo") and paediatrics.

Order no 553 from 2007 specified the backgrounds of those eligible to enter into higher specialisation in LFK/sport medicine, recovery medicine or manual therapy. One has to be a paediatrician, therapist, specialist in traumatology, orthopaedist, or neurologist (not allowed to enter into LFK/sport medicine).

Russian recovery medicine aims at improving the patient's "functional health reserves" in order to recover his/her optimal working capacity. Most of the recovery medicine is based on non-use of medication. The recovery procedures mention several procedures that are to be used within recovery medicine. It is worth noticing that the actual procedures are to be carried out by middle level medical personnel (nurses, instructors).

The Order from 2003 mentions physiotherapy, which in the Russian version mainly involves the use of devices for electrical treatment or alternatively water or mud). It also gives mention to LFK (lechebnaia fizkul'tura), which is closer to Scandinavian physiotherapy, massage, and reflex therapy. Ergotherapy, or occupational therapy, is not mentioned.

In order to strengthen recovery medicine there has been carried out a lot of training courses for medical doctors, nurses and others. According to the head of the Faculty of Recovery Medicine at the Mechnikov Academy, since 2005 elements of occupational therapy have been introduced into this training.

St. Petersburg is a big, European city with a high concentration of specialised branches of health sciences and professions. Trying to introduce a new profession or professional specialisation, like occupational therapy, therefore, has been met with some suspicion from other professions.



Also the fact that occupational therapy has been established on the basis of medical doctors may have contributed to certain confusion. This is, as one interviewee put it, “making a medical doctor convert to a nurse-like profession”.

### 2.1.3 Relevance in Russia

Russia’s health care practices, including recovery medicine, still have a tendency not to see the patients’ problems in their wider context. There is a tendency to isolate the problem to the limb or organ that is suffering. Occupational therapy makes use of a quite different approach. The patient’s problem is seen in the wider context his/her everyday life. The project owner puts it like this:

“The view of the individual, of the worth of the individual and of the human being as an active being, is areas where there are considerable differences between Russia and Sweden, especially when it concerns working with people in need of care and rehabilitation. This is something that the students find difficult in discussions with their fellow physicians. For this reason the implementation of the concept of rehabilitation is more difficult.” (*Citation Final report 3rd Programme*)

The relevance of occupational therapy should be quite clear. To what extent this means there as an ”operational relevance” is less clear. A crucial question here, is what the municipal authorities (in charge of providing basic medical treatment) would like to have. Do they actually want occupational therapists, what is the demand? Have they “ordered” occupational therapists, or doctors with an occupational therapy specialisation? Unfortunately, so far the answer is no.

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## 3 The project activities

### 3.1 The project design

#### 3.1.1 The objectives

The *objective* of the project was to introduce occupational therapy into Russia.

Although the project reports, in addition to “introducing occupational therapy”, refer to e.g. “training another 11 clinically active medical physicians” and the like as the project’s objective, these latter are mere sub-goals, or even *means*, to reach the overall objective. Since occupational therapy in the version endorsed by the World Association of Occupational Therapy does not exist in Russia, offering training in it without the intention of introducing it does not make sense. In fact, the project has suffered from lack of clarity of what is actually the objective of the projects. The project owners have not made a clear distinction between the main objective and the sub-goals. Neither have the difference between ends and means been analysed in a clear way.

Occupational therapy can be seen as *a field of activity*, or approach applicable for specialists within various medical professions. Alternatively, occupational therapy can be seen as a *specialisation* (within several professions, like medical doctors, nurses, and physiotherapists). Finally, it can be seen as a clearly defined *profession* in itself. The project documentation makes no clear distinction between the varieties, but tend to identify the introduction of occupational therapy a specialisation for medical doctors as its objective, although the other varieties are also being referred to .

Occupational therapy encompasses child habilitation, psychiatry, medical and geriatric rehabilitation and science-based methodologies. In the view of the project holders, the activities aim at a paradigmatic shift in Russian health care. Partly this is because occupational therapy did not exist as a profession in Russia, but even more importantly because the projects bring in social and developmental orientations that challenge the traditional Russian focus on medical and institutional issues.

While having graduated from the course, the students are supposed to be capable of describing occupational therapy as a scientific discipline as well as a profession.

Students are supposed to be able to assess, describe and explain the patients' ability of activity from a social, health and life cycle perspective.

According to the project documents the main target group has been "ergotherapists and occupational therapy students in St. Petersburg. The secondary target groups have been politicians on all levels, chief doctors, chief nurses, patients and their relatives, organisations of the disabled, and "everyone working in the Health Care Systems in North-West of Russia".

