SDC's contribution to reduce the NCD-burden of Bosnia and Herzegovina: The 'Reducing Health Risk Factors Project'

Results of the assessment mission to Bosnia and Herzegovina with options for the follow-up Phase II of the project

October 27, 2018

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ACRONYMS

AKAZ	Agency for Quality and Accreditation in Health Care FBiH
AP	Action Plan
ASKVA	Agency for Certification, Accreditation and Health Care Improvement RS
BD-BiH	Brcko District Bosnia and Herzegovina
BETF	Bank Executed Trust Fund
BiH	Bosnia and Herzegovina
CM	Community Mobilization (component of project arm 1)
CME	Continuous Medical Education
CPD	Continuous Professional Education
CVD	Cardiovascular Diseases
CVRAM	CVD Risk Assessment and Management
DoH BD	Department of Health, BD
DZ	Dom Zdravljas (HC of PHC)
EU	European Union
FBiH	Federation of Bosnia and Herzegovina
FCTC	Framework Convention on Tobacco Control
FM	Family Medicine
FMoH	Federation Ministry of Health
GP	General Practitioner
FMT	Family Medicine Team
HC	Health Centre
HIF	Health Insurance Fund
LAG	Local Action Group
LE	Law Enforcement (component of project arm 1
M&E	Monitoring and Evaluation
MH	Mental Health
MoCA BiH	Ministry of Civil Affairs BiH
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
OC	Outcome (in logframe)
OP	Output (in logframe)
PH	Public Health
PHI	Public Health Institute
PHR	Public Health Reform
PMT	Project Management Team
RETF	Recipient Executed Trust Fund
RF	Fisk Factor
RHRF	Reducing Health Risk Factors (project)
RS	The Republica Srpska
SCO	SDC Cooperation Office
SDC	Swiss Development Cooperation
ToT	Training of Trainers
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The Reducing Health Risk Factors Project (RHRF) was prepared in 2012, jointly by SDC, WHO and World Bank in consultations with BiH health authorities. Phase one of the project (01.12.2012 – 31.12.2018) was financed by SDC with an amount of CHF 7 million and implemented by the World Bank and WHO. **The project purpose is to contribute to a reduced burden of NCDs** and an improved health status for the population of BiH. The respective implementation strategy included (a) capacity building of health authorities for a better health risk management, (b) training of primary healthcare providers for better prevention and management of CVDs and (c) mobilization of civil society, the media, the private sector and municipal governments for effective advocacy on healthy environment and lifestyles.

Towards the end of phase I, **SDC requested a review** of progress and achievements of the project and a strategic outlook into a follow-up second phase, responding to three main concerns (TOR):

- the unfinished business on public health regulation and management of CVDs;
- the continuation of the WB-interventions related to the community mobilization component;
- the future scope and strategy of the project – with different options and their pros and cons, based on the findings of the assessment.

The mission team did an extensive study and analysis of achievements based on the planned outcomes and outputs of the original SDC logical project framework. These findings and a broad exchange with stakeholders and participants of all project components led to the **provision of a proposal for phase II**, with a rearranged project strategy and an adjusted operational set-up.

Assessments:

The multisectoral work with law- and decision-makers of various ministries (**WHO-led component 1**) has risen the awareness for the importance of a stronger NCD-focus and created the respective political and legal tools; while this is a positive achievement, there is still a big gap towards a concrete implementation and enforcement of the drafted laws and frameworks (action plans) due to a lack of political will and the short-term interest of decision-makers (especially on the tobacco front).

Over the past years, the training of FMTs in CVD assessment and management has reached a coverage of over 70% of health centres and health posts in both entities of BiH (**WHO-led component 2);** the methodology and tools are now well established and subjective judgements on the impact of the trainings were rather positive; but there were some doubts whether this acquired knowledge is really implemented in the daily practice of FMTs, preliminary results of a 'pre-post survey' with 13 indicators by quality control agencies couldn't prove yet significant changes in dealing with NCD/CVD-risk management.

The expert work on tobacco policies and frameworks at the level of the state and its two entities (**WB-component A**) reached – according to the WB as process leader – an achievement level of 'a major historic innovation in BiH'; while this optimistic judgement would mean that the expected component outcome is reached, concrete efforts to reduce tobacco risk factors among BiH's population are still rare, as e.g. the implementation of smoke-free public places, etc.; and no advancement has been obtained on the negotiation front for a tobacco tax increase.

The assessment of the achievements of the comprehensive social mobilization work (**WB-component B**) has been complicated by the fact that a change of the project logframe has been introduced by the WB as late as 2017 and therefore a real one-to-one check with SDC's originally expected results illusionary; but despite the short remaining time in phase I, a successful preparatory work has been accomplished for authorities and volunteers of four pilot municipalities, and people have been trained in modern, evidence-based methods for behaviour change and essential ingredients for actions to motivate and mobilise communities and relevant stakeholders; this has led to the creation of a 'movement ' ('local action groups') at the pilot municipalities involved on which to build on; but the success is still fragile, and the present operational setup not favourable for a sustainable progress and for a future replication of this project component.

Issue from SDC's decision not to engage itself in the implementation of such a complex project, an **'operational set-up'** had been established for the RHRF that - over time - proved to be rather inconvenient, with mandates to WHO and WB respectively. While it was the strong will of SDC (regarding all strategic decisions) and the two UN-agencies limited to the *'advisory role'*, this clear-cut separation of functions and roles was difficult to maintain – leading to misunderstandings between BiH-authorities, the agencies and SDC, and finally to problems in project implementation. For the WB managed components, the set-up was additionally complicated by the fact, that SDC's funds were split into two trust funds differently administered, a 'bank executed fund' (with WB's sole competence to invest and disburse) and a 'recipient executed fund' (where disbursements had to be cleared through the slow and complex BiH bureaucracy). For all these reasons, resulting in a lack of transparency and efficiency, a change of this setup is now requested by SDC – and a withdrawal of the WB from the project announced.

Outlook

This health project has a currant and urgent goal, a stringent and evidence-based approach in line with international recommendations and came at the right time; **and it achieved till now a reasonable number of results. It should clearly be continued**, especially because goals related to behavioural change require a particularly long-term commitment.

Nevertheless, a distinction had to be made whether, for some components, the level of progress was such that a withdrawal from foreign support was reasonable - in order to stimulate a self-sufficient and sustainable domestic process – or whether, for other components, a continued (or increased, or adjusted) support was necessary.

As a result of this analysis, and based on the findings, **the mission team proposes the following re-structuring and re-prioritizing of the project for phase II,** divided into two intervention arms, still in line with WHO's evidence-based two-pronged approach:

An intersectoral arm (= whole population approach, 50-75%):

- Prioritizing the 'Community Mobilization for Health component', with a continuation in the pilot municipalities and the start of expansion, based on clear criteria, of more municipalities (*CMH: 50-60%*);
- A 'Small Grants Support' for some targeted and time-limited activities, issued from NCD action plans or linked to the new NCD-related intersectoral legal framework – including a continued commitment for tobacco control advocacy and advisory (*SGS: 15%*);

A sectoral arm (= individual risk patient approach, 25-40%):

- Phasing-out and withdrawing from the 'FMT-training component';
- Analysing with an in-depth survey at HCs the problems in the Working Conditions of FMTs, problems hindering the application of the acquired knowledge from previous trainings on CVD-management, in collaboration with the MoH and the PHI (*AWC: 15-20%*);
- Technical and IT-Support of the Accreditation agencies (ASKVA and AKAZ) for their capacity strengthening, in order to establish a scientifically sound and sustainable monitoring system of the CVRAM-work of FMTs at HCs (*TSA: 15-20%*).

Concerning the operational set-up, the pros and cons must be weighed against each other, whether a more 'country owned' (and Paris/Accra Declaration conform) or a more 'efficiency and transparency' oriented option suits the project and the cause better. The mission team had not enough (political) background information to already privilege one of the two options.

The RHRF-project seems well embedded in SDC's overall country strategy, with its strong health focus and with a number of other projects closely related to it, like promoting healthy life-styles among youth, improving nursing care and mental health – or projects strengthening the role of municipalities or facilitating citizen forums, etc. **Coordination** with these parallel projects and benefit from **synergies** is a potential that isn't fully exploited till now (e.g. municipalities already involved in other projects could be candidates for the extension of CMH). Collaboration could equally be sought with local people and institutions offering specific capacities (like education or media skills). And last, but not least, a closer **exchange** with UNICEF in the field of nutrition should be explored (e.g. nutrition-friendly preschool program).

Overall, this project has a good potential for success, but needs after this assessment an intense planning effort to finalize a logframe and a credit proposal for phase II and to decide on and detail the most suitable operational set-up for the project implementation. The mission team hopes to have paved the way for this challenging endeavour.

ACKNOWLEDGMENTS

The mission team would like to address our thanks and appreciation to all our interlocutors during the assessment, especially to the representatives of the Ministries of Health of both entities, the colleagues from the Public Health Institutes and the Health Centres as well as the Accreditation Agencies. They offered us their precious time and their knowledge of the BiH Public Health situation and – of course – their insight into the progress and the problems of the RHRF-project. A particular acknowledgment goes to all the participants, official or voluntary, of the Action Groups from the Community Mobilization component of the project: they sacrificed hours to talk to us, allowing us to really understand their wishes and concerns.

Equally, many thank to the members of the 'implementing UN-agencies' WHO and WB. We appreciated their thorough documentations and their contributions at our common meetings.

We hope to extract the right and useful conclusions from all these encounters, favouring the continuation of the project and the launch of phase II next year.

As the mission leader, I would like to thank my colleague and local resource person, Jan Zlatan Kulenovic; without him, the mission would have been difficult and much less informative; he was always available, very attentive in the discussions and to the point with his contributions and requests.

A special thanks goes to our translator-ladies Bjanka Pratellesi and Amela Kurtović: they had a hard time with me, translating simultaneously back and forth from one language to the other, and I gave them often too little time to recover; many thanks for the hard work.

Last but not least, Maja Zarma Zaric deserves our great acknowledgment for the perfect organization of the mission, the trips, the hotels – and more importantly - her professional inputs that enriched our views and insights into the BiH reality and into the health sector - her special field of expertise.

