Chapter 5
Public Health Policy and the Gender-Based Approach

Growing Role of the Public Health System

State health policy in Russia has spent the last 10 years under the rubric of "transition policy." It is important to ask what such classification means for the role of the State as regards selection and implementation of national health targets. The health of individuals and society in any country depends on the economic, social and political environment in that country, and health should be viewed as a key criterion, along with criteria of equity and sustainable development, in the taking of political decisions at all levels. Policies aimed improving public health can regulate the social environment in various ways, but they require a sound legal framework in order to be successful.

The Russian legislature has adopted 37 federal public health laws in the last eight years alone and, according to available data, 256 public health laws had been adopted by regional assemblies in the 37 constituent regions of the Russian Federation by the end of 2002. The majority of these were legal acts whose goal was to restructure public health bodies and improve the quality of medical assistance.1

Such diverse legislative activity in constituent members of the Russian Federation adds urgency to streamlining of the legal framework and adoption of a public health code, which has been in preparation for over six years now. Many of the new laws at federal and regional level are valuable. They include the federal laws "On preventing the spread of tuberculosis in the Russian Federation" (2001), "On the quality and safety of food products" (2000), "On medical drugs" (1998), "On narcotics and psychotropic substances" (1998), "On the Immunotherapy of Infectious Diseases" (1998), etc. But these laws do not constitute a unified system capable of addressing all problems of the public health system or protection of the health of every Russian citizen.[2]

As an interdisciplinary field, healthcare can only fulfil its tasks if assisted by the efforts and resources of other spheres of society. Education, social assistance, public health policy and management, and mass media have direct or indirect influence on the well-being and health of individuals and society at large. The International Conference on Primary Health Care (Alma-Ata, 1978) radically changed the paradigm of healthcare worldwide, leading to development of a new conception that determined the responsibility of states for the health of their citizens. In the 1970s programs such as "Health for All," "Healthy City" (cf. Table A.3 in Addendum A) and others determined criteria for public health standards, opening up new fields of activity and showing that healthcare involves a very wide spectrum of services (not limited to medical care alone) whose goal is to protect, maintain and improve a nation's health. In other words, public health is "the science and art of preventing illness, increasing longevity and promoting health with the help of the combined efforts of society."[3]

Health should be viewed as a key criterion, along with criteria of equity and sustainable development, in the taking of political decisions at all levels

This approach lies at the heart of the European Public Health Strategy adopted by the World Health Organisation (WHO) in 1984 as well as of the Ottawa Public Health Charter (1986), which sets five main targets:

- to draft a public health policy;
- to create a favourable living environment;
- to encourage public participation;
- to develop individual knowledge and skills;
- to reorient public health services.

The core of this approach is inter-sectoral co-operation and an inter-disciplinary approach, whose necessity becomes especially apparent in the context of such factors as poverty, food quality, and the use of tobacco and alcohol. Even an ideal system of medical care would be unable to

reverse negative public health trends all by itself. This chapter focuses on mother and child health and on the gender-based approach to public health policy.

Mother and Child Health

Mother and child health remains a key target of the national healthcare strategy of every state today

Mother and child health has always been a top priority of public health services, since these population groups are the most at risk from various sorts of diseases. The WHO declared mother and child health to be one its priorities as early as 1948, making it the only WHO priority linked not to a specific disease but to a specific demographic risk group. Mother and child health remains a key target of the national healthcare strategy of every state today. In view of the intrinsic link between health of the mother and of the child, women's health must be accorded equal importance with health of children as a decisive factor for the future of any country.

Many indicators of mother and child health have deteriorated during the 10-year period of reforms in Russia. In particular, we should note the following trends:

- high rates of maternal and infant mortality;
- decline in the health of pregnant women, post-natal health and the health of new-born children;
- high incidence of disease among women;
- high frequency of abortions;
- poor physical development of children and growing incidence of child disease.

Maternal mortality in Russia is fairly high in comparison with other developed countries (2.5 times higher than the European average), although it has begun to decline rapidly in recent years (cf. Figure 5.1), showing a fall of 27% by 2001 from 1997.

The maternal mortality indicator is 1.5 times higher in rural than in urban areas (46.7 and 32.3 per 100,000 live births, respectively). The causes of maternal death have remained virtually the same across the Russian Federation in the last five years. Three quarters of all deaths are still due to three causes: abortions; haemorrhages during pregnancy, childbirth and the post-natal period; and toxaemia during pregnancy. The leading cause of maternal death continues to be after-effects of abortions, which accounted for 21.1% of maternal deaths in 2001 (compared with 24.3% in 2000).