### 3.1.2 The project's programme theory

The project has relied heavily on the assumed *effects of training and education*. By training a substantial number of trainers (teachers in occupational therapy) the project owner (the FSA) expected occupational therapy to gain ground as a profession in Russia. In order to make occupational therapy a profession in Russia, the project aimed at enabling the start of a regular four to five year ergotherapy programme at the university level in accordance with the Bologna Process. In order to arrive at a fully-fledged university study, the project aimed at "a certain number of ergotherapists having been trained and working according to international standards for the profession". In addition, the education of "a certain number of trainers capable of bringing the students through the two-year specialisation" as well as clinical tutors are singled out as necessary steps on the way to introducing occupational therapy in Russia.

The programme theory is discernible in the project's list of basic outputs expected. The main logic consists in creating a critical mass of trainers and tutors and gradually make them take over the training of new trainers. The programme theory was consistent as long as the focus was "internal" – on training (see chapter 3.1 on Project activities). When it came to the project's theory on how to influence the "external" world, in brief how actually to introduce the profession – not only introduce the training of trainers, teachers and tutors – a programme theory was hardly discernible.

## 3.2 The project activities

The *project activities* that lead to the objectives consist in establishing and carrying out a training programme in occupational therapy for professionals who already have a medical degree.

The training refers to the minimum criteria for an international degree in occupational therapy established by the World Federation of Occupational Therapists. Students get basic insights into the occupational therapy's field of work and responsibility. Theoretical training is being given with a focus on *the concept of activity*.

The activities consist in several modules on e.g. the theory of occupational therapy, labour therapy, project work, children habilitation, psychiatry, medical rehabilitation, geriatric rehabilitation and scientific methods. In each of them there are oral and written exams, individually and in groups.

The training takes place at the St. Petersburg State Medical Academy. The training is given by Swedish lecturers. The students go to Swedish hospitals for clinical training. The idea is that those students having been trained later on carry out training programmes and establish occupational therapy as a profession in St. Petersburg.

The 1<sup>st</sup> programme aimed at "training 12- 15 clinically active Russian medical doctors into becoming ergotherapists." The trained doctors "will then contribute to the continued building up of an occupational therapy education and occupational therapy as such in the St. Petersburg area" (Slutrapport 1998 – 2001).

The 2<sup>nd</sup> programme aimed at training “another 12-13 clinically active medical physicians from different specialities.” These doctors were to join the groups of trained ergotherapists from the 1<sup>st</sup> programme in establishing an occupational therapy education at the Mechnikov Academy (Final Activity Report 2001 -2004).

Likewise, the 3<sup>rd</sup> programme aimed at training “another 11 clinically active medical physicians from different specialities” who would later join the colleagues from the two preceding programmes in developing an occupational therapy education at the Mechnikov Academy.

The 4<sup>th</sup> programme aimed at training yet another ten medical doctors in occupational therapy.

In other words, the 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> programme phases each aimed at training 11 and 15 clinically active Russian medical doctors into becoming ergotherapists. In general the doctors who came to have additional training came from the ranks of district therapists, psychiatrists, paediatricians and neurologists, in other words professionals with a ½ or 7 ½ years’ education prior to the additional training. Their motivation varied. Some came on their own initiative; others had been assigned by their superiors.

The Mechnikov Academy was the main place for training, but the project tried to involve additional hospitals in order to create a network of clinical training bases.

The training was structured according to a curriculum that would give an equivalent to a Swedish Bachelor of Science in occupational therapy. Likewise, it corresponded to the minimal standards for occupational therapy education established by the World Federation of Occupational Therapists.

The training programme consisted of a minimum of 80 weeks of study divided into several courses, each with their own approved curriculum. Between 12 and 20 hours per week were time scheduled. The rest of the time was for private study or group activities. The internet has been used for much of the communication with teachers, tutors and project leaders, as well as for certain exams.

Altogether the courses gave 80 points (one per week). The courses were on:

- 
- The basis of occupational therapy (10 points)
  - Knowledge about disabilities (10 points)
  - Occupational therapy with children and youth (15 points)
  - Occupational therapy with adults (15 points)
  - Occupational therapy with elderly (10 points)
  - Clinical placement (10 points)
  - Thesis (10 points)
  - Psychology (5 points)

The clinical training took place in Sweden since occupational therapy did not exist in Russia. The trainees stayed several places in Sweden, like the School of Health Sciences in Jönköping, Huddinge University Hospital, Astrid Lindgren Children's Hospital, Lund University Hospital, Halmstad Geriatric Rehabilitation, the habilitation Centre of Jönköping, and the University Hospital of Örebro.