Matthias Kerker, healthFORUM, October 31, 2018

INTRODUCTION

Four types of NCDs – cardiovascular diseases, diabetes, cancers and chronic respiratory diseases – make up the largest causes contributing to death in the majority of countries in the world. These four NCDs are largely preventable by means of public policies that tackle four risk factors for NCDs: tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity.

The health SDG 3 *'ensuring healthy lives and promoting wellbeing for all at all ages'* stipulates in sub-goal 3.4 that *'one-third of premature NCD-mortality must be reduced by 2030 through prevention and treatment of NCDs…'* and in sub-goal 3.5 that *'the prevention and treatment of substance abuse should be strengthened…'*[1]

At the 73rd UN General Assembly this year, under the heading *'scaling up multi-stakeholder and multisectoral responses for the prevention and control of NCDs'*, high level decision-makers assessed progress in view of these SDG-Agenda items. **What they concluded was far from encouraging.** UN Secretary-General António Guterres stated that the international community is *'well on track towards an unhealthy future, unless it delivers on its promises'* and WHO's Director General Tedros Adhanom Ghebreyesus recognised that *'governments are dangerously off-course in efforts to reduce premature NCD deaths and that a very real possibility exists that SDG 3.4 will not be met'*.

According to the WHO Independent High-level Commission on NCDs[2] *'the current policy commitments are inadequate; evidence is growing that the response in countries is not meeting the lofty goals and that national budget investments remain woefully small';* and that ***'there is still a sense of business-as-usual*** *rather than the urgent response so desperately needed: policies are drafted, but structures to implement them are scarce'*. And all this despite a WHO global business case for NCD-control that showed that - putting in place the most cost-effective interventions for NCDs - countries would see a return of 7 dollars per person for every 1 dollar invested.

Two approaches are currently recommended, the first aiming at reducing risk factors among the whole population and the second addressing risk factors among patients. These 'WHO Best Buys'[3] target the risks factors for NCDs by promoting healthy lifestyles and through early detection and treatment of individuals at risks; they are considered the most effective and efficient tools currently available. Because NCDs share many of the same risk factors (e.g. metabolic syndrome, tobacco smoking, overweight and lack of physical activity), one intervention has often the potential to act on several NCDs at the same time.

Where stays Bosnia and Herzegovina?

According to 2016 epidemiological data, NCDs remain the leading cause of premature deaths, avoidable disability and disease burden in BiH. Cardiovascular diseases (myocardial infarction and stroke), diabetes type 2 and neoplasms are responsible for approximately three quarters of total annual mortality, CVDs alone for half of the annual deaths. And in the statistics of HCs, CVDs figure as main cause of morbidity and represent thus a key health concern among the population.

With this high NCD-burden and no consistent NCD-control strategy in place, BiH needed urgently to engage into a risk reduction approach – and SDC's offer made in 2012 to support a 'Reducing Health Risk Factor (RHRF) project' came exactly at the right time and with the right approach: it promised to intervene **(a) at the level of health services** with the 'Cardiovascular Risk Assessment and Management (CVRAM) training' for Family Medicine Teams (the 'sectoral' approach) and **(b) at the population level** through policy and regulatory action and community mobilization (the 'intersectoral' approach).

While the concept of this project was perfect, the implementation was challenging, for operational reasons (the various stakeholders had sometimes conflicting roles) and for its complexity, especially for the community mobilisation and intersectoral components. This resulted not only in **delays in progress and disbursements**, but even in the re-definition and re-launch of one project component close to the end of the planned phase. For these reasons, and for an outlook towards a continuation of the project in a second phase, SDC called for this assessment mission.

The mission team was welcomed by all involved actors and had intense discussions with health and other authorities of both BiH entities, with representatives of health services, the project facilitator teams of WHO and WB as well as with many committed volunteers of the community mobilization component. At the beginning, it seemed difficult to grasp all the facets of this 'holistic' RHRF-project, but a thorough analysis of achievements and obstacles enabled finally the team **to propose adjustments and options** for the continuation of the project into a second phase.

[1] Other SDGs relevant to the NCD and mental health agenda include SDG 1 (ending poverty), SDG 2 (ending all forms of malnutrition), SDG 4 (ensuring education), SDG 5 (achieving gender equality), SDG 8 (decent work), SDG 10 (reducing inequality), SDG 11 (making cities safe and sustainable), SDG 12 (ensuring sustainable consumption and production patterns), SDG 13 (climate change), SDG 16 (promoting peace and justice), and SDG 17 (strengthening partnerships).

[2] WHO Independent High-level Commission on NCDs / Think piece: Why is 2018 a strategically important year for NCDs?

[3] WHO's Best Buys, PDF

RHRF-PROJECT: SYNOPSIS OF RESULTS

The table below presents – in a nutshell – the main elements of SDC's RHRF project phase I, with its main components and the related foci of intervention, the summarized output results as of end of September 2018, and these results compared with the planned outputs (in an achievement scale between 1=low and 6=high), as perceived by the evaluation team; a summarized outlook towards Phase II is added at the end (with broadly phrased support proposals).

Reducing Health Risk Factors (in FBiH and RS)

WHO-implemented	Both agencies	WB-Implemented
Main Project Components		
Cardio-Vascular Risk Assessment and Management (CVRAM) package for Family Medicine Teams at Health Centres/Posts	Intersectoral Regulatory Framework Capacity of Health Authorities for Health Risk Reduction	Community Action for Risk Factor Reduction (with concentration on 4 key risk factors: smoking, alcohol, diet, physical activity)

Main Focus of Intervention							
Training of Trainers for CVRAM (by experts, by staff of Departments of Medical Faculties) Training of Family Medicine Teams of Health Centres countrywide	Quality of Training Development of standards / indicators Assessments by AKAZ (FBiH) and ACKVA (RS)	Regulatory Framework: Multisectoral NCD-policy Tobacco control	Tobacco control policies Tobacco taxation	Mobilization and advocacy for NCD-control at municipalities, schools, enterprises, media In 4 pilot communities 4 pillar approach, WB introduced 2017			
				Zenica	Mostar	Zvornik	Doboj

Concrete Outputs / Products							
Reports on Conferences, Training Workshops Training Coverage Reports (70% FMTs trained in both entities)	Process indicators developed (n=13, developed with WHO-expertise) (Nb. of HCs certified – compulsory, not part of project) Nb. of HCs/FMTs accredited (voluntary; fee-based)	Reports on Conferences, Meetings (attended by members of the policy task force, the intersectoral liaison network, the CVRAM task force) Drafts of laws/legal frameworks, ready for adoption NCD Action Plan RS (FBiH expected)		Reports on conferences/meetings, on trainings (of trainers, of community members) Needs assessments (surveys) Operational structures for priority setting and decision making (e.g. Local Action Group LAG)			
				(Action Plan)	? (no visit by mission)	Action Plan	Action Plan Ownership No-cost initiatives

Perceived overall achievement level (1=low; 6=high)							
5	4 AKAZ	5 ASKVA	5 RS, 4 FBiH	3	-	4	5

Support Proposal for Phase II			
Phasing out	Assessment of FMT working conditions **AWC*** Technical support to improve M&E **TSA***	Small grants for the implementation of selected RHRF activities at entity/state level **SGS***	Continuation of Community Mobilization **CMH**: Integration of lessons learnt, adjustment/streamlining of implementation structures, replication in additional municipalities

* Abbreviations of the proposed Phase II project components (see p.14ff)

RHRF PHASE I: RESULTS PER PROJECT COMPONENT

In this chapter an attempt is made to present the achievements of the different project components with more detail, organized according to the original SDC logframe outcomes and outputs, in table form. It includes again an (intuitive) judgement of the mission team on the level of achievement, followed by an overall conclusion on each (WHO and WB) component.

WHO implemented component

a) SDC-OC1 – Regulatory Frameworks for NCD Risk Reduction, and Capacities to develop them, improved

Output nb./definitions		Output-Results	Achievement level (1-6)
OP1.1	Health authorities are empowered to advocate for, coordinate, lead and steer consolidated multi-stakeholder and intersectoral responses to Public Health priorities	Governance, management and *operational structures* of RHRF-project in place: • Public Health Task Force; • CVRAM Expert Group; • PH Liaison Network (composed of non-health/other sectors' stakeholders) Both health and non-health stakeholders of the project *exposed to the best international practice and evidence* in PH policy development: • Policy conferences, dialogues and workshops offered to health/non-health participants (on responsive and participatory PH policy-making, social determinants of health, Health in All Policies/whole-of-government involvement etc.). • But attendance rates lower than target with health sector attendees 55% (vs T.90%) and non-health sector attendees 38% (vs.T.80%) • International capacity building trainings received, e.g. Summer Schools Lugano and Venice, WHO/WB flagship course on Health System Strengthening 12 WHO *documents of relevance translated* in official local language	Adequate operational project structure **6** Exposure to holistic PH-approach **4** Capacity building **5** Availability of relevant documents **6**
OP1.2	PH policy framework(s) have been developed (in line with WHO European health policy framework) and operationalized	A comprehensive *self-assessment of BiH's PH system/s* executed: • 80% of public health operations were considered in need of improvement, i.e. governance, financing, resource generation and service provision; • process of planning and formulation of PH policies need further prioritisation and strategic refocusing. An *analysis of new post-2016 laws with PH-relevance*, i.e. designed in the spirit and practice of *Health in All Policies / whole-of-government* approach (drafted by line ministries represented in the project's PH Liaison Network) showed that: • 19 laws (or 79% of all laws drafted) were PH-relevant; • 9 laws (or 67% of all enacted laws) were PH-relevant; • Project target (60% PH-relevant laws before end 2018) reached. *Tobacco control laws* and activities realized: • thematic inter-sectoral policy dialogues (WHO&WB) resulted in updated tobacco laws (and action plan) for both entities; • continuous support for the law adoption process in both Parliaments (no success till now - and setback because of elections); • communication plan drafted, broad lobbying/advocacy platform with international partners established and events organized ('No Tobacco Day' with 'Smoke-free Reception')	Self-assessment and critical analysis of PH-system **6** Whole-of-government approach improved with regard to PH-relevant laws **6** Tobacco control process supported (with WB-lead) **5**

The output-results of OC1/OP1, as claimed by WHO in its reports and verifiable again indirectly (meetings with the WHO PMT and representatives of both entity MoHs), show a rather high achievement level compared to the expected.