The infant mortality rate in 2001 continued to decline from its peak in 1993, and the index has fallen by 16.1% over the last five years (1997—2001). All the main causes of infant mortality have declined: respiratory diseases (by 34.5%); infectious and parasitic diseases (by 33.9%); innate anomalies (by 16.3%); and problems arising during the perinatal period (by 11.1%). The main causes of infant mortality are closely linked to maternal health problems. Perinatal problems, inborn anomalies and respiratory diseases continue to be the three main causes of infant mortality, but their relative contribution has changed since Soviet times. The contemporary structure of infant mortality took shape at the beginning of the 1990s and has remained practically the same ever since, and the two biggest causes are problems arising during the perinatal period and innate anomalies. These two together account for 68.8% of infant deaths.

The percentage of women of reproductive age in the total female population of Russia was 50.4% (26.8% of the overall population) at the beginning of 2000. The health of pregnant women, post-natal health and the health of newborn children is deteriorating. According to official statistics, 50—60% of pregnant women are diagnosed as having extra-genital pathologies, which can lead to pathologies during pregnancy and pathologies of the foetus. Between 1997 and 2001, the number of pregnant women suffering from anaemia increased by 13%, from circulatory diseases by 4.2%, from diseases of the urogenital system by 27.4%, and from late toxaemia by 23%. On the positive side, indicators of the outcome of pregnancy remained fairly constant in Russia over the same period, suggesting maintenance of standards by local obstetric services.

Only one woman in three gives birth without complications, and the number of inflammatory post-natal disorders is increasing. Due to inadequate treatment in hospitals and prenatal clinics, many of

these women end up with chronic gynaecological diseases. Over the last five years, the incidence of gynaecological disease is growing: edometriozomy grew by 50% and sterility by 5.8%.4

Diseases leading to complications in childbirth are on the increase. Per 1000 deliveries in 1999, there were 268.7 cases of anaemia, 203.1 cases of late toxaemia, 134.6 cases of impaired labour, 96 cases of uro-genital disorders and 64.9 cases of disorders of the circulatory organs. The main causes of complications are anaemia, impaired labour and late toxaemia. Growth in the number of children born sick has become a steady trend. Whereas in 1980 only 7.9% of live-born children were born sick or fell sick after birth, this figure grew to 38.2% by 1999. Moreover, innate anomalies increased by 2.5 times over the same period and were found among 3% of new-born children. Complications arising during the perinatal period affected 48.4% of these children. Figures for 1999 show that 6.3 of every 100 newborn children weighed less than 2.5kg.

Levels of disease among women are on the increase (cf. Table 5.1). The three leading types of disease among women are disorders of the circulatory and respiratory systems (19% each) and of the digestive system (14—17%). Heart and vascular diseases, which remain one of the principal causes of female mortality in European and other developed countries, are 2—4 times more frequent in Russia. The incidence of carcinomas of the reproductive system is also fairly high, but in Russia and the CIS cancer of the uterine neck, for example, leads to higher mortality rates than in Europe, and the difference between Russia and other countries for mortality rates from carcinomas continues to increase. As Table 5.1 indicates, the incidence of cancer is increasing, particularly of female cancers (breast, uterine and ovarian). These account for about 40% of all carcinomas among women, and their share increased throughout the 1990s.

There is a growing incidence of tuberculosis (a disease that was virtually eradicated in the USSR) among women. Tuberculosis has become a major national problem over the last 10 years, and in 2001, the incidence of tuberculosis among the population at large reached 88.5 per 100,000 compared with 34.0 in 1991.