The lecturers were highly qualified academic occupational therapists from Sweden. Also Russian lectures were made, primary to give the students an overview of the health sector with relevance to occupational therapy.

The project also aimed at having the trained doctors contribute to the continued building up of an occupational therapy education and occupational therapy as such in the St. Petersburg area. During the project period the students visited hospitals, polyclinics and other health care institutions to inform about occupational therapy and to establish contacts with the aim of being invited for clinical training.

As a part of the training several side-activities were needed, like developing model units for clinical training, translating literature into Russian as a basis for a curriculum. Likewise, the project aimed at equipping lecture rooms for the teaching of occupational therapy. Moreover, it envisaged as one of its results an education plan and syllabus for a regular occupational therapy education with international standard (undergraduate studies 4-5 years). It sought to develop occupational therapy departments in different hospitals and polyclinics for clinical education, and to translate relevant

articles and books into Russian. Finally, the project endeavoured to develop or adapt assessment tools for use in the Russian health sector.

Towards the end of the first project, an occupational therapy department was being planned at the stroke unit at Hospital no. 29 in the Petrogradskii district of St. Petersburg, and the FSA was actively engaged in the work. The unit was foreseen for clinical training.

The 2<sup>nd</sup> project (2001 -2004) was a repetition of the 1<sup>st</sup> project, only this time some of those graduated from 1<sup>st</sup> project were recruited as trainers. The 2<sup>nd</sup> project aimed at training “another 12-13 clinically active medical physicians from different specialities.” These doctors were to join the groups of trained ergotherapists from the 1<sup>st</sup> project in establishing an occupational therapy education at the Mechnikov Academy.

In all, four newly graduated occupational therapists took on the task of training the new class. In all, 18 Swedish occupational therapists gave lectures during the 2<sup>nd</sup> project. This was an element in the gradual take-over by the Russian side which had been foreseen in the project plan. Also, the establishment of clinical training opportunities was emphasised in the plan.

Five of the ten weeks of clinical training were carried out in St. Petersburg with tutors trained in the 1<sup>st</sup> project. The remaining weeks were carried out in Sweden. The Swedish Institute generously financed the students’ stay in Sweden for projects 2 to 4.

Likewise, the 3<sup>rd</sup> Project aimed at training “another 11 clinically active medical physicians from different specialities” who would later join the colleagues from the two preceding projects in developing an occupational therapy education at the Mechnikov Academy.

Four of the ten weeks of clinical training was carried out in Sweden, financed by the Swedish Institute.

Seven Swedish teachers have been involved as trainers in the 3<sup>rd</sup> project.

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The 4<sup>th</sup> Project was a repetition of the preceding projects. Four weeks of clinical training were carried out in Sweden, again financed by the Swedish Institute.

All four projects were finalised with the examination of the students. Among others in connection to this event the Mechnikov Academy arranged conferences in which about 100 people took part, managers of various clinics, administrative managers and politicians. These conferences – in all six were arranged – offered opportunities to promote occupational therapy for a relevant audience of a potential advocacy coalition.

### 3.3 The results so far of the projects

#### 3.3.1 Outputs

##### **1<sup>st</sup> project**

The 1<sup>st</sup> project (1998 – 2001) aimed at “training 12- 15 clinically active Russian medical doctors into becoming ergotherapists.” In March 2001 altogether 12 Russian students of occupational therapy – all those who started out – were examined, and all received their “Professional Degree in Occupational Therapy” combined with a Russian “Diploma in Therapia”. Five of the students from the 1<sup>st</sup> project achieved a bachelor’s degree at a later stage.

Among the twelve doctors trained in occupational therapy, three were “therapists”, i.e. basic district doctors, three were psychiatrists, the (the Russian version of) physiotherapists, one dermatologist, one specialist in internal medicine, one orthopaedist, and one epidemiologist.

The “production” of outputs was hampered by the fact that not all students were given leave of absence with pay from their superiors. This, of course, created some problems for the study progression. Another problem was that the syllabus did not exist in Russian.

In 2001 the Russian Association of Occupational Therapy (RAET) was established as a result of the project. With strong support from the FSA, RAET was accepted as a full member of the World Association of Occupational Therapy in 2004.



## 2<sup>nd</sup> project

The 2<sup>nd</sup> project (2001 -2004) aimed at training “another 12-13 clinically active medical physicians from different specialities.” In all, five of those trained in the 1<sup>st</sup> project functioned as lecturers in the 2<sup>nd</sup> project. Four of these only participated in some of the courses. One of those occupational therapists graduated in 2001 was given the task to develop a rehabilitation clinic at the Mechnikov Academy.