This could mean that the awareness for the importance of a stronger NCD-focus among law- and decision-makers has risen and that the political and legal tools for putting this focus into action would now be available. But this is offset by the fact that still (5 years after project start) little concrete implementation and enforcement of the drafted laws and frameworks has happened. The main reason is a lack of political will and – especially on the tobacco front – the short-term interest of decision-makers, fearing a loss of their partisan voters if taxes were increased and restricting health measures adopted.

b) ***SDC-OC3 - Access to and Quality of CVD Treatment and Prevention by FM-teams improved***

Output nb./definitions		Output-Results	Achievement level (1-6)
OP3.1	Capacities of Health Authorities to provide strategic guidance in promoting healthy behaviours and preventing CVDs improved	A series of *thematic inter-sectoral policy dialogues (IPDs)* dedicated to internationally recommended and evidence-based policy and regulatory measures for reducing NCD-related health risks in the population resulted in concrete actions of health authorities: • a *food environment description study* (in Sarajevo and Banja Luka) after persuading stakeholders to realize the need for obtaining relevant local information on dietary risks in BiH (results?) • an exploration of internationally *successful programmes for increasing physical activity*, identifying required multi-sectoral actions for creating enabling environments in order to promote active living and mobility of people in BiH • the continuous *support of tobacco control measures* (see OP1.2) • an initiative for *'smoke free PHCs'* and - based on the 'Quit and Win' model – a *smoking cessation pilot* with about 100 smokers among health professionals of FMTs involved in CVRAM (smoking rate 30%!): cessation rate 7% in FBiH (n=4), 20% in RS (n=41)	Sensitization of authorities through policy dialogues on NCD risks **6** Analysis of existing strategies for NCD risk reduction, launch of own RF-studies **6** Pilot on smoking cessation **5** Evidence for improved capacity **3**
OP3.2	CVRAM intervention package, targeting high-CVR individuals in PHC/FM practices, in gender sensitive manner, developed, quality-assured and implemented	A 'best buys'-comprising *package of CVD risks identification and management service* (= Cardio-Vascular Risk Assessment and Management *CVRAM*) has been introduced in HCs/FM practice by: • identifying formally authorised *FM educators/trainers* (n=66; FBiH 43, affiliated with 5 training centres; RS 23, affiliated with 2 training centres) • deciding on and formal authorisation of *key elements of CVRAM-package*: total CV-risk SCORE card, patient risk register, three metabolic and three behavioural risk factors (blood pressure, -lipids, -glucose; smoking, weight, physical activity) • *training of CVRAM-trainers* by a senior international consultant: 58 of 66 authorised trainers attended (T was 30) • developing, endorsing, printing and widely distributing of *CVRAM training/intervention package tool/s* to trainees, like 7 different guidelines (2000 copies each) and over 7 different leaflets (30'000 copies each) • establishing an FMT-training as a real *continuous professional development* approach (CPD/CME) at the level of PHC/FM-posts • *training a total of 2,624 FM professionals* (or 1130 ≈ 70% BiH FMTs) in a 2-day workshop (with final test and certificate on successful completion) • increasing therefore the *access of BiHs population to standardised, evidence-based, preventative CVD/CVRAM services* in FM/PHC to estimated 67.6% (T 60%) • creating a *database with all PHC/FM professionals* who completed the CVRAM programme as a first step in their CPD • implementing *a monitoring and evaluation (M&E) process* of CVRAM implementation in practice, based on consensually agreed minimal set of quality indicators (on structure, process, outcome, accessibility and quality of services for the population in BiH)	CVRAM concept **6** CVRAM planning & implementation process **6** National coverage of FMTs with CVRAM knowledge **6** Quality assessment of CVRAM practice, and impact on CVD outcomes **3** Available CVRAM M&E tools **3**

The appraisal of the results of the WHO component OC3/OP3 is again mainly based on reporting of the project implementor himself and on broad but not very specific information obtained at meetings with representatives of entity MoHs, because many documents were not yet available or in local language.

Especially for the **quality of FMT-trainings** and their real-life implementation, an in-depth field assessment was equally beyond the mission's scope. Some sporadic and subjective judgments on the project's impact were rather positive, obtained e.g. from a FMT-doctor at the HC Zvonik or from FMT-nurses at a Doboj LAG-meeting (WB-component OC2), **but an objective proof of increased quality of FMT's work related to CVD-prevention has not been established yet – and preliminary results of a 'pre-post survey' with 13 indicators by AKAZ stipulate even that there are no significant improvements** after the trainings (indicator list see annex). Only a better assessment methodology would be able to show the real effectiveness of this intervention – and yield arguments for necessary adjustments (reforms).

c) *Conclusions on the WHO-component :*

- **The *reported project outputs (OP1, OP3)* fulfill to a fair extent the planned outputs; in contrast, the results are ambiguous comparing planned and *achieved outcomes***: despite the strong financial and expert project inputs, legal frameworks and PH action plans are still mainly paperwork ***(OC1)***, and a broad based and sustained change concerning FMT's attitude towards prevention and management of CVDs is jeopardized by the slow paste in PH-reform and the resistance to reallocate necessary resources, despite evidence of urgency and a perspective of positive long-term returns ***(OC3)***.
- As a matter of fact, the implementation of a holistic NCD policy is now hindered by political obstacles, i.e. the lack of political will at highest level, despite the urgent claims for intensified action against NCD risk-factors, as recently made again by many presidents and ministers at the 73rd UN General Assembly through an unanimously accepted political declaration.
- SDC's leverage on such factors blocking the progress of the NCD-agenda in BiH is limited; therefore, after important Swiss contributions to support the establishment of CVD-prevention relevant policies and legal frameworks, **a future commitment of SDC should be confined to advocacy** and alliance building with like-minded actors in order to strive for their enforcement; however, a **'small grants component'** could be part of phase II for the financing of specific actions proposed in the just finalized entity Ministerial PH-Action-Plans.
- After SDC's intense investment in FMT capacity building, it is now up to BiH's authorities to transform the CVRAM-training into a continuous professional education (CME) for all FMTs, with regular and professional quality assessments; therefore, a phasing-out of this training component should be envisaged and the lead and responsibility for the continuation be placed in the hands of the competent health authorities.
- If SDC considers still a continuum of the FMT-training into phase II, a **focused expert support** could be considered: problems in the transfer of theoretical knowledge into every-day practice should be identified by **sample surveys of FM-work at HCs**; and the still **unfinished M&E methodology should be improved** and transformed into a full-fledged evaluation tool. Such a support has the potential to ameliorate the FM/GP work-environment and finally to increase the impact (and cost-effectiveness) of the year-long training efforts.

WB implemented component

a) *SDC-OC1 - Tobacco Control Legislation and Taxation ('WB component A')*

This component is financed through a Trust Fund of 1.6 Mio.US$, executed by the WB (BETF), of which about 1.1 Mio US$ or 2/3 have been disbursed (end of May 2018, WB accountability).

The results presented below are based on progress reports of the WB (05/18), on meetings with the Project Implementation Team PIT and with representatives of the MoH of both entities; again, a direct verification of this outputs (e.g. by analysing the claimed tobacco policy or its implementation plan) wasn't possible by the mission team. The achievement level is only partly satisfactory and of questionable cost-effectiveness.

Output nb./definitions		Output-Results	Achievement level (1-6)
OP1.3	**Tobacco control polices** in RS, FBiH and BD reviewed, amended and harmonized on the state level	Efforts were undertaken to mobilize, inform, sensitize, educate multisectoral stakeholders for the relevance of tobacco control (from ministries, health institutions, inspection services and civil society) in order to draft a revised tobacco control strategy with amended laws: • Workshops with international/regional experts, including consultations with WHO-Europe representatives (RS 11 workshops, FBiH 6) • Drafting of a new tobacco control strategy, harmonized with the FCTC and EU tobacco directives (slow and demanding process started April 15 only, resistance by tobacco industry) • Drafting of an implementation plan with priorities, costing and budgeting Process considered by the WB as 'a historic innovation in BiH', but sceptical about adoption by parliament (after November election)	Tobacco control legislation enforced **5** Harmonized tobacco control documents available **6** Public places, institutions (schools), workplaces smoke-free **2**
OP1.4	**Tobacco taxation policy** document amended on the state level	New studies on tobacco use have been launched and regular constructive dialogues were hold with key stakeholders at state and entity levels: • But there is lack of interest for additional action on tobacco taxation • Existing tax level considered as satisfactory, compared with neighbouring countries • Stronger sensitization needed for potential positive taxation effects (higher consumer expenditures, lower medical expenses, higher income resulting from saved healthier life years and higher productivity)	Mobilization of high-level decision makers **3** Significant increase of tobacco excise tax **1**

b) ***SDC-OC2 – Mobilisation of Community Stakeholders for Healthy Environments and Life-styles*** *('WB component B')*

This component is financed through a Trust Fund of 1.4 Mio.US$, executed by the 'Recipient'[4] (RETF), of which according to the latest WB expenditure report (01/09/18), only about 25% or 350'000 US$ have been disbursed.

The output results presented in the table below stem again mainly from reports of the WB (05/2018) and the FMoH (08/18), the mission team's own observations from the field visit (three pilot municipalities) are presented in chapter c). A one-to-one check of SDC-OPs with reported OPs by the WB isn't possible due to a changed WB-logframe after 2017.