Figure 5.1. **Maternal Mortality in the Russian Federation**

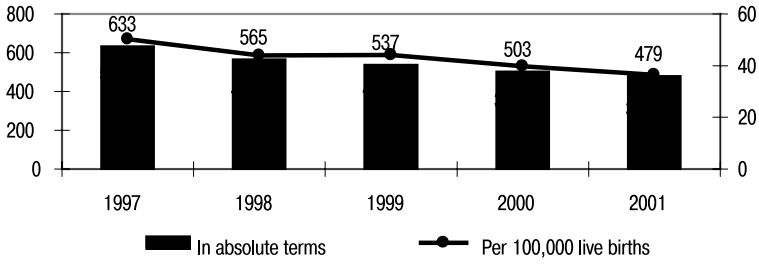


Table 5.1

Incidence of Selected Diseases Among Women (number of registered first-time patients per 100,000 women)

Year	1980	1985	1990	1995	1997	1998	1999	2000	2001
Carcinomas	228.0	237.2	246.9	262.9	282.5	291.4	295.4	302.4	306.5
including: Breast cancer	30.8	36.4	39.6	48.0	52.0	55.0	57.7	58.3	59.1
Cancer of the uterine neck and body and the placenta	23.6	19.5	30.9	31.8	33.8	34.8	34.8		
Ovarian cancer	...	...	12.9	13.7	14.3	14.9	14.8	15.3	15.4
Active tuberculosis	...	23.8	...	28.5	32.5	34.8	37.9	40.7	42.1
Alcoholism and alcoholic psychoses	...	64.2	37.1	50.0	40.0	38.8	38.7	48.1	51.9
Cervical erosion and ectropium	...	806.9	711.3	646.3	625.1	634.1	659.5	645.8	633.2
Menstrual disorders	104.3	72.9	126.1	306.1	390.9	433.3	480.3	520.4	540.1
Sterility	...	...	53.2	52.1	59.2	61.1	66.6	64.9	63.0
Pregnancy, labour and the postnatal stage (per 100,000 women between the ages of 15 and 49)	...	...	3653.4	3792.0	4089.9	4313.9	5503.5	5364.5	5604.3

Women are about 20% of HIV patients and 90% of them are of reproductive age, creating a risk of HIV transmission from mother to child during pregnancy and birth. Since official records have been kept, 3,774 children have been born from HIV-infected mothers, and 1,958 were born in 2002 alone (statistics of 1st December). Furthermore, one out of four women HIV-infected mothers did not receive consultations regarding pregnancy, and HIV tests were only carried out on these women just before delivery.

Frequency of abortions remains high in Russia, but their absolute number had halved by 2001 compared with 1990 (Table 5.2).

The state of child health gives cause for alarm (cf. Figure 5.2). It is characterised by the following trends:

- growing incidence of child disease;
- growing number of disabled children;
- spread of drug addiction, venereal diseases, AIDS and alcoholism among children;
- decline in the general physical development of children;
- psychological problems and anti-social forms of behaviour.

Both total incidence of disease and incidence of specific diseases among children are growing. During the period 1996—2000, the incidence of disease among children under 15 increased by almost 22% and among adolescents (15—18 years old) by almost 24%. The most widespread diseases continue to be disorders of the digestive system, eye diseases, traumas, poisoning, and disorders of the muscular and skeletal system.

There is a growing incidence of active tuberculosis among children. In 1999, there were 18 first-time diagnoses of tuberculosis per 100,000 children compared with 8 in 1990. Thus, the incidence of tuberculosis more than doubled over 10 years. The incidence of sexually transmitted diseases also increased. In 1999, 10 children per 100,000 suffered from syphilis, and by early 2002 there were 677 cases of HIV-infected children under 15 in Russia, including 355 girls. There were more than 38,000 cases of HIV-infection among adolescents between the ages of 15 and 20, including more than 2,000 girls between the ages of 15 and 18. Spread of these diseases is a serious blow for the young generation in Russia.

Growing alcohol consumption by children is another alarming trend: there were 27 first-time diagnoses of alcoholism per 100,000 children registered at clinics in 1999. Alcoholism among parents is major causes of alcoholism among children, and has turned a large number of children into virtual orphans even though their parents are still alive: such is the condition of almost 600,000 Russian children. In 2001 as many as 827 adolescents per 100,000 were abusing alcohol , which is three times more than among the population at large. Drug addiction has spread rapidly: since 1995, the total amount of drugs used in Russia has increased by 30% annually. The age at which drug users first tried drugs has substantially reduced (to 11—12 years), and incidence of drug addiction among adolescents has increased by 12.8 times in ten years. If the drug trade continues to expand at the same rate for the next 5—7 years, the number of serious drug addicts will be reach a terrifying level of 10 million, most of whom will be adolescents and young people.[5]