18 students started out in the 2<sup>nd</sup> project, but very soon 14 remained. The project produced 12 new ergotherapists (professional degree in occupational therapy and a Diploma in Therapia), five of whom also achieved a bachelor’s degree. Among the papers handed in for the bachelor’s degree were “Ergo therapy course for children with arm and hand trauma”, “Mother’s satisfaction and treatment effects”, and “Dependence in ADL among women with mild stroke”.

Among the 14 doctors trained in the 2<sup>nd</sup> project, four were neurologists, three were “therapists”(i.e. basic district doctors), three were paediatricians, one was psychiatrist, two were specialists in sports medicine (lechebnaia fizkul’tura), and one ear, nose and throat specialist.

Seven Russian occupational therapists took part in the WFOT World Congress in Stockholm in 2002, and five of them presented a paper.

The aim of gradual transfer of the project initiative to the Russian side was only partly reached during the 2<sup>nd</sup> project period. The necessary level of competence in occupational therapy was not reached among the Russian trainers the report stated although two of them had been trained to become full-time lecturers. Swedish lecturers and examiners were still considered necessary in the application for the 3<sup>rd</sup> project. Moreover, some of the contributions to the project implementation from the Russian partner did not happen. The training was hampered by bad localities. The Swedish project leader estimated that the training (of 16 students) would require a lecture room, a group room, a training apartment adapted for Russian conditions, a storage room, and a room for different activities and a lockable room where phone and computers were kept.

### **3<sup>rd</sup> project**

Likewise, the 3<sup>rd</sup> Project aimed at training “another 11 clinically active medical physicians from different specialities”. Eleven students started out, and all set up project plans, but only four students passed their professional degree, and no one passed the bachelor’s degree. Among the four trained there were two neurologists, one paediatrician, and one therapist (i.e. basic district doctor).

In the 3<sup>rd</sup> project three of the graduated from the first project and four of the graduates from the 2<sup>nd</sup> projects participated. Two of them were employed full-time to take care of some of the courses under the project.

In the 3<sup>rd</sup> period the training facilities were improved. The lecture room was improved, and some of the books and articles were translated into Russian.

In the original plans, the Russian partner (the Mechnikov Academy) was expected to take over the project in 2005. Unfortunately this was impossible. The skills on the Russian side were still considered unsatisfactory.

In the 3<sup>rd</sup> project only seven Swedish lectures were used, as compared to 20-25 in the previous two programmes. As from the 3<sup>rd</sup> course the Russian part of the cooperation has assumed responsibility over the program supported by a Swedish mentor. The areas where the Swedish mentor has been responsible have mainly concerned examinations and clinical training as well as the elaboration of manuals and assignments for the students.

### **4<sup>th</sup> project**

The 4<sup>th</sup> Project started out with ten medical doctors, but only four passed the exam. The remaining members of the initial groups quit during the training period.

In all, ten of those trained in the previous projects took part in the planning of the 4<sup>th</sup> project and in its implementation. One of them was employed full-time, and two half-time, to take care of some of the courses under the project.

Table 3.1 *Characteristics of graduates from the project's occupational therapy training (80 credit points)*

**1<sup>st</sup> project 1998-2001**

Participant No	Place of work	Position
1	Medical academy	Chief of department
2	Hospital (Sweden)	Specialist in training
3	Medical academy	Neurologist, ET
4	City polyclinic	Chief ET department
6	No data	No data
7	Medical academy	Chief of department
8	No data	No data
9	Has left the medical profession	-
10	Medical academy	Chief of ET division
11	Medical academy	Lecturer
12	Hospital (Sweden)	Physician

**2<sup>nd</sup> project 2001-2004**

Participant No	Place of work	Position
1	Medical academy and rehabilitation centre	Lecturer ET, neurologist
2	Medical University named after Pavlov	Neurologist
3	Rehabilitation centre	ET and Physiotherapy
4		
6	Private medical centre	ET and PT
7	Hospital	ET, neurologist
8	Has left the medical profession	-
9	City polyclinic	ET and neurologist
10	Private medical centre	Physiotherapist
11	Institute	ET
12	No data	No data

**3<sup>rd</sup> project 2003-2006**

Participant No	Place of work	Position
1	Rehabilitation centre	ET
2	City rehabilitation centre	Chief of ET department
3	Special medical centre	Neurologist and ET
4	Medical academy	Lecturer ET and Ergonomic
5	Social rehabilitation centre	ET

**4<sup>th</sup> project 2005-2008**

Participant No	Place of work	Position
1	Narcology dispenser	ET and narcologist
2	Hospital	Neurologist and ET
3	Geriatric centre	Neurologist and ET, chief position
4	No information	No information

(Source: Report 4<sup>th</sup> project)

**Model units**

The centre for Social Services of the Petrogradskii City District of St. Petersburg has been used as clinical training unit for the training courses.