SDC Outputs (original SDC logframe 2012/13)		**Achievement level** (1-6)	**Output-Results as of WB-Report 05/18** (according to new, different WB-logframe 2017) Start preparatory phase only 2017, real implementation 06/2018 (e.g. signature by Federation only 02/2018)
OP2.1	**Teacher and managers of Kindergartens, Schools:** Strengthen their capacity to implement healthy polices and related promotional programs	These stakeholders were involved in LAGs and 'thematic coalitions', APs have been drafted and first no-cost actions at schools and kindergartens (some with UNICEF support) have been launched **4**	▪ *Community surveys* for baseline analysis in 4 selected communities in order to define priority risks and potential protective factors to be fostered ▪ Based on the model 'communities that care' and the identified need for modernizing old-fashioned teaching attitudes, development of *the '4 pillar approach'* for the RHRF project (advocacy, social mobilization, education, M&E), with a logframe different from the original SDC project ▪ Identification of 'prevention *champions*' and creation of multi-stakeholder 'action groups' ▪ Training of group members on *behavioural change principles* (workshop Jahorina, various follow-up training seminars) to apprehend the '*4 pillar approach*', using evidence-based, modern behaviour change techniques (based on a specifically developed WB-textbook[5]) and to learn how to foster broad based participation and mobilize key stakeholders ▪ Development of an *implementation framework* (with expert support = contractors for each of the '4 pillars'), participatory development of TORs and *selection of the contractors* after open tender (finally 4 contractors for the FBiH municipalities, 2 for RS) ▪ Establishment of a *Local Action Groups LAG* in each municipality, generally led by the mayor's office, with 'thematic coalitions/action groups' (in various pillars), ▪ With the aid of the contractors, LAGs identified priority needs and drafted each an *Action Plans* (sometimes per pillar) with costing and non-costing activities/small projects and complementary training/expert requests ▪ First *non-cost health promotion actions* (e.g. tobacco free spaces in schools/HCs, events on healthy diet and active living/sports, information for parents/patients) have been launched by some LAGs (with big differences among the 4 pilot municipalities) ▪ According to WB, this whole effort was time consuming, demanded a lot of effort and coordination, but created – as *a unique, multisectoral, bottom-up project* – important new partnerships, ownership and a good chance for sustainability **Overall achievement level of this WB-lead /MoH implemented RHRF-project (disbursement level still < 20% of the allocated 1.41 Mio US$) 4**
OP2.2	**Employers:** Strengthen their capacity to implement healthy lifestyle polices and related promotional programs among the employees	Small proportion of employers in LAGs; neither toolkits for nor tobacco-free spaces in enterprises have been established **2**	
OP2.3	**Network of Civil Society organizations:** Establish and involve them in prevention of health risk factors	Some NGOs are present in LAGs, but till now no mini-grants for health promotion projects have been allocated **3**	
OP2.4	**All community stakeholders:** Develop and implement advocacy / mass media campaigns for the adoption and implementation of policy and regulation documents and for social mobilization focused on (gender-sensitive) behavioural change	A good number of community stakeholders (local government, education/health system, civil society) have been sensitized and trained by the RHRF, but relevant campaigns or policy implementation efforts are still rare **4**	

[4] *State: Ministry of Finance, Entities: Finance Ministries, FMoH / MoHSW; see also below 'Shortcomings…'*

[5] *A Handbook of Resources in Evidence-Based Risk Behaviour Prevention and Health Promotion (for the use of local communities, Policy- and decision-makers and practitioners on the RHRF project in BIH, October 2017)*

c) *Observations and lessons learnt from the field visit to three pilot cities*

The mission had the opportunity to visit three of the four pilot cities in FBiH and RS (Zenica, Zvornic and Doboj) and to talk with a large number of people involved in the project – most of them volunteers. While the impression of the mission team about the overall apprehension of the nature and essence of a community mobilization approach was different in each city, and as a result the perceived advancements or commitments, the following observations can be generalized, except for some city-specific examples presented separately (e.g. of concrete actions).

(i) Concerning the preparatory phase

Questions were raised on what selection criteria the four pilot cities have been chosen (at present appointed by MoHs) and if – in case of replication of the project to other municipalities – the selection should rather be based on an application process, where candidate cities had to fulfil a number of conditionalities to be elected.

Several reasons for the late start of this project component (2017 instead of 2013) were put forth (as pretext) by the WB (floods, change of staff, sluggish administrative procedures); this has profoundly jeopardized progress and did put additional stress on all stakeholders to achieve planned outcomes and raised unrealistic expectations; time constraints (aggravated by the unclear prospect concerning 'another extension' of phase I) has bothered most interviewees.

The role of the municipal government as leader and coordinator of the project (anyway formal contacts and signatory of the agreement with the respective MoH and the WB) was perceived by interviewed community stakeholders as rather positive, despite the risk of a biased selection of involved citizens and organisations based on partisanship, nepotism and other factors, and that some sections of the population and their health needs could be left out.

The intense and reiterated basic training workshops by international experts (Jahorina, Sarajevo, others) was very much appreciated by the participants; they were attended by initial project teams (selected through the Mayor's office in both entities and BD, with multisectoral, multiprofessional and multireligous backgrounds); most of them were enthusiastic to acquire new skills, learn about the 'modern evidence-based approach to behaviour change', about 'the 4 pillar concept', but realized also that 'there were no ready-made solutions', that the project implementation would be 'rather complex' and the time to deliver short.

At city level, these trained teams were instrumental in spreading the interest for voluntary participation in their respective communities or institutions (schools, municipality and health services, enterprises) in order to foster the creation of 'local action groups LAGs', supported in some pilots (Doboj) by official communication to the citizens, through involvement of the media or speeches by religious leaders, etc. Local 'influencers' or 'champions' were identified who were known and appreciated in the population and linked to a health risk reduction attitude (see poster Zvornik with local sports champions).

(ii) Concerning community organizations and activities

After this promising start, Local Action Groups (LAGs) were formed, generally one per 'project pillar', with the 'core LAG' linked to the 'social mobilization pillar'; in all cities, the municipal government had again the lead in the matter of selection and coordination of the groups, with team appointments sometimes officialised by a city Mayor's promulgation; the frequency of assemblies of these groups and individual commitments varied by city, but members were generally interested in working on and defining issues to be addressed through the specific 'pillar-focus', i.e. through 'advocacy', 'mobilization', 'education' and 'M&E'.

The core LAG consisted mostly of 15-20 people, including always a broad spectre of representatives from the field of education and health, sports and leisure, city administration and religion, sometimes entrepreneurs and media; the number of members in the other 'pillar-groups' or 'thematic coalitions' was smaller, and overlap of membership among pillars was common (leading to some confusions about the respective roles, etc., see below).

Professional support for this work came through expert agencies (and WB-consultants at an early moment in this process); the procedure to identify and hire these agencies ('contractor', one for each pillar, hired by the entity MoH with

WB-agreement after an open tendering[6]) was perceived by all interviewed project participants as too time consuming, but they appreciated their involvement in the selection process.

One of the first tasks of the 'contractors' was – besides, in some cases (Zvornik), taking a group leading and managing function - to identify with the group members the priority risk factors among the city population for the 4 target NCDs (smoking, alcohol use, unhealthy diet and lack of physical activity), through a number of surveys.

Based on this research, action plans (per pillar) were drafted, often requiring numerous meetings – obviously with some overlap in proposed themes and actions, due to (a) overlaps between group memberships and (b) the difficulties people had to follow the 'pure pillar philosophy', i.e. not being able to separate e.g. an 'advocacy action' from a 'community mobilization action', etc. As a result, the 'pillar concept' was considered as not operational, and a frequent request was to abandon it.

The mission has not been able to appreciate most of the action plans: some had already been adopted and signed by city Mayors, but others were still in the drafting stage. Generally, these plans consist of a list of potential actions and ideas, established by the respective action group: costing and non-costing actions are listed, without a feasibility, priority or effectiveness ranking. Preference for important hardware and infrastructure investments (e.g. kitchen and its utensils, sports- and play equipment, repairs, etc.) were frequently mentioned in these plans, ignoring the intended focus of financial project support (seed-money to initiate an action rather than an investment replacing public financing obligations for equipment and infrastructure); but in other cases the option of local fund-raising or match-funding for an action has been considered (Doboj: 'if we don't get project money from the MoHSW and the WB, we will try on our own…').

As the next step following the AP-drafting, the group members expected a rapid disbursement after submission of their proposals to the MoH, conditional on the compulsory tender process to select the implementing organization (a figure of 200'000KM per pilot was repeatedly mentioned); but there was concern that this process would again be slow, and momentum and enthusiasm would be lost. But depending on the degree of political will from the highest city authority, differences in the dynamics of the community work could be observed: e.g. groups in Doboj, encouraged by the Mayor and city administration, had been able to realize on their own a number of small actions and thus to assimilate the basic goal of the RHRF-project, i.e. a sustainable citizen movement not only depending on external support.

(iii) *Concerning presented proposals for actions to address Risk-Factors*

In all the three pilot cities concrete ideas and some already established actions (non-cost or locally funded) have been presented to the mission by all the groups, to show already achieved results of their battle for risk-factor reduction. Obviously, not all can be enumerated in this report, much less all the good ideas put forward. But in synthesis, the following topics were predominant:

[6] *FBIH: Association XY, Primera Sole Proprietorship, Revicon, Custom Concept (one pillar per agency);*
RS: Public Health Institute Banja Luka, SeConS (two pillars per one agency)

Topics:	Projects / Project ideas
Healthy diet	▪ Healthy food friendly Kindergarten (promoted / certified by UNICEF (see synergies) ▪ Diet courses at schools ▪ Healthy food campaigns / Carnival on health food (since 2016) ▪ Pilot community kitchen ▪ Use of catering classes at vocational schools for healthy food promotion
Smoking	▪ Fight against water pipe smoking among youth ▪ Joint action (of city council, mayor, parents) for prohibition of coffee-shops around schools
Alcohol	▪ See detailed example below
Physical activity	▪ Free sports facilities for all / promote open sports playgrounds ▪ Sports day (with schools, parents of pupils) ▪ Promotion of mountaineering ▪ Promotion of biking (BiH Cycling Federation) / Promotion of tourism by mountain biking
Actions through health services	▪ Oral health at schools (continuation) ▪ Schools health, classes by trained FMTs (synergy with RHRF-project) ▪ Sensitizing health workforce for Health Risk Factors (seminars) ▪ 'Use helmet while cycling' campaign (YouTube)
Actions through schools	▪ Smoke free school initiative ▪ As part of 'administrative classes' at vocational schools: healthy lifestyle courses ▪ Traffic safety courses by pupils of 'traffic classes' at vocational schools ▪ WS by trained teachers (ToTs) for parents of pupils
Mass media actions	▪ Annual calendar of RHRF-events ▪ Newspaper articles on RFs like smoking, obesity, … ▪ Information about the RHRF on social media (Instagram, Facebook)
Pressure on legislation	▪ Enforcement of smoking law / of city inspectorate ▪ Promotion of 'sugar tax' ▪ Foster legislation for the production of healthy food
Life-style Events / Festivals	▪ 'Walk of Pleasure' / 'Festival of Love' ▪ 'Procession of Health'

The majority of these project ideas have not yet progressed towards a concrete stage, and that's why the presented Action Plans must still be considered a collection of 'nice-to-have' projects. More work must be invested in the transformation process towards implementable action, with a basic logical framework and budget – a work to be assisted also by the paid experts. In contrast, a smaller number of ideas have reached the implementation stage – and this without the widely expected 'small grants'.

