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FAMILY MEDICINE IMPLEMENTATION PROJECT IN BOSNIA AND HERZEGOVINA

FaMI phase III

Final Report
January 2004 through March 2007

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Acronyms

BiH	Bosnia - Herzegovina
CPD	Continuing professional development
DZ	Dom Zdravlja (Health Centre)
FBiH	Federation of Bosnia-Herzegovina
FM	Family Medicine
HBP	Home bound patient
HIF	Health insurance fund
HUG	University Hospitals of Geneva
MoH	Ministry of Health
PHC	Primary Health Care
PHI	Public Health Institute
RS	Republika Srpska
SDC	Swiss Agency for Development and Co-operation
TOT	Training of Trainers course

1. Executive summary

This end-of-project report covers January 2004 through March 2007 of the SDC supported family medicine project in Bosnia and Herzegovina, Phase III.

Background

The former health care system of Bosnia and Herzegovina (BiH) was based on a network of Dom Zdravljas (DZ) and specialist-driven. Between 1997 and 1999, WHO elaborated health reform plans with the two respective ministries of health (MoH) to utilize the structure of the DZs with their attached ambulantas as the primary health care level. To strengthen this entry level of care, it was suggested that family medicine (FM) be introduced as the "gatekeeper" of patients and that the FM teams be empowered by making them provide a greater range of high quality medical/nursing services.

The SDC-supported family medicine project (FaMI phase 1&2) in 2001-2003, supported the BiH health reform efforts and demonstrated successfully the feasibility of implementing family medicine at the primary care level in six selected municipalities of the Northern part of BiH. Based on the experiences gained during these two phases, a new project was designed following the priorities expressed by both Ministries of Health to scale up the implementation of FM at the regional and cantonal level of the country.

Project main objective

The purpose of Phase III of this project was to extend the support to the implementation of a locally-owned and sustainable model of family medicine, transitioning from a municipality-based to a region- and canton-based focus.

Methods

Until end of 2005, the project developed new structures and entered a partnership with BiH health professionals in order to facilitate the transfer of responsibilities from the Swiss driven to BiH driven project activities. Then a new approach was tested and implemented, basing the partnership on existing institutional structures, rather than with individuals to promote institutional empowerment.

Project outcomes

During Phase III, the project has met the objectives set in the project proposal. In addition, innovative opportunities were seized and developed with the local partners to increase the access to family medicine and the quality of FM services for the population of BiH.

The local partners like MoH representatives, DZ and Public Health Institute directors, and Mayor of municipalities, have been playing an active and decisive role in the direction and implementation of all project activities. As a result, the project is fully integrated and supportive of the national health reform efforts. The strong appreciation of the participatory approach promoted by the FaMI project and the local ownership of the FM activities was particularly evident in the willingness of the partners at various levels and sectors to co-finance the project activities. For a total sum of 2'340'000,- KM invested by the SDC in reconstruction and equipping, an additional amount of 1'246'000,- KM was invested by BiH.

Additional project achievements for this project include:

- Four autonomously operating training centers (Sarajevo, Doboj, Zenica, Foca) were established, the latter without extensive mentoring and management inputs from the project staff
- Training activities during the three academic years 2004 to 2006 resulted in certification of 617 doctors and nurses, instead of the 320 originally planned
- All training activities were completely integrated and supported into the overall professional health training activities of the MOH.
- The project TOT certificate is officially recognised by the MoH for training doctors or nurses in FM. 84 professionals were awarded such a FM TOTs certificate
- All TOT training activities were transferred to the local partners, with only coaching and backstopping from the expatriate training specialist
- Continual professional development approaches for both doctors and nurses were elaborated and implemented during two years in Sarajevo canton
- Monitoring results related to patient satisfaction with FM services (EUROPEP instrument), rational drug prescription, smoking cessation, and benzodiazepine prescription were analyzed and presented at the annual WONCA meeting
- 161 FM practices were reorganised and rehabilitated in four cantons and three regions, instead of the 90 initially planned. All these sites were inaugurated with full media coverage in both entities
- Smoking cessation education was scaled up involving 300 doctors and nurses and provided increased use of techniques with patients interesting in quitting
- Palliative care services were developed, tested and implemented, integrated within the FM network in Orsaje municipality
- A course to improve the care of home-bound patients in Sarajevo was conducted
- The patronage nurse system and its linkages to FM in Zenica was improved

Lessons-learned during the reporting periods include:

Knowledge management

- Additional workshops, seminars, and other opportunities for exchange, contribute to further quality improvements beyond the training courses.
- Supervision by head doctors and nurses was found to be more effective for the implementation of FM than supervision by peers.

Dissemination of best practice

- If good examples are available and local conditions in place, an implementation/training site (Foca Training Centre) may be able to take some “short-cuts” and reach full implementation more quickly.

Partnership and ownership

- Having local partners and institutions implement project activities with staff support leads more quickly to sustainability.

Co-financing:

- There are many forms of co-financing, and local willingness to co-finance increases with time and level of trust established in the target area.
- Local co-financing remains a cornerstone to local ownership and sustainability of FM. The flexibility for the local partners to determine in what project activities they are willing and able to invest also contributes to the strength of this approach.

Health promotion:

- Additional health services, e.g., smoking cessation and palliative care, can be integrated successfully at the DZ level once a FM network has been successfully organised

2. Context

In Bosnia and Herzegovina (BiH), poverty and inequalities are an increasing concern. Because the country has recognized the link between development and health, the BiH health sector reform addresses access to cost effective basic health services and invests together with different donors in the implementation of a family medicine approach.

Between 1997 and 1999, WHO elaborated strategic health reform plans with the two respective ministries of health (MoH) of the Federation and the Republic Srpska. At that point, the MoHs of both entities made a reform of the primary health care system, through family medicine, their priority. The main approach is to maintain the structure of the Dom Zdravljas with their attached ambulantas, but to introduce family medicine (FM) as the "gatekeeper" of patients, and empower the FM teams by making them provide a greater range of high quality medical/nursing services.