Also the “cabinet of occupational therapy” at the St. Petersburg City Centre for Recovery Medicine for Children Psycho-neurological Disturbances serves a model unit. Among a total of 1200 patients annually 200 go through training at the centre’s cabinet of occupational therapy. The patient goes through an individual course consisting of ten meetings (30-40 minutes), which are carried out by specialists twice a week.

Model units have been established at the department of neurology at Hospital no. 2, the open geriatric care unit in the Udelnaia city district, the child and youth rehabilitation in Volkhov, the early Intervention Institute, and the rehabilitation centre in Pushkin.

### **Translated literature**

Throughout the project periods basic occupational therapy literature has been translated into Russian, among others articles from Willard and Spackman's *Occupational Therapy*, which is updated every second year, and is considered a work of reference for the profession.

### **Other outputs**

By late 2008, two medical doctors from the project are doing their masters thesis in occupational therapy in Sweden.

One student from the 2<sup>nd</sup> course has achieved an equivalent to a Swedish PhD in medicine (in Russian: candidate of medical sciences) with a thesis on "Modern methods of rehabilitation of pre-school children with cerebral palsy". Two students from the 2<sup>nd</sup> course have published a paper with two Swedish colleagues in the Journal *Occupational Therapy International*, ". Daily life activities among St. Petersburg women after a mild stroke."

An article on occupational therapy has been printed in the journal "Chelovék i Zdoróv'e" (Man and Health).

Two 5 point courses have been carried out, and to medical doctors have been trained as tutors. Two Russian teachers in occupational therapy passed an exam (7.5 points) in children rehabilitation and neurological rehabilitation at the School of Health Sciences in Jönköping.

In all, ten Russian doctors have achieved a BSc in Ergotherapy as a result of the project, one has even presented a doctoral thesis.

### **3.3.2 Outcomes**

The project activities have left behind a framework (among others translated literature, curricula, trained teachers and tutors, model units) that form a potential basic for reaching outcomes. This, however, hinges on the actual use of the framework left behind after FSA's programmes are over.

Training in occupational therapy is going to continue after the finalisation of the project. Ten day courses (on disabilities) will be arranged at the Mechnikov Academy as a part of the post-diploma

training of medical doctors in recovery medicine. This will enable doctors to apply elements of occupational therapy in their daily work. In addition the course aim at making students aware of occupational therapy and possibly interested in further specialisation.

The 31 medical doctors trained in occupational therapy apply their new skills, although to a varying degree, in their permanent positions. Occupational therapy has struck roots in some of St. Petersburg's health institutions.

In the Institute for Early Intervention occupational therapy is being applied by people who have been trained through the project. The educational training base (baza) is in the Petrogradskii city district. Here, occupational therapy is being applied in the stroke department, the child department and the traumatology department. Also St. Petersburg's Hospital nr 2 applies occupational therapy on a high level in its neurological rehabilitation. In Pushkin and Volkhov in the Leningrad region occupational therapy is being applied as a result of the project.

There is a strong potential for further development of occupational therapy in the Gerontology Centre at Fontanka. Also, in some of the social-medical rehabilitation centres that have been established in several city districts (under the sector of social protection) occupational therapy is being practiced

The ergotherapy activities, e.g. at the Child rehabilitation centre at Frunze street 10, is being showed to visitors from other Russian regions who come to study St. Petersburg's health care system at the Mechnikov Academy. The Centre has an occupational therapy cabinet under the Department of Recovery Medicine.

The Association of Russian ergotherapists (to be found at [www.raet.spb.ru](http://www.raet.spb.ru) although the web site has not been updated since May 2007). RAET is the first Russian organisation for the promotion of occupational therapy. The main purpose of the organisation is establishing and promoting of Occupational Therapy in Russia as full-time profession and educating new specialists. The association has contacts with interested people and institutions in Russia (Arkhangelsk, Primorskii krai, Nizhnyi Novgorod, Kaliningrad) as well as abroad.