An example for it is the following action addressing the risk factor 'alcohol' where – according to the group report – the following steps were key for an achievement:

Example on Alcohol Action: presented by the leading coalition of the 'Advocacy pillar', Doboj	
13 steps of a successful action:	
Step 1	▪ Have a multidisciplinary (multi-sectoral / multi-religious) group of citizens
Step 2	▪ Have assessed the problem, its importance and priority and defined the need for intervention
Step 3	▪ Have the necessary enthusiasm combined with a certain knowledge of the topic (alcohol abuse by youth)
Step 4	▪ Define the objective: reduce the availability of alcohol and prevent alcohol use among minors
Step 5	▪ Decide on approach: identification and application of existing legislation, sensitizing of pupils and parents
Step 6	▪ Meet ideally with all group members involved
Step 7	▪ Draft a plan of actions with the support of the experts (SeKonS)
Step 8	▪ Plan realistic, think about budget and sponsoring
Step 9	▪ Work towards a common agreement for the plan by the whole group (members from elementary and secondary schools, parent associations, pedagogues/experts, police, inspectorate, ombudsman for children)
Step 10	▪ Let the group sign a Memorandum of Understanding on approach and actions
Step 11	▪ Organize venues/premises and a phone list of involved stakeholders, for easy coordination/communication
Step 12	▪ Print leaflets, posters; disseminate information also through municipality media outlet
Step 13	▪ Measure the results: involve the M&E people/experts from the beginning

(iv) Concerning problems encountered and concerns revealed by the people involved in the project

The following expression of discontent or dissatisfaction with the course of the project at local level has been collected in the meetings in all three pilot cities. They are sometimes emotional statements of single dissatisfied community members, and tend to be contradictory in some cases. But they are useful and give indications for adjustments for phase II, but shouldn't be taken as opinion or conclusion of the mission.

Domain:	Statements of interviewees / group members
Group work	▪ More time and meetings are necessary ▪ Organization of meetings is not satisfactory: too short notice, too short meetings ▪ Priority setting process of topics to treat not enough transparent, participatory ▪ More innovative thinking needed ▪ Frequent turnover of group members jeopardizes progress
Role of contractors/experts	▪ While professional support is needed, contributions of experts not enough need oriented, often not useful ▪ Experts shouldn't lead/coordinate groups, they should be extern and intervene on demand
Synergies with local resources	▪ Synergies (and cooperation) with local expertise (e.g. in health sector, education sector) not exploited by the project, by the groups: life-style-classes exist already in school curriculums, FMTs do prevention and health promotion on a daily base; resources are available at local Pedagogy Department, local Public Health Institute/Centre for Health Promotion, etc.
School action	▪ Absence of teachers for ToT-training seminars creates problems ▪ New education-approach of evidence-based behavioural change and comprehensive risk-factor work difficult to understand ▪ Time and personal, and guidelines for an integration in class work is lacking ▪ Role of teachers to identify 'pupils at risk' unclear
Health system action	▪ Lack of human resources for preventative/promotive work with patients at risk (>35 patients/day) ▪ Respective role of FMTs and project teams unclear (see synergies)
Operational structure	▪ There is overlap between the work, members and objectives of the pillars (except M&E) ▪ The operational architecture with 4 full-fledged pillar groups is theoretic, not feasible, 'divisive' and should be dropped ▪ The structure should be more community based, bottom-up, local stakeholder driven ▪ The autonomy of the municipality (for decision on project financing) should be stronger, the MoH (and WB) role weaker (budgetary and decision-making decentralization of the project) ▪ Risk of loss of credibility and motivation if decisions and disbursements are delayed by complicated administrative processes
General comments	▪ The project isn't enough visible for the population (Website? Social Media?) ▪ 'We are tired of waiting'; 'we went from enthusiasm to disappointment'

(v) Major lessons learnt from the field visit

The RHRF-project (component B) is generally very positively rated among those involved. It is especially appreciated as an innovative community-based pilot project involving – with its holistic approach – a broad range of stakeholders from a variety of sectors and disciplines as well as the municipal authorities. Such is the overall perception obtained during the field visit of the mission. In one pilot city the mission has even been told that 'the population is aware of the project and is thankful to SDC for helping focus on priority health issues through such an innovative approach' and that it would create an important 'added value' to the still weak domestic efforts to reduce health risk factors.

More specifically, the various training opportunities offered to the participants in modern evidence-based behaviour-change methodology and the 4-pillar concept have unanimously been praised as very interesting and useful.

Obviously, there is a bias in these positive appreciations due to (financial and other) incentives received as a 'voluntary' participant. In the transition to 'the real life', i.e. the implementation phase of the community work where material incentives faded away, commitment problems and dissatisfaction surfaced.

It is at this stage that the political support and will from highest levels makes a difference, difference clearly on display among the three city pilots. A feeling of ownership did develop where the principles and the processes of the project were internalized by the participants, resulting in stronger commitment and better achievements.

A transparent and participatory leadership culture in the various local action groups was equally crucial, i.e. a striving for decisions that are supported and owned by all group members (e.g. on needs and priorities to be addressed).

Many of the mentioned concerns and complaints are the result of shortcomings of these cited aspects. In phase II of the project – especially if a potential replication is envisaged – emphasis should not only be on new education theories but equally and importantly on the essence of a 'participatory community action project'. To become aware that a project doesn't start with the influx of foreign money (and stall when there isn't), but that it 'flies' sustainably only when intrinsic, sustainable processes of collaboration have been established, based on new knowledge on one side, but equally on local resources, collaboration and synergies.

These aspects have to be strengthened in future seminars and workshops, because it is precisely at municipal levels where – despite high prevalence of corruption and nepotism - real political will for the good of the cause can be found.

All involved people in the 3 pilots struggled with the 'operational architecture' of the project, i.e. the imposed establishment of the 4-pillar procedure, the parallel group/coalition structure for the project implementation. While in theory the 4 elements (advocacy, mobilization, education and monitoring) are crucial ingredients of success of a project aiming at behavioural change, it shouldn't be replicated at operational level. Confusions on roles, overlap among the 'pillar-groups' etc. have led to confusion and frustrations. Another 'architecture' should follow for the project implementation in phase II.

In summary, the project has created a good foundation for a local, population-based health promotion effort. As a result of this – and due to forwarded promises – urgent monetary expectations (small project grants) did regularly arise in all pilots. It is now important - as a short-term reaction to this fact - to respond adequately to these expectations to avoid widespread disappointment breaking down this foundation. Rapid decision on reasonable investments and non-bureaucratic disbursements should be envisaged – as a precondition for a smooth transition in a second RHRF-project. A broad communication to all stakeholders concerning the decision of a phase I extension would be appreciated.

d) Conclusions on the WB-component:

- The **RHRF WB-component A (SDC-OC1**), i.e. the expert work on tobacco policies and frameworks at the level of the state and its two entities, with professionals from health and other sectors involved, reached – after a demanding process with several backlashes - 'a major historic innovation in BiH' (WB report 05/18).
- Thus, **one major goal of the project seems fulfilled,** and it's now up to the newly appointed politicians to adopt the drafted laws and – once the respective responsibilities after the November election settled - to re-engage in the tobacco tax issue (second goal of this WB-component, unsuccessfully negotiated by the Bank).
- **But in terms of real-life outcomes the achievements are still weak**, concrete efforts to reduce tobacco risk factors among BiH's population rare as e.g. the implementation of smoke-free public places (SDC-OC1 target for year 2018) or formal limitations of access to cigarettes by pupils around schools, etc.
- Therefore, SDC might still continue with some **support to the adoption and enforcement of the tobacco control** legislation at state and entity levels, using all occasion to advocate for smoking-related risk reduction activities and provide the expertise required to advance developments related to this most important risk factor.

- The participants in preparatory phase of the **RHRF WB-component B (SDC-OC2**) have learnt modern, evidence-based methods that can change risky behaviours (the 4 pillars) and essential ingredients for actions to motivate and mobilise communities and relevant stakeholders.
- This has led to **a successful creation of a foundation, of a movement**, at the pilot municipalities involved, upon which sustained community initiatives can be built; this achievement stands for a potential to replicate this approach in other municipalities across both entities, conditional however to a transparent, participatory and criteria-based selection process for new applicating cities.
- The **probability for sustainability** of these achievements varies between the pilot cities; it is high if top-level political will to support the endeavour is present and if a good leadership culture (among those who participate) fosters ownership and innovation.
- The present operational setup isn't favourable for a smooth and successful progress as well as a future replication of the project; **the existing momentum and enthusiasm among the volunteers are fragile** and need a short-term motivation push, since the initial incentives, like remunerated participations at interesting training seminars etc., have disappeared.

THE CURRENT RHRF PROJECT IMPLEMENTATION SETUP: SOME QUESTIONS

As the RHRF-project itself, the set-up – or 'operational architecture' - for its implementation is complex.

As SDC itself didn't want – and was not in the position – to implement with its own staff such a large project, the option was chosen to assign *'the realization of the project'* to the local representations of two international organizations: one component to the WHO and the other to the WB, based on their respective comparative advantages. The idea was that these organizations would *'primarily play a facilitation role'* and provide *'technical advice'*: WHO on international expertise for the fight of NCDs (transfer its 'Best Buys Concept' to BiH), and the WB on lessons learnt for civil society mobilisation and law-making, especially for tobacco control.

Apart from these arguments, it was the strong will of SDC *'to have the entity MoHs in the driver's seat'* (regarding all strategic decisions) and WHO and WB limited to the advisory role.

This arrangement survived for the past eight years, but more and more problems arose of conflicting roles and competences, and – the good intentions notwithstanding – administrative hurdles created discontents, delays and inefficiency. The BiH political reality with the multitude of layers and actors between state, entities, cantons and municipalities did add its part to complicate the issue.

WHO: Facilitator or Implementor?