The SDC-supported family medicine project (FaMI phase 1&2) in 2001-2003, demonstrated successfully the feasibility of implementing family medicine at the primary care level in six selected municipalities of the Northern part of BiH. Based on the experiences gained during these two phases, a new project was designed following the priorities expressed by both Ministry of Health to scale up the implementation of FM at the regional and cantonal level of the country. A sustainable model of an integrated FM approach was developed during the phase covered by this report in order to promote ownership and transfer of expertise, so that BiH health institutions could develop their capacity and take over the implementation of the reform from the project.

3. Objectives and activities

The overall objective of the project was:

To support the extension of Family Medicine (FM) in Bosnia and Herzegovina from a municipality-based to a region- or canton-based focus through the development and implementation of a locally-owned and sustainable model of an integrated FM approach to health care.

1. By September 2006, an integrated FM approach to health care will be operational in selected regions or cantons of BiH (Doboj region, Zenica-Doboj and Posavina Cantons, Sarajevo Canton), fully sustained by a critical mass¹ of FM practitioners

2. The FM approach to health care will serve as a source of practical guidelines and strategies for FM implementation in other cantons and regions.

3. The FM approach to health care will also rely on partnerships at cantonal and regional levels to foster synergies and collaboration between health projects and social projects.

¹ The "critical mass" concept is one aspect of addressing the assessment of feasibility of implementing FM (other aspects being financial, legal issues, motivation and expertise in FM implementation). When FM is meeting a lot of resistance, we see the critical mass of retrained doctors in FM as one way to overcome constraints raised by health professionals. But this it depends very much on each location; resistances are not the same in each Region/Canton, so the critical mass can be different as well. Former Minister of Health of RS, Dr. Milorad Balaban (2002) was taking 60-70 % as a critical mass for the Doboj Region. Probably, this figure has lowered due to a better understanding of FM and its need for PHC reform.

This final report follows the project's objectives of FaMI (Phase III) of the Project Document, developed in close cooperation between BiH, SDC and the project management, reflecting the wide spectrum of activities carried out within the framework of the project that contributed to the development of an integrated family approach to health care:

- Infrastructure building
- Retraining in FM
- Training of Trainers and Supervisors (TOT-TOST)
- FM Monitoring
- Implementation of FM
- FM Advocacy and Promotion
- Health Promotion

Each of the listed components is elaborated in more detail below.

3.1 Infrastructure Building

For each selected region/canton, an organisational infrastructure is established, composed of all the local stakeholders and experts that are playing a role in the FM reform process, to become fully responsible for the training and the FM implementation.

3.1.1 Activities planned

Activities related to this sub-objective consist of organizational and human resources arrangements aimed at facilitating the progressive transfer of responsibilities to local stakeholders. Local FM implementation managers will be designated at the regional/cantonal levels, as well as FM retraining and TOT/TOST coordinators, FM facilitators and implementers. Two local working groups/advisory boards will also be constituted.

3.1.2 Achieved results

Until the end of 2005, the project was working in partnership only with the health institutions it was familiar with, assisting the local partners to gradually assume total responsibility for the project activities. On the basis of this working relationship, the didactic re-training courses for doctors and nurses in FM, the field supervision, the implementation of FM in the workplace, and quality control have been taken over mostly by our BiH counterparts.

This approach was very appropriate when an activity had to be tested first for its feasibility and efficacy. It has permitted ownership of the targeted activities and their dissemination without increasing the project budget. However, this approach also has certain limitations and constraints:

- In order to have BiH institutions take over project's activities, these institutions need to have an adequate legal and human resources framework that is compatible with the proposed activity. For instance, in the field of FM implementation, no specific BiH institution was assigned the leading role at that point. Because of the need to have a multidisciplinary approach (DZ, hospital, PHI, municipality and MoH), a new system had to be created, the working groups.
- Creating a new system, like these working groups, always produces a concern about their sustainability.

- The FaMI project and the health authorities (MoH) might have different opinions on which institutions to choose to partner with the project.

Therefore the project developed a new approach of supporting existing structures and institutions so that they can design a program according to their structure and, if necessary, develop new tools and procedures. This increases the likelihood that they become autonomous from the project and will operate the selected program. This new approach, that was not initially planned, is elaborated in the next chapter.

3.1. bis Institutional empowerment

The FaMI project is empowering selected health institutions so that they can take over the Primary Health Care reform from international agencies, following the objectives and methods of the Paris Declaration²

3.1.1. bis Activities planned

- Identifying the pertinent institutions that have the tasks and responsibilities of implementing the PHC reform plan
- Having health authorities support these institutions
- Supporting the selected institutions with the FaMI project to develop project proposals that target the PHC reform and the FaMI phase 3 project
- Presenting and getting the approval from steering committee members for project proposals submitted by local partner institutions
- Monitoring and evaluating the project implementation
- Promoting the “market-value” of these institutions by improving their visibility toward BiH authorities and international organisations

3.1.2. bis Achieved results

The BiH institutions were chosen using the same criteria as those used for the transfer of expertise³ (see for details the annual progress report 2005, chapter 3.0) and based on their motivation to implement such a project. Five institutions were selected (see annex 1: an example of a contract with a BiH institution), and these provided six projects proposals (see table 1 below) to the FaMI project. All projects begun with preparation and/or implementation of their activities during 2005 and were completed early 2007.

These six projects have numerous results. In addition to the specific project outcomes, the following should be noted: 1. the most relevant was certainly a very high satisfaction of the partner’ institutions that could get support from a Swiss Government project, to elaborate and get funding for “their” project. Once the objectives were met, these institutions could truly make visible their expertise and the credit they receive from an international donor. 2. A second important outcome was that the local partners gained experience in proposal development and project implementation (writing grant application, narrative and financial reporting, approaching donors) so that their institutions become compliant with international donor requirements. 3. Finally these project proposals created

² Paris Declaration 2005 <http://www.oecd.org/dataoecd/11/41/34428351.pdf>

³ Criteria for selecting institutions: a. Is the target institution entitled to run such activity and does it have the expertise; b. who is finally accountable; c. Can the institution pay health professionals to run the activities; d. What kind of contract can be signed between the two parties

synergies and collaboration between cantons and regions, across entities, re-establishing links that were weakened because of the war.