A proposal for a four-five years university education in ergotherapy has been prepared by the chairmen of the Swedish and the Russian associations of ergotherapists, the Swedish course and Russian teachers in ergotherapy. In May of 2007 the chairmen of the Swedish and the Russian associations of ergotherapists, visited the Ministry of Social Affairs in Moscow to discuss the establishment of an ergotherapy profession and ergotherapy education. The purpose is to start a regular ergotherapy education in the country and also to establish the profession of occupation therapy.

The modified 80 credit program was approved by the World Federation of Occupational Therapists (WFOT) in 2002.

The RAET chairman and one of Russia most distinguished specialists in recovery medicine and rehabilitation, professor Mikhail Didur at the Pavlov University of St. Petersburg, have developed a curriculum for occupational therapy as well as physiotherapy, that are going to be presented to federal authorities later in 2009. This initiative might well have been taken without the FSA programmes, but most likely the training offered by FSA has been useful.

Although the project activities have been confined to St. Petersburg and to a certain extent the surrounding Leningrad region, they have attracted some interest from other parts of the Russia (Arkhangelsk, Nizhnyi Novgorod) as well as Kazakhstan. Trainers trained through the projects have given lectures, assisted in setting up curricula, and are referred to as “the expert group from Petersburg”.

To sum up, the outcomes of the project consist in the fact that a) occupational therapy training has been established, and probably is going to continue; b) an association of Russian ergotherapists has been established, and does some dissemination and c) the 31 ergotherapists who have graduated are applying occupational therapy skills and approaches at their work places

Beyond the scope described above, occupational therapy has not been established in Russia as a result of the projects.

### 3.3.3 Impacts

To what extent has the introduction of occupational therapy as a professional training activity at the St. Petersburg Mechnikov Academy led to the establishment of occupational therapy in Russia? Occupational therapy is still no profession in Russia ten years after the initiation of the project, and the project has not made much effort to introduce it. The project has concentrated on the local training activities at the Mechnikov Academy.

To what extent has the activities led to the strengthening of new methods and perspectives in the exercise of professions “adjacent” to occupational therapy? The project activities have not linked up with ongoing developments within the Russian system of recovery medicine and have missed potential opportunities to strengthen occupational therapy through existing professions.

After ten years of project activities and almost ten million SEK spent it is reasonable to expect some sort of impact. Reportedly, occupational therapy is being summed up as being efficient in rehabilitation work in the institutions where it is being tried out. Apart from this, the project has had little impact. There is little evidence that Russia is closer to including occupational therapy in its nomenclature of officially acknowledged professions today than it was at the outset of the first project in 1998. If a decision is made to make occupational therapy a profession in Russia, the efforts made by the FSA and its counterparts, may prove to be useful since the programme leave behind a core groups of trained occupational therapists, model units and a curriculum .

## 3.4 Cost effectiveness

The main output of the project has been the trained doctors. The training of each individual doctor has been expensive according to Russian standards (and even to Swedish standards where the cost of educating a occupational therapist amount to 240,000 SEK). Here, one might add that a higher cost per unit is to expected for a project abroad (use of Sweden lecturers etc) as compared to a normal, domestic activity. But the figures below show that the cost per trained student has risen considerably as the Swedish component has been gradually brought down:



Table 3.2 *Cost of the projects and number of trained doctors*

	Sum granted (in SEK)	Number of trained doctors	Training cost per doctor (in 1000 SEK)
1 <sup>st</sup> project	2,400,000	12	200
2 <sup>nd</sup> project	3,453,230	12	288
3 <sup>rd</sup> project	1,715,000	4	429
4 <sup>th</sup> project	1,442,900	3	481

(Source: *Final Activity Reports*)

In addition, the clinical training in Sweden under the three last projects was financed not by the project, but by the Swedish Institute. The extensive use of Swedish lecturers is the main reason why the projects have been so costly. The use of Swedish lecturers, however, was gradually reduced from project to project.

Even with a cost-profile like the one presented here, the projects might have come out as cost-efficient, which could have been the case if the project activities had led to significant outcomes or impacts. Since this has happened only to a negligible degree here, the projects have been cost-inefficient.

### 3.5 Sustainability

What will remain from the project are 32 medical doctors who have been trained and who to a certain degree will apply skills and perspectives from occupational therapy in their daily work. A group of supporters of occupational therapy gathering in RAET will continue looking for foreign partners in order to continue promoting the discipline of occupational therapy. Also, at the Mechnikov Academy a ten weeks course in occupational therapy will be offered medical doctors.

The results of the project activities are very vulnerable. The key factor for sustainability would have been an official recognition of occupational therapy as a profession. This would have made it possible for health organisations to employ medical doctors as occupational therapists.