For the assignment, WHO established a three person 'Project Management Team' and offered premises and infrastructure. It was clearly due to the effort and diplomatic skills of this team that an elaborated multisectoral 'project governance and management structure' could be established, integrating state and entity/BD representatives for a broad based political and technical work (on OP1, OP3).

But, especially for the CVRAM-project component, the role of this team significantly exceeded the stipulation of the original agreement, i.e. the facilitator function, in that the team was increasingly caught in a 'micro-management' task, organizing individual services (for courses of family medicine doctors or nurses), overwhelmed with administrative work (WHO: 'it was a nightmare'). The reason was that the 'real implementor' (of the FMT-training in one part of RS), the one 'in the driver seat', was not ready to fulfil the job (in this case the University of Banja Luka, mandated by the MoHSW).

At this moment it became evident that WHO didn't have the adequate role in the project implementation setup, but a role incompatible with the core function of WHO, i.e. the provision and dissemination of globally acknowledged expertise on health issues. Therefore, in phase II, WHO and the successful but partly overloaded team should be allowed to return to their core capacity.

The World Bank: A Funding Agency as an Implementor?

As for WHO, the WB established its own 'Project Institutional Setup' with its steering and coordinating superstructure and a 'Project Implementation Team', offering again premises and infrastructure. Again, the overall work of this team must be reckoned positive, especially the 'WB-component A, tobacco framework' (OC1, WB).

Nevertheless, the situation with the WB-mandate was equally unsatisfactory. Again, facilitation and implementation roles were mixed, and this aggravated by the fact, that SDC's funds were split into two trust funds differently administered. The BETF was a 'bank executed' fund, where the WB had a rather free hand and competence for how to invest and disburse[7]. For the other fund, the RETF, disbursements had to be cleared through the complex BiH bureaucracy (state, entities, ministry) to reach the organization 'in the driver seat', i.e. the entity Ministries of Health, and even at that stage, open tender procedures had again to be launched for final implementation.

For this and other reasons, the 'WB-component B, community health promotion (OC2)' had its take-off very late in the project phase. In addition, despite this delay, the WB (the 'facilitator') launched a redesign of the project component, and this - according to members of both health ministries - without them participating adequately (i.e. without 'the implementor in the driver seat'). Even if the 'new concept' (4-pillar approach) was later well received in the trainings of the project volunteers and was scientifically sound, the 'ownership demand' by the local authorities wasn't met – and thus the support only lukewarm (an impression gotten especially at the MoHSW-RS).

For all these reasons, the WB has expressed its wish to withdraw from the project for phase II, but to proceed as much as possible in an extension of the phase I till mid 2019. There is no final decision whether there is extension of phase I, but SDC is keen to see the remaining time exploited at maximum with the objective to also abandon this form of collaboration with the Bank at the end of the phase.

[7] *After an initial phase without supervisory option for SDC on this trust fund, SDC insisted to establish a Project Steering Committee which did only meet twice since its inception some months ago, finally under the name of Advisory Board*

The following table gives an approximate impression of the disbursement situation of the WB-component, by broad item categories (total budget 3.05 Mio. US$, expenses end of August 2018 1.6 Mio. US$ = 53%) :

Item	Proportion of: Planned Expenses	Executed Expenses	Procurement level per item	
Staff costs (both WB-components)	16%	23%	**44%**	++
Consultants (both WB-components)	25%	47%	**88%**	++++
Grants (mainly WB-component B)	46%	22%	**-52%**	--
Others	13%	8%	**-38%**	-

According to these figures (no more accountability details were available at SDC!) investments in component B are still strongly lacking behind; and the procurement made by the Bank for grants to the implementors (MoHs) are de facto not disbursed yet: no grants are established or paid, which makes the real disbursement discrepancy among component A (BETF) and B (RETF) even greater.

Because of the complex money-flow reality, and a rather generous delegation of spending competence by SDC to the Bank without obtaining detailed accountability reports, not only transparency of the utilization of these funds is weak, but also an even approximate effectiveness estimation is impossible. The rather intuitive impression of the mission team is, that the cost-effectiveness of this component has not reached a very high level.

It is clear – and desired by both, the WB and SDC – that this arrangement should change and the assignment with the Bank come to an end.

PHASE II: OUTLOOK WITH OPTIONS

Rationale for a continuation of SDCs RHRF project in a second Phase

This health project has a current and urgent goal, a stringent and evidence-based approach in line with international recommendations and comes at the right time. But it is also very challenging for its complexity and its interventions on very distinct fronts. Despite this, it has achieved a number of results and thus demonstrated that the required comprehensive strategy is feasible.

But the project encounters a difficult political environment, and the commitment for behavioural changes of people and institutons is demanding and needs a long breath. While outputs and certain outcomes are achievable in a reasonable time, the expected impacts will not be reached so fast, and political profit cannot be drawn so easily from the link between investments and results. This is the reason why such a project often lacks the urgently needed political will and support: what counts in politics is 'the short term', in BiH and elsewhere.

Despite this difficult environment, it is the strong opinion of the mission team that this project is of high importance and that efforts to reduce health risk factors among the BiH population should continue. But the lessons learnt from phase I, as presented above, leads the team also to the opinion that a narrower focus and a leaner operational setup should be envisaged in the next phase. Supporting this opinion is the fact that some objectives of phase I had reached an achievement level allowing the respective BiH authorities to now take over – and that the assistance of the Swiss tax payers can be relocated.

On this general conceptual background, the following outline for a phase II project has been designed.

The adjusted Focus of the RHRF-project, Phase II

The project title should obviously remain, but some components will come to an end, implying the dissolution of certain agreements and appointments, and a reorganization of committees or taskforces established by the WHO or the WB for certain components. The new project could be organized along two arms: the *intersectoral* and the *sectoral* arm.

a) The intersectoral arm (A1):

The aim of this arm is mainly a continuation of the WB-component of phase I, divided into two different components:

*(i) Community-Mobilization for health awareness and risk factor work (**CMH**)*

In this major project component the process and the lessons learnt in the pilot municipalities are continued and adjusted (***CMH-cont***) and replicated ***(CMH-new)***. The inefficient and problematic '4 pillar group' operational architecture should be abandoned (as is already the case de facto in some pilots) to be replaced by a single 'local action group LAG' as core structure of the community mobilization. Within this group a variable number of thematic subgroups can be established (often called 'coalitions') to work on specific issues raised at the LAG. Till now, the membership of these groups was rather broadly based and a selection bias wasn't obvious, despite the clear lead by the municipal authorities; but for other cities adequate selection criteria should be defined and become conditional on participation (see below).

In the pilot municipalities (***CMH-cont***), comprehensive action plans have been drafted that will translate into smaller or bigger activities to reduce health risks. Few such activities have already been launched recently in phase I. In phase II, more such concrete activities will be detailed and proposed for financing to the 'Project Steering Group' and its advisory body 'Stratec' (Strategic and Technical Advisory Board). For the necessary expertise to obtain professionally sound projects, local

resources (see chapter 'Cooperation and Synergies') or experts should be involved in planning, monitoring and evaluation (e.g. how to make a media campaign successful, or how to monitor the success of a smoking cessation campaign at secondary schools, etc.).

A replication of this approach to new municipalities (***CMH-new***) should be envisaged progressively, following a call for application and a selection process based on agreed upon criteria (organizational facilities, expressed political will, existence of committed volunteers, willingness to accept inclusive LAG-membership criteria, etc.); this step successfully passed, identified project participants of the new municipalities will undergo a preparatory sensitization and training phase like for the former cities; the format for these trainings could be similar to phase I, but the inclusion of pilot-city peers for exchange of experiences might result in shorter and more practical trainings (lowering the preparatory budget accordingly). Resource persons for these trainings should ideally be the same as in phase I, to be organized with the help of the former implementors WHO and/or WB.

To foster the sustainability of the community mobilization movement, all projects should seek local support (financial or at least in kind). Furthermore, financing conditionalities like 'fix budget frame per municipality' or a 'match-funding clause' could be considered. Experts supporting the project with different capacities (advocacy, education, M&E) could be identified to be available to those who request them; they should not belong to the local groups or even lead them, but intervene on demand, and therefore be financed e.g. on a per diem basis.

This community-based project component should have clear priority in the new project (50-60%).

*(ii) Small Grant Support (**SGS**)*

As reported in the chapters above, a number of laws and action plans related to public health and health risk reduction have been developed and drafted, through both, the WHO- and WB-component, together with stakeholders of various public sectors at state and entity levels. It is now the task of the respective authorities – sometimes without and sometimes only after parliamentary approvals - to realize these plans and to apply these frameworks and laws.

As a follow-up of this policy-making effort of phase I, SDC could reserve some financial resources to back the respective ministerial authorities with **well targeted and time-limited activities aimed at NCD-risk reduction**. Demands from authorities could be e.g.: a contribution to a social marketing campaign, sponsoring of a promotional event (for more physical activity, for healthier foods), co-financing a strategic workshop on how to reduce the daily intake of salt, etc. Such activities form part of the NCD-Action Plans of both entities, where potential sources for technical and financial support are already listed, like the UN, EU, NGOs etc. – and obviously Bilateral Agencies including SDC.

More specifically, concerning the most important risk factor tobacco smoking, **enforcement of the tobacco legislation should be supported**, including a continuous advocacy for increased tobacco taxes; for the necessary expertise, resources of this component should equally be available.

This 'Intersectoral Small Grant' component should be of minor priority in the new project (10-20%).

b) The sectoral arm (A2):

During phase I, through the WHO-implemented CVRAM project-component, over 70% of FMTs have been trained to pay a specific attention on CVDs, to apply evidence-based procedures to patients at risk and to sensitize them to a healthier lifestyle. But the mission team has got some doubts whether this acquired knowledge is really implemented in the daily practice of FMTs: numerous FM doctors and nurses complained that in reality these additional obligations could not be satisfied – due to a lack of human resources and various organizational obstacles.

Already in 2010, an evaluation on reform progress in FBiH stated[8] that *'existing staff in the services is overburdened by large numbers of patients and organizational issues and cannot implement fully FM-principles'* and *'still insufficient financial resources are allocated to PHC'* or '*patient health records and health statistics are not adjusted to FM scope of work'* etc. All these shortcomings seem to persist despite health sector reform efforts in BiH since 1996 (WB, EU), with a particular emphasis on Primary Health Care, Family Medicine[9], human resource development and financial reforms (e.g. in the FBiH, performance-based financial incentives were tested by the HIF but abandoned since).