The project staff concluded that institutional empowerment is the best approach to have BiH institutions taking over the PHC reform, having them building their capacity for family medicine implementation now, but also having them ready to invest in new components of the next strategic health care plan.

Table 1: The selected institutions and the project proposals

Institution	Project	Time period
1 University of Eastern Sarajevo – Medical Faculty in Foca	Additional education in family medicine ⁴	March – December 2005 March – September 2006
2 Public Health Institute (PHI) of Republika Srpska	Improvement of primary health care activities in smoking cessation ⁵	January – December 2006
3 Dom zdravlja Orašje	Improvement of preventive and promotional activities of patronage nurses in the family medicine teams ⁶	April – December 2006
4 Public Institution Dom zdravlja Kantona Sarajevo	Continuous professional development of the family medicine teams ⁷ Improving health care of homebound patients by family medicine teams	March – December 2006 March 2006 – May 2007
5 Institute of Public Health of Zenica-Doboj Canton	Improvement of preventive – promotional activities and palliative care within the family medicine team ⁸	April – December 2007

3.2 Retraining in FM (formerly CME)

Retraining in FM is extended to a regional/cantonal scale. It is promoted and supported in BiH through direct implementation and FM advocacy activities with decision-makers

3.2.1 Activities planned

The retraining activities were planned to take place in 3 reconstructed and equipped centres, located in Sarajevo, Doboj and Zenica, each staffed with local coordinators and facilitators. Altogether, 8 groups of 20 doctors and 20 nurses were to be retrained in FM (total of 160 doctors and 160 nurses).

3.2.2 Achieved results

Retraining in family medicine took place at four training sites: Doboj, Sarajevo, Zenica, and Foca. The Foca training centre was opened in 2005, following a request from the RS MoH, to scale-up training activities.

⁴ See chapter on Retraining in FM

⁵ See chapter on Health Promotion

⁶ See annex 2 (summary of Patronage project in Orasje)

⁷ See annex 3 (summary of CPD in Sarajevo Canton)

⁸ See annex 5 (summary of Community nurses project in Zenica)

Against the 8 training courses planned, 15 were organised during these three academic years due to strong local demand. Instead of the 320 planned originally, 617 doctors and nurses completed the FM training courses.

All the centres were integrated within an existing health structure, using its system and human resources. The structure was selected according to the specificities in each canton and region:

- The main Dom Zdravlja: in Sarajevo and Doboj
- The Public Health Institute and the main Dom Zdravlja in Zenica
- The Medical Faculty: in Foca

The selection of the structure was done taking into account the most reasonable option in each site, including expertise, workload capacity, the sustainability and the support of the health authorities. Family medicine specialists have been integrated as teachers and coordinators in the retraining efforts. The quality assurance monitoring for the retraining courses was carried out by local nurse-doctor teams that coordinated and supervised the practical part.

The ability of the FaMI program to adapt to local conditions was one of its greatest strengths:

- Flexibility in training arrangements, which allowed participants to balance work and other commitments
- Local empowerment and participation in course design, implementation and evaluation
- Training content based on needs and resources
- An approach in line with the strategic and operational plans of the cantonal MOHs
- Capacity development at local levels with development of teaching expertise

Some important constraints could not be solved during this period:

- The university department of family medicine in Sarajevo is still weak and does not play a leadership role in FM
- The role of the patronage nurse as a part of the FM team is still not defined in the FBiH

Table 2: Family medicine training courses per location 2004-2006

Institution	Project	Time period
1 Dom zdravlja Doboj	Additional education in family medicine	September 2003 – June 2004 September 2004 – June 2005 September 2005 – July 2006
2 Dom zdravlja and Public health institute of Zenica canton	Additional education in family medicine	October 2003 – June 2004 October 2004 – June 2005 October 2005 – June 2006
3 Dom zdravlja Ilidza in Sarajevo canton	Additional education in family medicine	September 2003 – June 2004 September 2004 – June 2005 September 2005 – June 2006
4 University of Eastern Sarajevo – Medical Faculty in Foca	Additional education in family medicine	March 2005 – Dec. 2005 March 2006 – Sept. 2006

The training courses included participants from the Doboj region, Sarajevo canton, Bosansko Podrinjski canton, Zenica Doboj region, Posavina canton and Foca (see annex 18)

Table 3: Number of doctors and nurses trained per year and per location

Training centres in FBiH	2003/2004		2004/2005		2005/2006		Total
	doctors	nurses	doctors	nurses	doctors	nurses	
Sarajevo	40	41	22	23	19	24	169
Zenica	19	23	35	45	14	31	167
Total FBiH	59	64	57	68	33	55	336

Training centres in RS	2003/2004		2004/2005		2005/2006		Total
	doctors	nurses	doctors	nurses	doctors	nurses	
Doboj	20	22	39	43	26	59	209
Foca	0	0	12	24	12	24	72
Total RS	20	22	51	67	38	83	281

Total number of participants trained	2003/2004		2004/2005		2005/2006		Total
	doctors	nurses	doctors	nurses	doctors	nurses	
Expected	60	60	60	60	40	40	320
Achieved	79	86	108	135	71	138	617
Achieved (%)	132%	143%	180%	225%	178%	345%	193%

3.3 Training of Trainers and Supervisors (TOT-TOST) course

Capacity of the local partners to implement all aspects of FM retraining, supervision and implementation support is increased through the training of trainers (TOT), supervisors and DZ management

3.3.1 Activities planned

One local TOT/TOST project coordinator will supervise a local coordinator in each retraining centre. Activities will be based on an integrated TOT/TOST curriculum. Handover of the programme to local professionals will be facilitated through the provision of a complete set of checklists, guidelines and ready-to-use documents and hand-outs. Altogether, 4 groups of 20 participants will attend the TOT/TOST course (total of 80 trainers).