The number of disabled children under the age of 16 receiving social pensions significantly increased in the 1990s: the figure rose from 16.5 per 10,000 children in 1980 to 43.1 in 1990 and 203.8 in 1999. In 2001, measurements of the number of disabled

Table 5.2

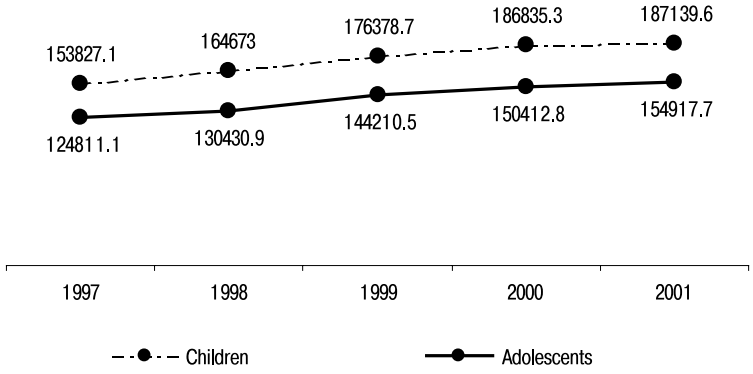
Termination of Pregnancy (Abortions) in the Russian Federation

Year	Total number	Per 1,000 women between the ages of 15 and 49	Per 100 deliveries
1970	4,837,700	136.6	253.4
1975	4,670,700	126.3	221.0
1980	4,506,000	122.9	204.4
1985	4,454,400	121.5	187.4
1990	4,103,400	114.0	205.9
1993	3,244,000	88.4	235.0
1995	2,766,400	72.6	202.6
1998	2,346,100	60.6	182.6
1999	2,181,200	56.2	179.4
2000	2,138,800	55.0	168.7
2001	2,014,700	51.8	153.6

children included children under the age of 18 for the first time. The total number of disabled children reached 617,096 (189.3 per 10,000 children), of whom 58.1% were boys and 41.9% were girls. Children between the ages of 16 and 18 were 14.3% of the total number of disabled children (cf. Figure 5.3)

A nation-wide prophylactic medical examination for children was announced in April 2002 and subsequently carried out. Preliminary results show that 93% of all children in the Russian Federation were examined and 60% of them had health problems of various types.

Figure 5.2. **General Incidence of Disease Among Children (0—14 years old) and Adolescents (15—17)** (per 100,000)



Source: Mother and Child Health Services in 2001. Ministry of Public Health of the Russian Federation. Moscow, 2002, p.55.

Gender Aspects of Health

Gender ranks with other factors such as age, family status, income, and level of social care, as a major determinant of the health of individuals, groups and society at large. Equality of results of health measurements need to be treated with some caution, since medical studies show, for example, that women have certain biological advantages over men regarding life expectancy at virtually all stages of the life cycle. Social norms and practice may reduce or increase the advantages of women as regards life expectancy[6] (cf. Box 5.1).

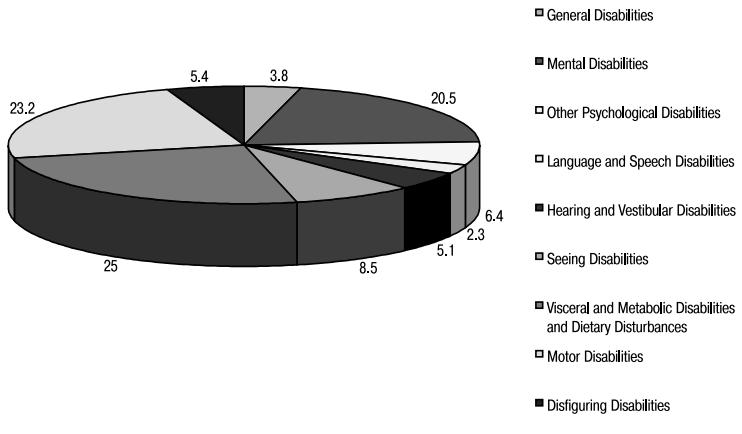
Gender equality in itself is not the goal but a means for ensuring sustainable development of society as a whole and of healthcare in particular. A gender approach to healthcare may influence the allocation of state resources in the public health domain.

Gender equality in healthcare presupposes the following:

- equal access of men and women to medical assistance provided through the public health system;
- their equal consumption of medical services in accordance with real needs;
- equal quality of medical services for men and women.