As a consequence, the impact of the CVRAM-project is jeopardized by this slow and insufficient reform process: the inadequate general work-environment hinders the application of acquired knowledge and attitude – thus finally compromising impact and cost-effectiveness of a year-long SDC-investment.

This project arm has the potential to stimulate change processes and to contribute to the improvement of this situation through two components:

[8] *Reform Effort in Selected Areas of PHC in FBIH, 2010 (WB-supported evaluation of the Health Sector Enhancement Project)*
[9] *e.g. FBIH: 'Strategic Development Plan for the Health Sector 2008-2018'; 'PHC Development Strategy'*

*(i) Assessment of the working conditions of FMTs (**AWC**)*

A study of a representative sample of HCs and Dom Zdravljas, **with a specific focus on the application of the CVRAM-principles** could clarify the real-world situation and problems of FMTs. This study could be executed e.g. by the Public Health Institutes of each entity in collaboration with the two accreditation agencies ASKVA (RS) and the AKAZ (FBiH). External scientific expertise for the study protocol could be offered, if required.

The analysis of the results of this study would be the base for **the elaboration of concrete measures on how to improve the implementation of CVRAM**, measures to be proposed and discussed with the competent authorities. The convincing facts from the field and feasible proposals for change could boost the slow PHC-reform, at least for the priority issue of CV-health risks management.

*(ii) Technical support of BiHs accreditation agencies (**TSA**)*

The two accreditation agencies of BiH could equally contribute to an improvement of the situation; they have the mandate not only to execute the compulsory certification of all health institutions[10], but did start an accreditation pilot program of FM-teams in both entities (voluntary and fee-based), with the CVRAM-standards as quality criteria using - at the moment - 13 indicators (developed in collaboration with WHO during phase I).

A scientifically sound and wide-spread accreditation of FMTs would strongly enhance the quality of CVRAM-procedures and could finally lead to the desired impact of the FMT-trainings. But at present, accreditation tools, methodologies and resources are still inadequate, in scientific as well as in technical terms: while in RS the data of the 13 indicators are collected electronically and analysed centrally by ASKVA, the data management at FBiH is still mainly paper-based; but even in RS scientifically sound results cannot be delivered and a technical support has been requested (by the agency as well by the MoHSW in its NCD action plan).

Through this component, the two agencies could be supported in their endeavour to **improve their M&E tools**, specifically regarding the quality of CVRAM-work of FMTs. Such a support would encompass a review of the presently tested (13) FMT-accreditation indicators, **the transformation into a more meaningful and IT-based monitoring methodology** including a financial contribution to the IT-infrastructure. While the project would differ from one entity to the other due to the different levels of technological advancement, a professional exchange between ASKVA and AKAZ should be fostered. In addition, external expert support is necessary (on modern data collection and -management), e.g. still through WHO (as in phase I), but equally from the local private sector or by exchanging with accreditation agencies of more advanced neighbouring countries, etc.

This sectoral arm, about 20-40% of the whole project, could lead to a revitalization of the collaboration among the stakeholders dealing with Family Medicine, Public Health or Quality Control, like the MoHs, PHIs, HIF and the accreditation agencies; this could end up with the creation of 'a Public Health Reform Hub', a useful platform for exchange and change, a desire of one of our interview partners…

Options for a new, lean operational set-up for a more efficient implementation

The lack of transparency and the important delays for some program components of phase I call for a new operational set-up for phase II, a need imposed also by the withdrawal of the WB from the project. Procurement procedures should be streamlined and the implementation process become more cost-effective than in phase I. The following two options are presented below, with their respective advantages and shortcomings. Both options start with the same assumption that SDC isn't in the position to implement itself the phase II RHRF-project, but will – in a first step - propose an adjusted project proposal to the authorities of BiH (organized similar as in phase I) for further development and approval. But the implementation pathway and financial resource flows will vary with regard to advantages and risks.

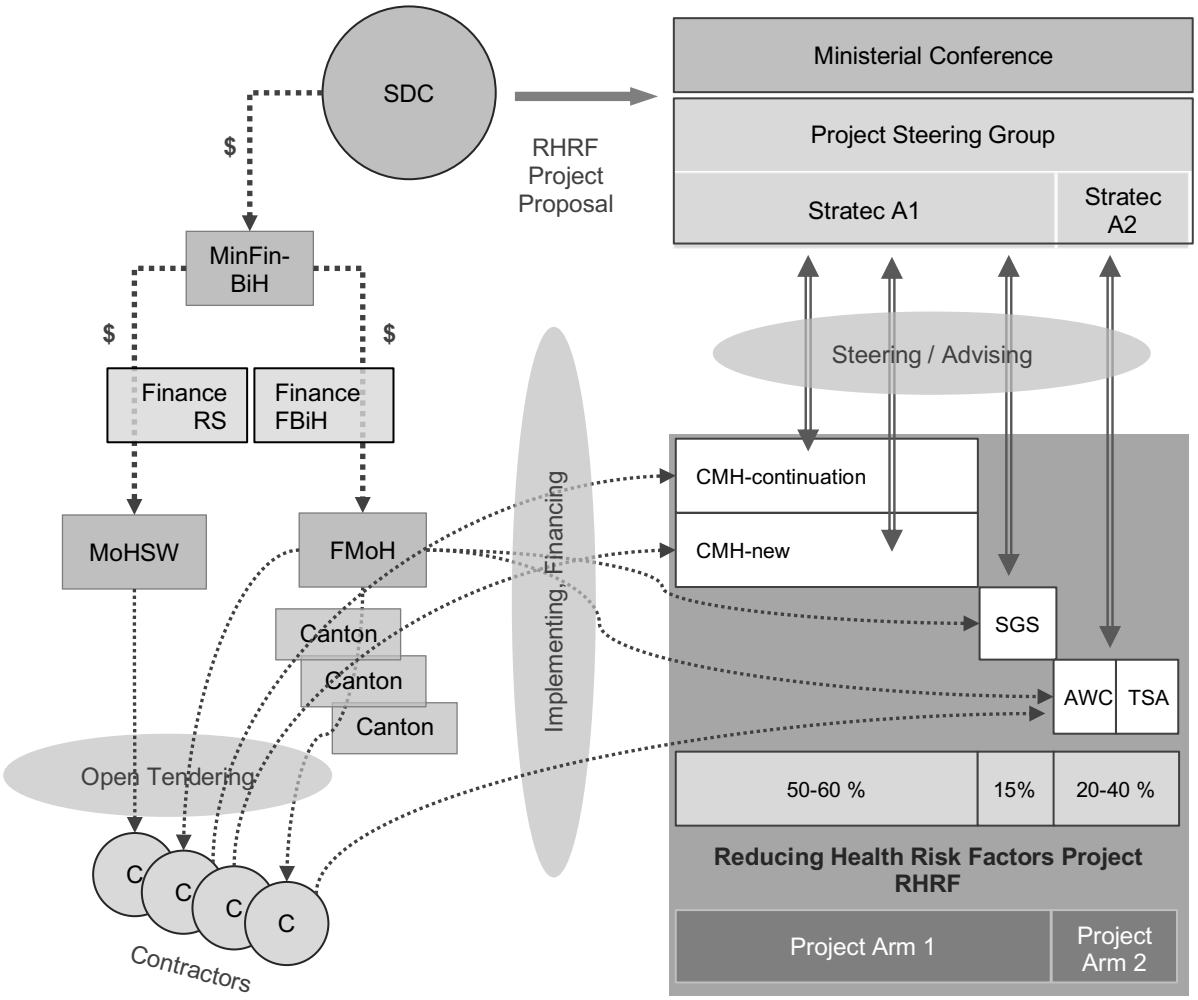
a) Option 1: 'Ownership' focus

This option puts priority on the aspect of 'ownership' and tends to be aligned to the Paris and Accra Declarations on 'Aid Effectiveness' (Ownership, Alignment, Harmonization), calling for:

- Countries to put in place national development strategies with clear strategic priorities
- Countries to develop reliable national fiduciary systems or reform programmes to achieve them
- Donors to use, as their first option, fiduciary systems that already exist in recipient countries
- Donors to use, as their first option, procurement systems that already exist in recipient countries
- Aid programmes to use country structures for implement rather than parallel structures created by donors

[10] *AKAZ booklets printed 2016 in English: 'Q label – the Culture of Quality'; 'On the Path towards Healthy, Safe and Quality Medical Practice – establishing a system of safety standards in Primary Health Care'*

While these arguments are reasonable and should be envisaged by donors, it is questionable whether in BiH with its complex political and decision-making structure the objective of 'reduced delays' and 'increased effectiveness' can be reached – especially taking into consideration, that nepotism and corruption is a widespread and publicly recognized (and deplored) fact, and that money flows through too many channels. The architecture presented below, following the formal procedures for procurement, has therefore the inherent risk to fall back in the trap of phase I, despite the good intentions. If such an autochthonous set-up can be streamlined and the risks reduced, it might become a feasible option; the mission team isn't in the position to take into consideration all the relevant administrative details, a work to be done in a next step.