3.3.2 Achieved results

Three local training coordinators, Alma Alic (Zenica), Vildana Bilic (Sarajevo) and Amela Lolic (Banja Luka), who are also doctors and trainers, were identified and monitored the whole training process alongside with Vivian Jacot, Swiss TOT Manager and at the end the only expatriate trainer. The coordinators helped participants to build on their past experiences during the course and the evaluation process, and they supported trainers in developing the content of their units and their training methodology.

All local trainers were selected from previously trained and motivated TOT participants (nurses and doctors) coming from several regions. They had expressed willingness to take on responsibilities and to become trainers.

The TOT courses covered theoretical issues related to adult learning and to supervision skills, and at the same time, a strong emphasis was placed on practical strategies to enhance future practical implementation.

Between October 2003 until June 2006, 85 participants got their TOT certificates (see Table 5).

We focused, at the end of the project, on quality control while building capacities, training and coaching local teams in order to transfer competencies. This was done with the view to assure progressive assumption of all responsibilities by the BiH professionals, not only for the pedagogical approach, but for the whole process.

The accreditation of the course and the validation of certificates are paramount for the TOT project team. A tight network and working relationship of all partners involved at a general and political level was essential. Additional steps have already taken place with authorities to assure sustainability with the elaboration of a CPD (Continuous Professional Development) accepted curriculum. Credits can now be obtained by participants and trainers from the Doctors' and Nurses' Chambers.

Table 4: International and local TOT trainers throughout time

Courses	Dates	Expatriate	Local
TOT 1	Oct-03 - May-04	5	12
TOT 2	Sep-04 - Feb-05	2	14
TOT 3	Apr-05 - Sep-05	1	21
TOT 4	Nov-05 - May-06	1	21

The expected number of 80 TOT participants that would complete the training and get the certificate has been exceeded by 6.25% - 85 participants have been certified (see annex 19)

Table 5: Number of TOT participants from 2004 to 2006

Courses	Dates	Number of participants
TOT 1	Oct-03 - May-04	18
TOT 2	Sep-04 - Feb-05	26
TOT 3	Apr-05 - Sep-05	21
TOT 4	Nov-05 - May-06	20
Total number of participants		85

3.4 FM Monitoring

A set of monitoring indicators of the FM performance is developed and tested within the project, using selected indicators to analyze the newly implemented activities in FM

The monitoring of FM performance has been developed into an independent component, since the usual project evaluation approach is not sufficient for a project that is dealing with reforms and implementation of new services. Assessing the quality and the quantity of the newly implemented services has two main purposes. First to promote a continuous quality improvement of health services and secondly to increase the visibility of newly established services with the health authorities and stakeholders. In order to have a monitoring system that can support these purposes, the process that was used to collect indicators had to be carefully designed. The project, in collaboration with its BiH

institutional partners, designed an appropriate evaluation system for each component, taking in account the reasons for that evaluation and the local specificities of the sites:

- Self-assessment to raise awareness of health professional about continuous quality improvement: integrated within the FM courses
- Promoting the reorganisation of the FM practice by evaluating some aspects of the practice management: using the structure of the newly established FM departments
- Increasing the visibility of FM services towards health authorities: using the Public Health Institute (PHI) data collection system (palliative care, EUROPEP)

“Action research is not only a research that describes how humans and organizations behave in the outside world but also a change mechanism that helps human and organizations reflect on and change their own systems” Reason & Bradbury, 2001.

3.4.1 Self-assessment of FM practices in the management of hypertension and diabetes

It has been demonstrated that in the health sector, continuous quality improvements are most effective when health professionals are involved in the assessment, the development of action steps, and their implementation. Moreover, the process of self-assessment of quality is interesting in itself, because it introduces an internal critical analysis of what is provided to the patient.

Within the course of FM, four topics were chosen (Hypertension, tobacco use, diabetes, and PAP smear) for which each participant collected data, analysed them, and presented the findings to his/her colleagues at one point of the course. Data were collected and presented by each FM practice (80 patients per practice) involved in the training course, having 350 team surveys presented over the three years. Quality control of these surveys was performed (see annex 6: WONCA Greece 2005 - Audit on HTA in FM teams) by supervisors and validated by coordinators.

3.4.2. Continuing professional development in Sarajevo and Orasje

Based on other international experiences, one of the best potential approaches to improve the quality of FM services lies in the training system (both, the FM retraining courses and the CPD system) where health practitioners can make recommendations to the educational centre coordinators about topics for which additional knowledge or skills should be improved. The introduction of CPD activities (a collaboration of the FaMI project and the Canton of Sarajevo health authorities) for the first time in 2005, is now the preferred approach to increase the impact of the training and also the satisfaction of the participants enrolled in CPD activities.

3.4.3. Palliative care

It is well known that home services are not well developed in BiH. The Orasje municipality initiated a project in partnership with FaMI in 2004. New services targeting palliative care patients were introduced together with a strong monitoring system. The main purpose of this monitoring system was to demonstrate the amount and the type of services⁹ provided by the FM teams to the Cantonal MoH for having these activities integrated in the health system (see Annex 7: Bihac 2007 - Palliative care in Orasje municipality)

⁹ As initially planned for the FM monitoring component

3.4.4. Rational drug prescription

Looking at the cost-effectiveness of their services, doctors learn in the FM training course to follow national guidelines in prescribing drugs. They learn to apply evidence-based treatment and prescribe the most suitable medication/s. The monitoring of rational drug prescription was achieved in Dobož and followed by feedback seminars to family medicine doctors on how to change prescribing habits.

3.4.5. The satisfaction of the patient with FM services

The EUROPEP survey is standardised approach used by European countries, measuring the satisfaction of the patients with a 23-item questionnaire. This questionnaire has been used extensively with the sites in the new target areas. The base-line study, conducted in 6 Dom zdravlja's in Dobož region, Zenica canton and Posavina canton in 2003, was repeated a year and a half later in 2004. There was a high overall rating for all the questions in both surveys. However, the repeated EUROPEP survey showed statistically significant higher patient satisfaction with FM. The role of health professionals other than doctors has been strengthened through FM implementation. Access to health has been increased, and further implementation of FM reform should continue to improve it. (see annex 8: EUPHA Helsinki 2007 – EUROPEP survey).