An important role can be played here by life expectancy at birth and incidence of disease (two of a limited number of health indicators that are available to scholars in most countries, including Russia). The mortality rate of men exceeds that of women almost everywhere in the world, but, as previous Russian Human Development Reports have already pointed out, this disparity is particularly great in Russia. The striking disparity of 13 years between the average life expectancies of men and women in Russia points to both demographic and social problems. If this trend continues, millions of women will become widows, and Russian cities and towns will become communities of single women over 60 (a situation which is already observed in rural areas, where the ageing of the population is more clearly visible). According to available estimates, the number of individuals passing out of the economically active age group in 2015 will be

Figure 5.3. **Distribution of Disabled Children According to their Principal Disability** (in percent)



BOX 5.1

Gender differences in healthcare are differences between men and women with respect to health indicators, availability and quality of medical assistance, effect of prophylactic campaigns, lifestyle and attitude towards health resulting from socio-economic conditions and the ethnic, cultural and historical traditions of a society.

Source: N.S. Grigorieva and T.V. Chubarova, The Gender Approach to Healthcare. Moscow, 2001 (in Russian).

1.7 times greater than the number of individuals entering that age group. By 2016, the number of young people between the ages of 17 and 19 will decrease from 6.7 million to 3.8 million. In healthcare, the ageing of the population will lead to a greater emphasis on providing health care for the elderly.

The incidence of various diseases also has a gender bias. Analysis of medical examinations of Moscow schoolchildren shows that boys are examined much more frequently than girls. The reason for this is very simple: compulsory military service. However, this bias in favour of boys is clearly unjustified, since 75% of girl high-school graduates are found to suffer from chronic illnesses, which helps to explain why the incidence of disease among adult women is greater than among adult men. Women seek medical assistance more often than men (25% more often on average) and they are hospitalised 15% more often than men. Women have special medical needs connected with their reproductive function, although men are more subject than women to heart and vascular diseases, cancers of certain organs, violence, traumas, suicide and work-related illnesses. It is interesting to note that the majority of medical personnel are women.

According to official statistics, the number of women alcoholics increased from 37 to 39 per 100,000 women over the period 1990—1999 and the total number of women alcoholics in 1999 was 29,800. The relative share of women in the total number of alcoholics has greatly increased over the last decade. Specialists note that alcoholism among women is more difficult to treat than among men. This is partly due to the fact that society has a much more severe and intolerant attitude towards women alcoholics, so that the latter try to hide their condition and only seek assistance when the condition is far advanced, if at all. Drug addiction among women follows a similar pattern, and it grew more than five-fold over the period 1993—1999.

Consumption of beer has greatly increased in Russia: sales have grown by a factor of 2.1 over the last 10 years. The drink is particularly popular among adolescents and young people, including girls, and this is largely due to commercials, which popularise a certain type of behaviour. However, there are no warnings in school textbooks and other books for children and adolescents about the effect of alcohol on reproductive health. Television also remains silent on this topic.

Study of the causes and effects of domestic violence has great relevance in Russia, and understanding of what deserves to be classified as domestic violence differs among gender groups. However, a survey conducted in Russia as part of the UNIFEM "Life without Violence" Regional Information Campaign found that 92% of respondents recognised the existence of domestic violence and recognised that its most negative effect is the harm, which it causes to women's health: psychological harm (87.2%), physical harm (74.1%) and reproductive harm (34.8%). It is interesting that more men than women take the view that a woman who has been a victim of domestic violence will be unable to have a child (47% and 31%, respectively).[7]

A gender-based approach to healthcare may be very useful in determining the objectives of public health policies. Unsatisfactory levels of female health are linked to the relatively heavier biological and social burdens of women, who have most of the responsibility for continuation of the species and must often bear this responsibility in difficult social conditions. Society must therefore help women and find the necessary technologies to encourage women to put a high value on their own health. First steps in this direction have already been taken: in 2002, the draft of an official document entitled "The Social Status of Men and Women in Russian Society: A Gender Strategy of the Russian Federation" was presented for deliberation. If adopted, this document should determine state gender policy in Russia for a long time to come.