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### 3.6 The relevance of the project

On a “philosophical” level, there is reason to conclude that introducing occupational therapy, or at least skills, perspectives and approaches from the discipline, is highly relevant in Russia. There is need for professions that try to see patients in their everyday context, and not only in the light of what ails them.

On a “practical” level, the relevance of the project objectives is contingent upon at least two main questions. Firstly, is the idea of what an ergotherapist actually is sufficiently clear? In other words, is it a separate profession, or is it a specialisation within the wider field of rehabilitation? Secondly, is there a perceived need on the part of the authorities that ergotherapists are needed as a profession within the Russian health system? Is there a demand?

The project could have made itself much more relevant if it had skipped the idea of introducing a new profession into Russia. In Russia, the idea of introducing a new profession from outside without extensive prior preparations is being received as quite absurd, as it most probably would have been in a Nordic country. Making existing recovery/rehabilitation professions acquainted with core perspectives from occupational therapy would probably have been taken as quite relevant by a wider audience of decision-makers.

## 4 Conclusions and recommendations

The objective of the projects was to establish occupational therapy as an autonomous profession in Russia for use in various branches of health care and social protection. This objective has not been reached. The projects have failed despite efforts throughout ten years and grants amounting to almost ten million SEK.

The assumed links between the project activities and the results aimed at were not very realistic. From carrying out training to introducing a new profession there is a long way to go, and the project owner hardly left the training stage. The project owners had no clear idea about what mechanisms the project was to set in motion.

The project would have gained from distinguishing between varieties of introducing occupational therapy. Introducing it as a profession is but one among several varieties. Alternatively, occupational therapy could be established not as a fully-fledged profession, but rather as *a field of activity* applicable for specialists within various medical professions. Likewise, it could have been introduced as a standardised *specialisation* for medical doctors, nurses, physiotherapists and other health professions.

The project met serious problems at an early stage. There is reason to ask why the project methodology was not altered, or adjusted, during the project cycle. In stead the project owner repeatedly applied for funds to replicate the previous project. In fact, there is reason to ask why the project was not discontinued at the end of project 2 or 3.

The projects were carried out with a dominant Swedish side (FSA) and a Russian partner (Mechnikov Academy) that did not follow

up its project promises, for instance on providing the necessary training premises. The Swedish partner was not very attentive to – or knowledgeable about – Russian realities, e.g. the set-up of the medical sector, and worse, they do not seem to have got much help from the Russian side in acquiring such insight. The development of Recovery Medicine throughout the project periods seem to have gone unnoticed by the Swedish partner.

The lack of links to an overall reform strategy within the Russian sector of health care might not have been a big problem in 1998, but five years later it was. Among others, it explains why it has been difficult to secure Russian funding of project activities (refurbishing training premises; paying Russian lectures among others).

The Russian partner clearly showed signs of loosing interest as the project periods passed by. The Russian project partner seems to have got second thoughts as early as during the first project period, but was apparently not ready to discontinue the project formally.

Neither has the Russian partner provided the institutional underpinning for a take-over. According to the Swedish side, the necessary skills on the Russian side to carry on with the training without Swedish assistance has not happened.

Although the project has not reached its objectives, it nevertheless leaves behind a group of people that seem to be ready to carry on promoting ergotherapy. Around the project, a group of St. Petersburg-based medical doctors of different specialisations has developed. Its formal structure is the Association of Ergotherapy with its 45 members. The group mainly consists of people who have gone through the ergotherapy training. They practise elements of ergotherapy in their daily work, and see its benefits. The association has developed contacts elsewhere in Russia and abroad and is involved in new international projects.

Unfortunately, this group seems to suffer from some of the same weaknesses as the project, i.e. lack of links to ongoing reform initiatives. Without being linked up to strong central reform initiatives in Russia, projects are likely to end as failures.

The project suffers from a serious sustainability problem. The introduction of occupational therapy into the Russian system of

health care, to which the project was conceived as a contribution, has been a failure.

The main reason for the failure is not to be found in the efforts made by the Swedish project manager, or the Russian occupational therapists directly involved in the project. They have worked energetically to reach the project objectives. The whole project has been victim of its own lack of preparatory work. The project started up without a preparatory investigation into the Russian system of rehabilitation into which the project owners (FSA) wished to implant occupational therapy.