3.4.6. Smoking cessation survey

A first assessment of smoking prevalence was done with a convenience sample of 1850 patients, interviewed consecutively in FM practices to assess their nicotine dependence, their readiness to quit smoking, and the relationship of tobacco to the past war conditions. The combination of high prevalence of smoking and a significant number of smokers interested in or trying to quit, provided the motivation for a new project that started in 2004 and that has been scaled-up in 2005 and 2006¹⁰ (see annex 9: WONCA Greece 2005 - Smoking habits in PHC structures of Bosnia and Herzegovina).

3.4.7. A benzodiazepine (BZD) use

A survey was conducted to establish the BZD use and the reasons for having doctors prescribing it. This survey was initiated after having recognised BZD over-prescription as an important problem in BiH, especially related to patients with mental health disorders for instance Post-Traumatic Stress Disorder (see annex 10: EUPHA Helsinki 2007 abstract).

3.4.8. Referral rates

One indicator of FM performance is the rate of referrals from the primary to the secondary health care level. A baseline study on referral rates conducted at the beginning of the FaMI project in one municipality covered by the project was repeated two years later. The results showed that the referral rate remains high (25%), though the reasons for referral differ greatly from the baseline. The number of referrals to confirm a diagnosis or at “the request from the patient or patient's family,” has decreased significantly, suggesting improved skills of FM doctors and greater confidence of patients in the FM providers. On the other hand, referrals due to requests¹¹ from specialists increased significantly. It may be concluded that a more comprehensive approach to FM is needed, one which would, in addition to an update of the knowledge and skills of FM doctors, also deal with the improvement of the communication channels between the different levels of care, the flow of patients between the primary and secondary health care level, and appropriate

¹⁰ See health promotion chapter

¹¹ The specialists request that the FM doctor refer the patient back to the specialist on the next patient consultation

promotion of change in the population and secondary health care professionals with respect to referral (see annex 15c: Poster - EUPHA Montreux 2006 – Significant change in referrals from primary to secondary health care level after FM implementation).

3.5 Implementation of FM

Reconstruction, provision of medical equipment and reorganisation of a selected number of existing DZs and ambulancias is achieved to allow good practice of FM

The primary care reform replacing the old model of narrow specialities with a system of integrated general practice (family medicine) generates resistance to change, which was overcome by a system-wide participative approach.

Regular working group meetings favoured direct communication between the strategic level (representatives of ministry of health) and the operational level (directors of primary care facilities) to discuss and solve practical issues. It also reinforced individual and institutional competences to get the family medicine services integrated in the existing health structures and institutions. These meetings were also used for peer exchange and to invite directors of institutions where the reform was not yet under way, to inform them about the process and prepare them for future family medicine implementation (dissemination).

Directors of **public health institutes** were involved to define coverage area for family medicine teams with registration of patients (see related chapters) and health promotion related issues. For effective reallocation of budget to family medicine services and correct refunding the participation of representatives of the **health insurance fund** was essential. **Hospital directors** were concerned when referrals to hospitals and collaboration and reallocation of staff were discussed. **Community and municipality representatives** (mainly mayors of town) were invited to the meetings to get their participation in financing of rehabilitation of health institution and priority setting. Their commitment was also essential for the sustainability of the family medicine services and their promotion towards the population.

In each targeted municipality (see BiH implementation map) the modalities of the implementation were discussed during the working groups. The objective was to develop specific operational plans. But the frame of the implementation process remains the same in each site:

First are the so-called “pre-conditions for family medicine implementation”

- **Coverage plan:** the municipality is divided geographically in smaller parts in which one or more medical practices are made accessible to the population. This plan is essential to assure that rural population will have an equal access to health.
- **Adaptation of the damaged infrastructures and the equipment** of the medical practices according to WHO standards. Family medicine does not need a lot of technology to be practiced. However, some basic medical equipment is needed. A rehabilitated practice is also the visible part of family medicine implementation. It is a strong incentive for health professionals and directors of the health institutions to move from their speciality-oriented system to family medicine. The community which will benefit from family medicine services was asked to participate financially (see the **co-**

- financing** chapter), either by funding the rehabilitation of a health unit or by providing material and staff. Their participation insured sustainability of the health structure.
- **FM team identification** and allocation to each selected site (medical practice). Each medical practice that has been selected for the reform is allocated with a doctor and nurse team.
 - **Registration of the population** to each FM team (maximum 2500 persons per team). A clear attribution of patients to the different family medicine teams was done by directors of primary care facilities in collaboration with public health institutes and following local law. Active or passive registration was used according to the available resource.
 - **Training of health professionals** in family medicine: the course consisted of 8-10 modules of three days that took place during one academic year. In parallel to the training, supervision at their workplace helped them to implement family medicine and to practice their newly acquired skills (see the supervision under).
 - **FM promotion** strategy towards the population. Family medicine was advertised so that the population could understand the benefits of these new services and have practical information on how to contact the medical practices, the appointment system and the free access these services.

Management of the change or reorganisation of the practice

Once the preconditions were fulfilled, the reorganisation of the FM department and the implementation started. In the implementation of FM of a health structure, supervision is one of the most important activities. On-site practical supervision and teaching to the FM teams in their working place (ambulanta and DZ) is essential in order to help the teams to use their newly acquired skills in their daily work.

Supervision consists of a doctor or nurse visiting his/her colleague working in the ambulanta. The main goal of the visit is to discuss what kinds of problems they are facing with the new organisation and how to solve them. The second purpose is to support them in this difficult process, by providing any kind of input, reference, advice, literature, contact, medical material and psychological support. In order to have a uniform approach to the supervision activities, the supervisors received evaluation forms (see annex 12) with all the topics listed for each visit. The needed interactivity for the full appreciation of any problem makes the “on-site” visit necessary. The FM teams performance indicators were collected (see Annex 12b) through a different process (not through the supervisor), for instance by the PHI.