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There are many different approaches to defining health, but a much-cited definition is that of the WHO, according to which health is a positive concept, including not only physiological well-being, but also social and personal capacities. Such a definition recognises the complex influence of biological and social factors on human health and illness. Nevertheless, practice shows that the so-called "medical" approach to health is far from having been overcome in Russia, and state institutions are very conservative in this regard. Mother and child health, and general health, require an interdisciplinary approach with participation of specialists from different fields and, above all, interaction between the social and medical domains, implying logistical and financial co-operation between healthcare institutions and social services. This does not take place in practice in Russia. Federal targeted programs for improving mother and child health resolve isolated healthcare problems but are inadequate for changing the situation as a whole or for ensuring steady positive improvement.

The mechanisms that are used for implementing healthcare reform in Russia make it impossible for ordinary people to play an active part in the changes.

The different situations of men and women in society, differences in their way of life, and the need for public policies that maintain or change gender roles show the need for gender analysis in the field of healthcare. Such analysis has not yet been made mandatory for public health reviews in the Russian Federation, even though, as pointed out by the WHO, "the consideration of gender aspects in conducting research programs and initiatives is one of the best long-term approaches to make healthcare and prevention strategies more target-oriented and efficient".[8]

Health is a positive concept, including not only physiological well-being, but also social and personal capacities

[1] N.F. Gerasimenko, "Formirovanie zakonodatel'noy bazy v oblasti okhrany zdorovya v Rossiyskoy Federatsii" in Okhrana materinstva i detstva v Rossii i Velikobritanii: mezhdistsiplinarny podkhod. Meditsina Publishing House, Moscow, 2002, pp.15—21.

[2] S.I. Kolesnikov, "Vremya prinyatiya Kodeksa zakonov ob okhrane zdorovya skoro pridet..." in Upravlenie zdravookhraneniem, 1, 2001, pp.8—14.

[3] E.D. Acheson, Public Health in England: Report of the Committee of Enquiry into the Future Development and the Public Health Function. London, 1988.

[4] L.V. Gavrilova, "Sovremennye problemy v oblasti okhrany reproduktivnogo zdorovya zhenshchin v Rossii" in Upravlenie zdravookhraneniem, 2, 2002, pp.7—14.

[5] "Narkomaniya, alkogolizm, SPID — ugroza budushchemu Rossii. Obzor materialov parlamentskikh slushany Komiteta po okhrane zdorovya i sportu 19 dekabrya 2002 g." in Upravlenie zdravookhraneniem, 3, 2002, pp.74—88.

[6] N.S. Grigorieva and T.V. Chubarova, Genderny podkhod v zdravookhranenii. Alfa-Print Publishers, Moscow, 2001.

[7] Rossiya: nasilie v semye — nasilie v obshchestve. Moscow, 2002; Domestic Violence and its Impact on Health: A Report on the World Situation. WHO, 2003.

[8] European Public Health Report 2002. WHO, European Series #97, p. 74.

BOX

Education in Russia in 2002: The Results of an Experiment to Introduce a Common State Examination and Registered Government Bonds

The 2000 and 2001 Human Development Reports for the Russian Federation gave detailed consideration to the government's "Conception for Modernising Russian Education up to 2010" and main trends in reform of state education. For this reason, the present Human Development Report does not contain a separate chapter on education, and preliminary results of education reform are presented in this Box.

In 2002 previous strategic decisions on education reform were worked out and made more specific. Decree #2866 of the Ministry of Education, dated 23rd July 2002, contains a plan of action in 2002—2004 for implementing the government's Conception. This document contains two sets of measures with the following aims:

I. Respect of state guarantees on access to quality education.
II. Raising the quality of general and vocational education.

Measures towards the first aim are as follows:

- to draft recommendations defining competencies of education management bodies and social services in providing targeted social assistance to schoolchildren and college students who are from low-income families, or have disabilities, or who are orphans or children without parental custody, for covering expenses for housing, food, medical care, summer recreation and health resorts, textbooks, etc.;
- to draft recommendations for postponing military service for graduates of higher and secondary vocational establishments who majored in education in order to allow them to work full-time as teachers, educators and vocational masters in state-registered general educational establishments, children's homes, boarding schools and primary vocational establishments;
- to raise the accessibility of pre-school education; to create a system of guarantees for the payment of educational services in pre-school establishments at the state's expense, to maintain and expand their resource base at the founder's expense, and to fund the upkeep of children at their parents' expense with the support of targeted social assistance programs for low-income families;
- to create cultural educational centres, manufacturing training centres and medical centres at educational establishments (especially in rural areas);
- to provide special conditions for children with health problems at schools;
- to study and generalise the results of an experiment to create a Common State Examination (CSE); to draft managerial decisions for developing the CSE on the basis of the results of the experiment at each stage of its implementation and to monitor public opinion; and to increase the number of constituent members (regions) of the Russian Federation participating in the experiment to 75 (out of total 89) by the year 2004.