The fact that the project was initiated during the years of Russian crisis contributes to this. At the time, due to the administrative chaos, “everything seemed possible”, even introducing new professions “from below” (and outside). And no one on the Russian side set the foot down because the economic crisis made any project opportunity welcome. Unlike most other crisis-ridden countries into which projects are invited, Russia overcame the crisis. As soon as administrative order was re-established and the economy was on its feet, only very relevant projects survived. Unfortunately, the occupational therapy project does not seem to have passed this test.

The Russian partners have made sense of the project as seen from their own perspective. They have made use of the knowledge from the training to introduced elements of occupational therapy into the everyday work of recovery medicine, but they have not made any efforts to introduce a new profession. There are good reasons for this, among others that there are professions that easily could absorb the basic “ideology” of occupational therapy into their own practice. This, however, has not been clearly communicated from the Russian side to the FSA.

### **Recommendations**

Since the project has come to an end, the recommendations below are of a general character for use in ongoing or future projects.

#### Be ready for normalcy

Most often foreign projects are being established in very complex situations. The fact that a country’s administrative structures are in chaos or disintegrating is many times the reason why a foreign

project is set up. Russia was quite chaotic at the time the project was started up and at the time it might have made some sense to try and establish a new profession “from below”.

Since 2000, however, Russia has changed. Project ideas basing themselves on manoeuvring in an unstable environment, had to adapt quickly or perish. In many ways, the skills needed now are the opposite of the skills needed in the 1990’s. Now, only project ideas that take legal, administrative and political institutions very seriously will have a chance. It is not enough for a project to be linked up to the reform agenda in its country of origin (in our case Sweden). First of all, a project taking place in Russia must link up with the Russian reform agenda. In case a project is accepted as useful for the ongoing reforms, the chances the project will yield results are great. Reform support is more efficient than policy transfer.

For instance in Russia occupational therapy could have been linked up to the reforms of recovery medicine to form part of the training of doctors in this specialisation. It could be included as part of the re-training all Russian medical doctors have to undergo every five years, and it could be introduced in the medical colleges for nurses and in the re-training of the category of “nurses with a higher education”.

*Recommendation:* Prepare for project implementation in stable, well-structured countries, and link up with reform agendas in the target country.

#### Do not underestimate the knowledge-intensity of the project

In the case of the project on occupational therapy, the project started up on the basis of an invitation to do so by one high-ranking representative of St. Petersburg’s regional health authorities. Not much was done in FSA to investigate the situation within Russian rehabilitation. This is somewhat paradoxical as the FSA is an organisation deeply involved in analysing and influencing the political authorities and administrative structures in Sweden.

*Recommendation:* Carry out an in-depth appraisal or pre-feasibility study before starting up the project. There is a need to investigate the situation prior to intervening with a project. Make a study (un-

biased) on the need for introducing a new profession. Remember, that informants might be biased, and not ready to tell the whole story. Check whether the function that the project aims at introducing is not being covered already by other, similar, professions. In that case, link up with their efforts, and do not treat them as rivals.

#### Use Russian in Russia

Russia belongs together with the USA, France, Great Britain, Germany, Spain, Japan and many other big countries to the category of states where activities take place in the national language. The selection of students on the grounds of their knowledge of foreign languages may prove to be unfortunate.

*Recommendation:* Translate basic literature into Russian as early in the process as possible, and make use of Russian-speaking trainers as much as possible. This is costly, but since Russian is the everyday language of the Ukraine and Belarus, and urban dwellers of a number of other countries in the region, there are possibilities to benefit from the economy of scale on this point.

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## List of interviewees

Göran Carlsson, head of office SEEC

Ernst Michaeli, senior adviser SEEC

Inga-Britt Lindström, President of the Swedish Association of Occupational Therapists (FSA)

Tina Sandulf, general secretary of the Swedish Association of Occupational Therapists (FSA)

Liudmila Zueva, vice-rector, professor for the post-graduate education, head of the department of epidemiology, head epidemiologist of the North-West federal district, head epidemiologist of the St. Petersburg committee of health care

Aleksandr V. Lapotnikov, head of the faculty of recovery medicine, Mechnikov Academy

Raisa G. Iur'eva, head doctor, St. Petersburg City Centre for Recovery Medicine for Children Psycho-neurological Disturbances

Elena G. Mnatsakanián, medical doctor, St. Petersburg City Centre for Recovery Medicine for Children Psycho-neurological Disturbances

Evgeniia L. Solodova, medical doctor, St. Petersburg City Centre for Recovery Medicine for Children Psycho-neurological Disturbances

Sergei B. Mal'tsev, president Russian Association of Ergotherapists (RAET)

Tat'iana S. Vlasova, head of Center for social services Petrogradskii city district St. Petersburg

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