No seminar of any kind could replace this supervision, especially when the work regards management issues. Regular meetings to exchange information between all the supervisors were needed to monitor and to improve the process. At the end of the academic year, the supervisors and coordinators of each centre reviewed together the supervision forms. Afterwards, the coordinators of the centre of Doboje and Zenica met twice, to up-date the forms according to the suggestions made by the supervisors, exchange their experience, and to continue a common approach in future (see Annex 13 - Quality improvement reports).

The components below were considered for the reorganisation of the practice and the implementation of FM:

- **Task division:** A clear task division between doctors and nurses was defined. Following the experience of the first two phases of FaMI, the task division between

these professionals was realized through the supervision visits where new activities were implemented.

- **Regular staff meetings:** Within each FM department, a weekly meeting was encouraged to have all involved looking together at the management of the service and to understand that everybody can be committed and improve the function of the structure.
- **Appointment system:** To give patients the possibility to schedule an appointment in advance with their doctor or nurse, the health professionals had to stabilise their place of work, to have advance planning of the working time, to have a system for managing appointment and to provide the patient with clear explanation.
- **Reorganisation of time:** The FM department had to extend the day and W-E coverage for their patients. The population was used to go to the emergency department (EM) from 1 pm due to the fact that the GP was closed from this hour. By introducing two shifts (two FM teams cover from 7 am till 6 pm) in one medical practice, the patients could be seen in the FM department without having to queue in the EM. It also relieved the burden on EM, allowing the reallocation of health professionals to FM.
- **Problem oriented medical file:** In some DZs, medical files were not used anymore after the war. It was important to re-introduce it to be able to collect in one place all data for the patient. In other DZs, patient files were spread across different departments. To improve the filing system and availability of patient information, it was decided to centralise all files in the FM department. Finally, the patient files were updated with additional tools allowing to better record information, improving the follow-up of patient with chronic diseases and the early detection of pathology.
- **Medical advice by phone:** Telephone lists with advice for different medical problems have been handed out to the doctors and nurses. The main objective is to be able to solve some specific problems without having the patient come to the practice.
- **Nurse's consultation and empowerment of nurses:** According to the scientific literature, nurses are skilled in counselling patients. So far the nurses in the PHC level were mainly working to keep the record books and for administering care. In many DZs, doctors understood the importance of empowering nurses and delegated some tasks to them. Even some patient group counselling was realised with success, piloted only by nurses.

See annex 20 for the sites that benefited from the implementation process with the support provided during the years 2004-6.

3.6 FM Advocacy and Promotion

Family medicine practice is advocated and promoted through the media, community outreach activities, and lobbying activities at the Government level. Family medicine practice is also advocated and promoted through synergies with selected local social sector projects, aimed at providing adequate social/health care for beneficiaries

Inauguration and certification ceremonies

Inauguration and certification ceremonies are among the best tools to promote FM. For such events, the local community, municipality, DZ directors, representatives of the MoH and the SDC, including FaMI project representatives were always present. Media were informed, and most of the time TV, as well as newspapers covered the events. These events were not expensive to the project, since the media were not requesting any payment for their attendance.

The presence of the local community created a very favourable moment for spreading the FM concept and the new services that were introduced. The project staff also suggested to the hosts of these events to invite managers of DZs that had not started activities in FM implementation to make them realise what can be achieved:

Table 6: Sites inaugurated after the completion of reconstruction and equipping

Year	Sites inaugurated
2004	• Modrica FM department in the Dom Zdravlja (June 2004)
2005	• The new FM retraining centre in Medical Faculty in Foca (March 2005)
	• Prud FM ambulanta in Odzak municipality (June 2005)
	• Samac FM department in the Dom Zdravlja (June 2005)
	• Derвента FM department in the Dom Zdravlja (June 2005)
	• Babinja rijeka ambulanta in Zenica town (August 2005)
	• Jaliya ambulanta in Zenica town (September 2005)
	• Visegrad DZ in Eastern RS (November 2005)
	• Gorazde DZ in Gorazde canton (November 2005)
	• Foca DZ in Eastern RS (December 2005)
2006	• Bijeljina DZ, setting for nine FM teams
	• Lopare DZ, setting for four FM teams
	• Visoko DZ, setting for two FM teams
	• Visoko, amb. Buci, setting for one FM team
	• Visoko, amb. Mostre, setting for three FM teams
	• Visoko, amb. Gracanica, setting for one FM team
	• Ugljevik DZ, setting for three FM teams
2007	• Tesanj Tesanjka, setting for one FM team (May 2007)

Table 7: Certificate ceremonies for the FM and the TOT courses

Year	Location of ceremonies
2004	• Sarajevo (June, 2004)
	• Zenica (June, 2004)
	• Doboj (July, 2004)
2005	• Sarajevo (June , 2005)
	• Zenica (June , 2005)
	• Doboj (July 2005)
2006	• Foca (March 2006)
	• Doboj mid-term conference (February 2006)
	• Sarajevo (June 2006)
	• Zenica (June 2006)
	• Doboj (July 2006)
	• Audit presentation in Sarajevo and Zenica (June 2006)

Dissemination of the results

- WONCA (World Organization of Family Doctors) Europe Conference in Greece 2005 (see Annex 6 – Poster on blood hypertension)
- WONCA (World Organization of Family Doctors) Europe Conference in Florence, Italy, 2006 (see Annexes 14a: Influence of smoking cessation education on practice of family medicine doctors, annex 14b: Doboj Centre for additional education in FM, annex 14c: Regional approach to FM implementation in Doboj region, annex 14d: Presence of risk factors in patients with DM)
- EUPHA (European Public Health Association) congress in Montreux, Switzerland (see Annex 15a: TOT in BiH, annex 15b: Access to medical education: examples of sc counselling, annex 15c: Significant change in causes of referrals from primary to

secondary level after FM implementation, annex 15d: Integration of comprehensive homecare service in a FM network: community nurses project in Orasje)

- The Geneva Forum, Towards Global Access to Health, in Geneva (see Annex 16 - Geneva Forum, Capacity building)

3.7. Health promotion

At least one health promoting/preventive activity (e.g. smoking cessation or prevention of sexual transmitted diseases including HIV/AIDS) is promoted and supported within the project and through synergies with selected social sector projects.