Measures for achievement of the second aim are focused on modernising education:

- to introduce specialised curriculum programs in senior high schools; to reduce the burden on students of general educational establishments and to improve the preparation of schoolchildren entering the system of vocational education; and to carry out relevant measures such as drafting concepts for a new model school and developing textbooks for such a school;
- to raise the health of schoolchildren and inmates of children's homes and to develop and implement the subprogram "Physical Education and Improvement of the Health of Children, Adolescents and Young People in the Russian Federation";
- to provide public support for innovative educational establishments serving as platforms for the modernisation of education;
- to conduct structural and institutional reforms of vocational education, to optimise the network of vocational establishments, to develop different models for inte-

Table 5.3

Results of the Experiment to Introduce a Common State Examination

Indicator	2001	2002	2003 (projected)
Number of constituent members of the Russian Federation participating in the Common State Examination (CSE)	5	16	49
Number of graduating high-school students participating in the CSE	30	300	715
Percentage share of graduating high-school students participating in the CSE (in the total number of graduating students)	2	23	58
Number of higher educational establishments participating in the CSE experiment	16	117	245
Number of schools participating in the CSE		7,849	18,581
Number of CSE Collection Centres		2,027	3,940
Number of CSE Primary Processing Centres		289	532

grating primary and secondary as well as vocational and higher education and to establish university complexes.

Experimental introduction of a Common State Examination (CSE) was expanded in 2002, bringing 16 Russian regions into the experiment (cf. Table 5.3).

The goals of the CSE are

- to make vocational education more accessible;
- to develop a system for more objective evaluation of high-school graduates and ensure equal conditions for entering higher and vocational educational establishments;
- to assure a smooth transition between general and vocational education;
- to achieve equivalence of marks on state certificates attesting completion of general secondary education;
- to assure state quality control of general education through an independent and more objective assessment of the standard of high-school graduates.

For purposes of legal regulation of the experiment and in accordance with Government Decree #222 "On Participation of Secondary Vocational Educational Establishments in the Experiment to Introduce a Common State Examination", dated 5th April 2002, the Ministry of Education approved a series of regulations entitled "On Conducting the Common State Examination" (Injunction #1306, dated 9th April 2002).

These regulations define procedures for certifying graduates of general educational establishments and for conducting entrance examinations and accepting students to vocational and higher educational establishments in the constituent members (regions) of the Russian Federation in which the experiment is being held. The CSE is meant to combine the certification of graduates of general educational establishments, on the one hand, and entrance examinations to vocational and higher educational establishments, on the other. The CSE is recognised by general educational establishments as a high-school certification examination and by vocational and higher educational establishments as an entrance examination. CSE student examination papers are assessed with the help of points (on a hundred-point scale) and marks (on a scale of five). High-school students who pass the CSE receive (a) a general secondary education certificate and (b) a report with their CSE results, which is valid until 31st December of the same year. If a student decides to postpone entering a higher educational establishment, he will have to take the CSE again in the year in which he intends to begin his higher studies. A state examination committee is created in each constituent member of the Russian Federation for holding the CSE and make-up of the committees is approved by the Russian Ministry of Education.

Last year, a new mechanism of financing higher educational establishments using so-called registered government bonds (RFBs) was also tested. The declared targets of the bond system are:

(1) to make the system of state support for higher education more flexible and consequently more available to different categories of high-school graduates;

(2) to make use of funds allocated to the higher education system more efficient by making higher education establishments function on a competitive basis and by making the flow of finances more transparent.

Under Decree #6 "On Conducting an Experiment in 2002—2003 to Finance Selected Higher Vocational Educational Establishments with the Help of Registered Government Bonds", dated 14th January 2002, the Russian Government approved conditions and procedures for conducting this experiment in 2002—2003. These regulations stipulate that the experiment to finance higher educational establishments using RGBs is implemented together with the experiment to introduce the CSE. It defines the RGB as a "proof of the results of the Common State Examination taken by the individual with a note that attests the category of the bond that will serve as a basis for the allocation of federal funds to a higher educational establishment to cover tuition costs of the individual during the entire course of studies in accordance with state educational standards." For those individuals who did not take the CSE (graduates of previous years, graduates of educational establishments that did not participate in the experiment, etc.) or who took it in a field, which differs from the specialisation of a given higher educational establishment, state examination committees that administer the CSE will organise tests that correspond to the form and content of the CSE.

The list of higher educational establishments participating in the transition to RGB-financing was approved by Decree #1013 of the Minister of Education, dated 25th March 2002, and includes six higher educational establishments in three constituent members of the Russian Federation:

- Mari-El State Technical University;
- Mari-El State Pedagogical Institute;
- Mari-El State University;
- Chuvash State University;
- Chuvash State Pedagogical University;
- Yakut State University.

The higher educational establishments in the Mari-El and Chuvash Republics had previously participated in the CSE experiment.

It should be said that the list of selected higher educational establishments did not include private higher educational establishments and affiliates in the Mari-El and Chuvash Republics of state higher educational establishments, whose centres are located elsewhere. Moreover, departmental higher educational establishments refused to participate in the RGB experiment, which made the latter's participants less representative of the total pool of establishments in the selected regions.

Higher educational establishments participating in the experiment had to determine and publish the cost of tuition in each field of study, and the precise field and form of study, no later than three months before they started receipt of documents from potential students. These establishments had to accept new students in all fields of study exclusively on the basis of the RGB. The number of students whose tuition expenses were covered entirely by RGBs without additional payments by the students had to be at least 50% of the total number of students in the establishment and at least 25% of the total number of students in each field of study. If the tuition costs of a student were not completely covered by federal funds and exceeded the financial support of the RGB that he was awarded, he or she must sign a contract with the higher educational establishment for his studies and pay the difference between the tuition costs and the amount of RGB financial support as stipulated by the contract.

The conditions emphasise that federal funds are allocated to higher educational establishments participating in the experiment in accordance with the legal norms governing treasury implementation of the federal budget. Higher educational establishments depending on executive bodies of the constituent members of the Russian Federation and establishments depending on executive

bodies of municipalities are financed from budgets of the constituent members of the Russian Federation and municipal budgets, respectively. The Ministry of Education and the Ministry of Finance published joint Decree #1597/39n "On Adopting the Method of Planning and Financing Federal Expenditures for Higher Vocational Education Using Registered Government Bonds", dated 29th April, to enforce this financing system. Five categories of RGBs are introduced for the period of the experiment, corresponding to the number of points received by a student in the CSE (cf. Table 5.4).

Table 5.4

Correspondence Between CSE Results, RGB Categories and Their Cost

RGB Category	Number of Points Received on the CSE	RGB Financing* (in roubles)
Category 1	more than 80–100	14,500
Category 2	more than 68–80	7,500
Category 3	more than 52–68	3,900
Category 4	more than 43–52	2,800
Category 5	more than 35–43	1,200

* Approved by Decree #1,013 of the Minister of Education of the Russian Federation of 25th March 2002.

RGB funds cover the expenditures of higher educational establishments for salaries, the single social tax and other running expenses.

The RGB system gives high-school graduates the right to receive a higher vocational education at the state's expense, but the amount of financing depends on their CSE results and the amount of funds allocated in the state budget for higher education in a given year (cf. Table 5.4).

Table 5.5

Distribution of First-Year Students at Higher Educational Establishments Participating in the Experiment, according to RGB Category

RGB Category	First-Year Students (in %)	Graduating High-School Students Taking the CSE (in %)
Category 1	2	8
Category 2	38	9
Category 3	37	34
Category 4	11	25
Category 5	5	17
No Category	1	13

The six higher educational establishments participating in the experiment received applications from 35,000 high-school graduates, of which they accepted more than 14,300 for first-year studies during the 2002/2003 academic year, and 8,400 of these students (58% of the total) were accepted on the basis of RGBs.

The distribution of first-year students participating in the experiment according to RGB category is shown in Table 5.5.

Our analysis of the main trends of state education reform in 2002 shows that state education management bodies are keen to begin practical development of experimental pilot programs for reform of general and vocational education. Such an attitude will help adaptation of the educational system to market conditions, but state structures need to react much more quickly and to adjust and elaborate reform strategy where needed.

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