The smoking cessation pilot project, originally funded by the Consortium partners, was expanded after 2005 by the FaMI project. This expansion project was designed by the Public Health Institute of Dobož and submitted to the FaMI project. It follows the new institutional capacity building approach.

Background: In order to successfully implement a “Program for Prevention and Control of Non-contagious Diseases” for smoking cessation, it is necessary to inform and train health professionals. The implementation of anti-smoking campaigns and laws issued by the RS regulating smoking will have an impact on public health only when the health system, especially the primary health care level, is ready to support the increasing number of those willing to quit smoking. At that point it will become possible to assess the claim of WHO that “reduction of tobacco use is the most important public-health action that a country can take for both health and economic well-being”.

General objective: To improve the quality of the “Program for Prevention and Control of Non-contagious Diseases” with respect to smoking cessation activities

Specific objectives

1. To train a group of doctors in smoking cessation counselling, as well as in peer group management and to serve as peer trainers
2. To educate primary health care doctors in smoking cessation counselling
3. To educate health professionals from the PHI of RS and the health insurance fund (HIF) of the RS to be able to perform monitoring and evaluation of the smoking cessation activities

Results

- Sixteen doctors from Dom zdravljas from the whole RS have completed the TOT course for smoking cessation counselling.
- 325 doctors from 42 Dom zdravljas and one private ambulanta in RS have applied for the education in smoking cessation counselling. Training workshops took place in Banja Luka, Laktasi, Gradiska, Dobož, Bijeljina, Zvornik and Foca.
- 299 doctors and 22 nurses in total have passed the exam.
- In order to prepare the RS PHI and its branches, the regional institutes, to perform high-quality monitoring and evaluation of primary health care activities in smoking cessation, an additional training of 11 doctors and nurses was organized. The 3-day seminar was also attended by a doctor from the medical sector of the RS Health Insurance Fund (HIF).
- The evaluation forms for smoking cessation counselling and a form for practice review were developed.

- 500 guidelines for health professionals on smoking cessation counselling and 12'000 patient brochures were printed. Additionally, 255 copies of the guidelines and 15 000 patient brochures were printed through a reallocation in the budget. It is important to mention that the Guideline has been catalogued in ISBN Agency under number ISBN 99938-781-5-4.
- A conference on smoking cessation was held in Banja Luka on 24th of November 2006, where project results were presented and future actions discussed. The Conference was attended by representatives of MoH RS, HIF, Agency for Control and Improvement of Health Care Quality, directors of some of the DZs, participants of the project.
- A part of the evaluation of the project was a review of practices conducted before the training and six month after the training. The findings showed a statistically significant improvement in the identification of smoking status, the assessment of nicotine dependence and the advice given according to the stage of change of the patient.

3.8. Alternative Source of Funding

Possible additional local and international funding is sought to complement, enhance and scale up project activities

The co-financing component was introduced on the recommendation of the Swiss Foreign Minister, Mme Micheline Calmy-Rey, after her visit to the FaMI project in September 2003.

According to the new Memorandum of Understanding (MoU) of the FaMI project, up to 30% of the total amount of the Trust Fund budget (1 Mio CHF or 1.2 Mio KM), meaning 300'000,- CHF (360'000,- KM) should be invested by the BiH side in the same areas targeted by the FaMI project.

While it appeared initially that the co-financing requirement would be a great challenge or even a constraint to the progress of the project activities, it has become clear that co-financing is actually becoming a factor of the success in the implementation of family medicine. Therefore local co-financing was sought not only for equipping and reconstruction but for all other activities to complement, enhance and scale up project activities. The co-financing by the BiH institutions demonstrates their willingness to invest in the health care reform and acceptance of the SDC FaMI project.

The following **situations** have been encountered by the project regarding co-financing:

- 1) The health institution invests in a structure; the FaMI project supports the health institution by adding resources when the rehabilitation has been completed.
- 2) The health institution decides to invest in a structure and each party covers a part of the investment (the most frequent situation).
- 3) The project invests in one structure according to the health institution's plan. Because of additional needs, the institution decides to invest as well.
- 4) Each partner (project and health institution) is responsible for different activities (i.e., contracting a company individually), targeting the same structure, but with different tasks. So two separated contracts are organized in parallel.
- 5) Structures and their fixed costs are offered to the project (the space of the two offices of the FaMI project, the three training centres with electricity and heating system) at no additional cost to the donor.

- 6) The partners are providing the human resources and are paying them through their own structures to achieve project activities (example: Dobož region supervision activities, 2005-6).
- 7) Local partners and health professionals jointly invest in making it possible for them to attend international conferences.

One immediate consequence of co-financing is that the project can achieve more results than initially planned with the same resources. However, an even more important benefit of co-financing is that it builds the partnership among the co-financing institutions to achieve the project activities. This includes partnerships with the project, as well as partnerships among local institutions (e.g., health system, municipalities, health insurance fund, etc.). This partnership strengthens the commitment of the partner institutions, their ownership of the joint activities, and the transfer of expertise. These three factors are essential for the sustainability of the activities supported by the project. Finally, co-financing is also a good indicator of the priorities of the local institutions and health authorities to move along with the PHC reform. On the other hand, co-financing is not always a smooth and easy process, and the following issues can and have on occasion been observed by the project:

Potential issues with co-financing:

- The partner influences the activity in an inappropriate way, and therefore the project objective is not adequately met
- The partner is not meeting his obligations, therefore the activity cannot be completed
- The partnership negotiations are more complex than expected and slow down the project schedule
- The financial format for the activity is not compatible for the project (donor) and the partner institutions; one approach is chosen, raising legal issues
- The project is losing the control over the activity

The co-financing of activities by our local partners is listed below (see table 8). Over the 2 Mio CHF invested by the SDC (Trust Fund of the FaMI and the BFM 2005-6 projects), 600'000,- CHF (or 720'000,- KM) was expected to be invested by BiH. The project could achieve a higher amount, with more than 1 Mio CHF (1.246 Mio KM) invested by BiH, reaching 53% of co-finance instead of the 30% expected. For the detailed co-financing activities see Annex 17.

Table 8: table of investment and co-finance for BiH 2004-2006

Investment and co-finance	TF* (KM)	BFM** (KM)	TF + BFM (KM)	Co-invested amount (KM)	Percentage co-invested
Total 2004	369,385	0	369,385	360,262	97.53
Total 2005	211,564	571,590	783,154	361,000	46.10
Total 2006	645,131	543,660	1,188,791	525,027	44.16
TOTAL 2004-2006	1,226,080	1,115,250	2,341,330	1,246,289	53.23

* TF: Trust fund

** BFM: Bundesamt für Migration

4. Lessons-learnt

The Paris declaration can guide implementation approaches. Coordination and harmonisation with the local partners is very feasible at the level of project implementation. Both MoHs have gradually begun to assume a leading role, guiding international donor support to obtain a better donor harmonisation and to improve coordination with BiH institutions in Bosnia-Herzegovina.

Donor coordination:

Donor coordination can improve the impact of projects and the willingness of the BiH MOHs to support the activities. Having multiple and uncoordinated international actors working in the same fields is creating confusion for the partners and the target groups of the projects (like DZ directors for the FM implementation).

Ownership principles:

The best outcomes in term of ownership have been achieved when an activity was designed from the start in collaboration with our partners and the appropriate political and organizational structures, so the responsibility of the activity was given to them.

We have seen a huge difference in having activities conducted with local **partnership** and having them implemented by local institutions with FaMI project support. The second approach is of course producing the most sustainable results.

Two recent examples illustrate that:

- The palliative care activities in Orasje
- Smoking cessation in Dobojska region

However, it must be pointed out that this approach is unlikely to have worked at the onset of the project. The SDC, the Consortium and its team benefit now from several years of establishing the local partnership and building trust.

Institutional capacity building:

Capacity building can be better achieved by giving BiH institutions the responsibilities to define their specific needs, elaborate an implementation plan, and conduct the activities. This is especially true for activities that have already been tested and successfully implemented in BiH. By having BiH institutions more involved inside the assessment of the needs, the design and the execution of one new program, it favours the acceptance by the population and the health professionals and its visibility for the government representatives. It has also allowed **scaling up** the project to new regions and cantons that were not originally included in the project plans. Ultimately it will allow reducing BiH dependency on international expertise and relying more and more on its own institutions.

Co-financing of project activities:

There is no single right approach for **co-financing**; specific and individual approaches are needed in order to help our partners to fund their own structures. Municipalities where pre-conditions are met for FM implementation and where DZ managers see their interest of having a partnership with the project are more likely to agree to co-finance the jointly planned activities.

The co-financing approach increases the commitment of BiH institutions in the planning and the execution of project activities significantly. In addition of making more funds available for implementing activities, co-financing has created a dynamism in the process of the implementation of FM and improved the sustainability of the new services.

5. Recommendation for the next phase

The external review of FaMI phase 3 conducted in early 2006 (Wyss & Sehovic, January 2006) concluded that the project had largely achieved its objectives and expected outputs. It was observed that FaMI phase 3 was fully in line with national, cantonal and municipal priorities for health reform and assisted successfully the country in modernising and restructuring the sector by introducing family medicine. High ownership by local and national actors over project activities and capacity strengthening at local, regional and national level had been successfully achieved. Various elements introduced by the project have been scaled-up by others and become the national standard. Phase 3 also retrained large numbers of family medicine teams (over 600 family nurses and doctors) and reconstructed a sizeable number of ambulancias (more than 150). Thereby complementary co-funding by municipalities in Federation BiH and Republika Srpska, as well as by the Swiss Federal Office for Migration (BFM), played a catalytic role. New activities in the area of palliative care, patronage and health promotion were introduced. The pilot-testing showed to be very successful with ownership and motivation of involved partners and high potential for replication.

The external review outlined options for future lines of activities within the phase 4 of FaMI project. Among these, the following were recommended (Wyss, 2006):

- Access of poor and vulnerable groups to family medicine services should become a greater concern and benefit from more attention.
- Family medicine should remain in the centre of the future project, but include
 - A strengthening of the relationship between of service provision at the family medicine level and the communities and hospitals (e.g. the gatekeeper role of family medicine).
 - Promotion of the interactions with beneficiaries, especially poor and vulnerable groups, through patronage/community nurses, building on initial experiences of FaMI phase 3 in the area of palliative care.
 - The extension of the current service package, for example in the area of prevention.
 - The role of health promotion within family medicine and the relation between family medicine and social welfare and mental health services should be further clarified, and collaborations with NGOs might systematically be promoted.
- Greater attention on capitalisation and dissemination of pilot experiences to different stakeholders.
- Retention of flexible approaches towards project implementation and promotion of ownership at the level of national actors.

6. Work plan for FaMI phase 4

6.1 Bridging Phase overall objective:

To set up a local entity (LE) that will have the overall responsibility for the FaMI project phase 5 starting from 1st of January 2008 onwards. The LE will support initiatives of local institutions in the sector of the primary health care in Bosnia and Herzegovina and empower stakeholders in the exercise of effective leadership.

6.2 Bridging Phase Objectives:

To integrate the activities of the FaMI project phase 5 into the national development strategies and to coordinate it with the support of the stakeholders of the health and social sector of BiH by:

- a. Strengthening the position and the structure of the local entity
- b. Empowering local capacity building and assuring participation of public institutions, NGOs and other relevant organisations of BiH in the project's activities
- c. Designing and conducting a comprehensive assessment for the new phase.