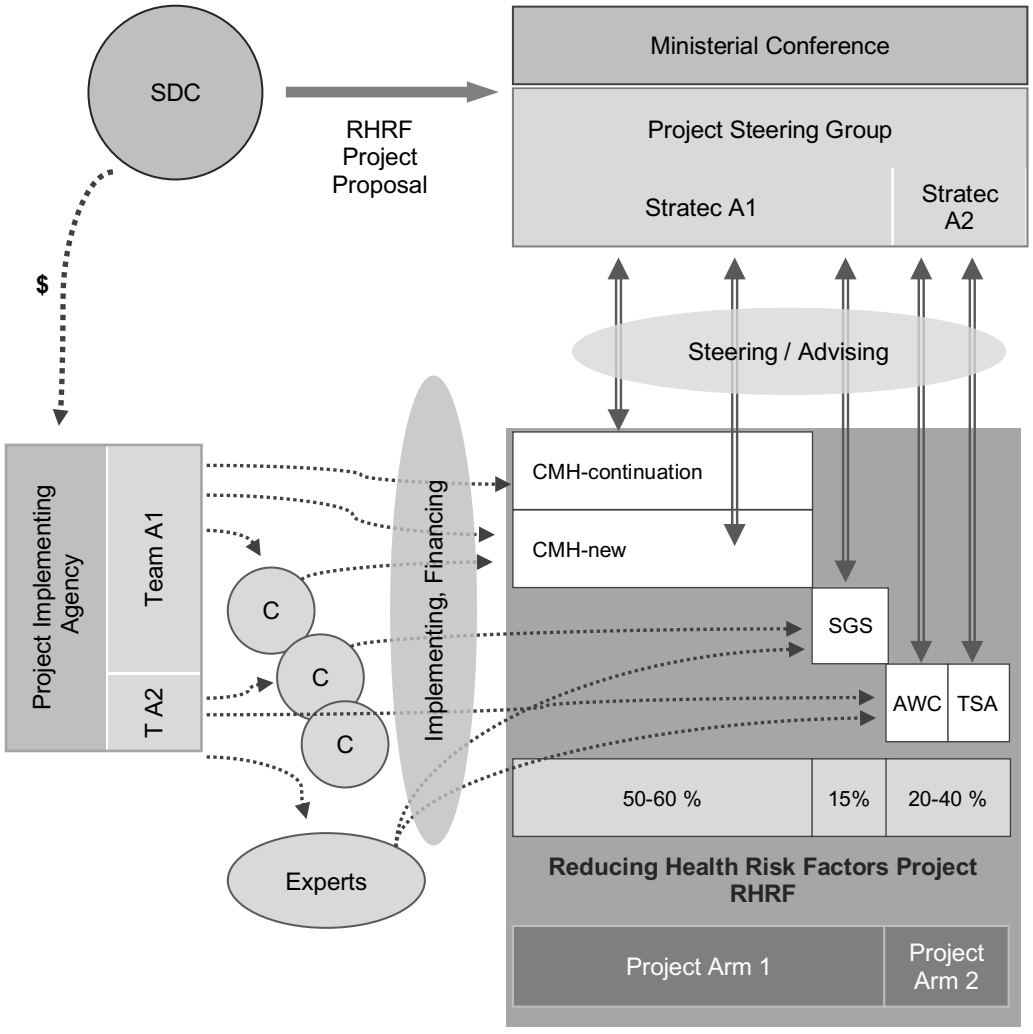
Ministerial Conference:	MoCA BiH, FMoH, MoHSW, DoH BD
Project Steering Group:	Focal Points of MinConf, PHIs (entity and ev. cantons if involved), WHO-representative, Representatives of municipalities involved in CM, Implementing agency, SDC, Stratec-members on call)
Stratec 1 or 2,	Stratec and technical advisory group: Resource persons and experts, Steering group representatives, SDC)
C:	Contractors (local NGOs, other)

CMH	Community Mobilization for Health (continuation of pilot municipalities or new municipalities)
SGS	Small Grant Support (for implementation of action plans, legal frameworks, laws)
AWC	Assessment of Working Conditions of FM-teams
TSA	Technical Support for Accreditation Agencies

b) *Option 2: 'Effectiveness' focus*

This second option puts the priority on feasibility and effectiveness. The ownership aspect is lagging behind, but for the strategic orientation and the project steering role the authorities, especially the entity MoHs, can still be considered influential (and still sufficiently occupying the 'driver seat').

If there is no legitimacy obstacle (BöB art.3, par.1. lit.d) to establish a (probably international?) implementing agency, knowledgeable in the health field as well as in community work, this operational set-up would be leaner and the finances would flow more rapidly, directly and transparently. This approach would be 'old fashioned' in the sense that the prerequisites of the mentioned international declarations were not adequately considered, and it would have the disadvantage that a time-consuming international tender procedure must be launched to start with.



Ministerial Conference:	MoCA BiH, FMoH, MoHSW, DoH BD
Project Steering Group:	Focal Points of MinConf, PHIs (entity and ev. cantons if involved), WHO-representative, Representatives of municipalities involved in CM, Implementing agency, SDC, Stratec-members on call)
Stratec 1 or 2,	Stratec and technical advisory group: Resource persons and experts, Steering group representatives, SDC)
Project Implementor:	Organization for project management (with expertise in health field), exempt from Federal Act on Public Procurement
Team A1, A2:	Offices of the Project Implementor dealing with project arms (A1,

Both presented options are limited by the incomplete knowledge of the mission team on many underlying conditionalities to be taken into consideration and must be seen as 'brainstorming'. However, the following table of arguments might give some hints for the decision-making process:

Options	Arguments	
Option OS1: Focus on ownership and alignment	**Pros**	**Cons**
	Fosters autochthones leadership Supports national institutions and procedures Delegates project authority to country institutions Complies with principles of Paris/Accra Declaration on Development Effectiveness	Overstrains institutions and staff Increases complexity of management and procurement procedures Reduces transparency and limits donor oversight Opens ways for nepotism and corruption
	Potential	**Risks**
	Capacity to exercise leadership is developed Institutional weaknesses are improved (including option for secondments of local project staff) Incentives are created for effective partnerships Sustainability is increased for established approaches and processes	Resource allocation is biased and inefficient Competent staff is lacking Project progress is slow and deadlines not fulfilled Administrative hurdles delay disbursements, like e.g. compulsory tendering procedures, etc.
Option OS2: Focus on effectiveness of implementation	**Pros**	**Cons**
	Increases transparency Facilitates access to data on progress and resource flows Simplifies administrative procedures Involves project stakeholders closer in decision-making processes Accelerates selection procedures (e.g. of experts/contractors for project components) Facilitates support of NGOs and other civil society actors	Creates a parallel implementation structure Limits autonomy of the local authorities (MoHs at entity, cantonal level, etc) Underrates capacity building of involved authorities Requires a tender procedure to identify/select an adequate implementation agency Increases overhead costs Insufficient compliance with Paris/Accra Requirements
	Potential	**Risks**
	Effectiveness and timeliness of project implementation is improved Misappropriation of funds is limited Management procedures are streamlined and more efficient, number of steps in the decision-making chain reduced Procurement processes are less bureaucratic	Sustainability of the approach and related processes is jeopardized Support from higher hierarchies is weaker (or obstacles are imposed) due to their lesser involvement in the project implementation Capacity building of institutional staff is limited due to their limited involvement

Cooperation and Synergies

During the field mission, the team collected comments and complaints concerning cooperation and synergy issues, studied SDC's other health and community/municipality related projects in BiH and talked to other institutions dealing with issues close to those of the RHRF-project. As a conclusion, a more explicit consideration of potential synergies or collaboration is recommendable for phase II, mainly for the community mobilization component of arm A1, CM:

a) Resources at project municipalities

A good number of remarks were made in the group discussions in the pilot cities that 'certain things were already done' in the community (and that 'the wheel didn't have to be invented again'), or that the potential at local institutions was not exploited: e.g. at schools, teachers that were already engaged in classes for 'healthy life-styles' or 'the Health Promotion department of the local Public Health Institute' or 'the trained Family Medicine nurses at Health Centres', etc. Municipalities engaging in the future project should motivate the LAGs to reach out to 'like-minded' actors and institutions and to try to involve them more in their endeavour to reduce health risks and to overcome qualms about losing influence or privileges (and not sharing 'advantages of being part of a project'): it is important 'to think out of the box' and to be innovative in looking for synergies.

b) SDC-Projects

In the portfolio of SDC-BiH several projects deal with overlapping themes, in health, attitude and life-style change and good governance and community participation at municipalities. It would be very useful to assess these overlaps more in depth in order to find out where there are potentials for exchanging experiences or even collaboration with the RHRF-project. It might be advantageous for RHRF-project e.g. to consider experiences with strengthening municipalities that engage already in participatory needs assessments and improved planning (projects i and ii), or learn about approaches among youth that strive for 'an uptake of healthy, nonviolent and gender equitable lifestyles' (project iii), etc.

(i) Project 'Strengthening the Role of Local Municipalities (and MZs[11])'

(ii) Project 'Integrated Local Development (ILDP)'

These projects (beneficiaries are more than 50 municipalities) encompass aspects that could be useful, and the municipalities involved could even be motivated to apply as new 'RHRF-project municipalities', because they have:

- 'Improved quality of life of the citizens by enhancing local services, increasing democratic accountability and social inclusion'.
- 'Improved *transparency, efficiency and effectiveness* of public management, as per EU-standards.'
- 'Address *needs of citizens* and accelerate growth through inclusive, accountable and result-oriented development planning.'
- 'Facilitated citizen forums to identify local needs and existing capacities, and create community-led initiatives (in 2016, 156 forums were held, organized in 77 MZs, where 4500 people gathered to define priorities for their communities).'
- 'Provided MZs with tools to maintain forums on a regular basis so they become a standardized *form of citizens' participation*...'

Municipalities with this development history would have a comparative advantage in the 'CM-project': their advance in accountability and auto-responsibility could be a comparative advantage in an application for RHRF-membership.

(iii) Project 'Promoting Healthy Lifestyles and Gender Equitable Attitudes among the Youth'

The project's overall goal is 'to increase the uptake of healthy, nonviolent and gender equitable lifestyles among young men and women', so clearly focused at (health) risk reduction; their experiences with methods and approaches they use could be beneficial for the RHRF-CM-project, where the following issues are equally on the priority list:

- 'Changing practices at the school and community level: increasing capacities of youth organizations' staff and high-school teachers to deliver non-formal and formal *life-skills education*.'
- 'Raising awareness and *changing attitudes of youth toward various aspects of health*, violence and gender equality.'
- '*Youth-led campaigns, on healthy lifestyles*, violence prevention and gender equality.'
- 'Social movements/citizen coalitions active in encouraging governments to actively promote gender equality, prevent gender-based violence, and *promote life skills and health education in schools'*.

(iv) Project 'Improving nursing care for better health services'

(v) Project 'Mental Health'

The link between these two projects and the RHRF-project is evident; nevertheless, more emphasis could be put into thoughts how these projects could be more instrumental e.g. in the components 'Family Medicine Reform FMR' or 'FMT-M&E'. This could consist of:

- Mobilizing the nurses to insist more on adequate working conditions (to implement really CVRAM-protocols);
- Sensitize doctors and nurses for the importance of good reports and data illustrating their difficult reality, in order to convince decision-makers and push them to act, to invest, to reform.

Such synergetic inputs could boost the chance for achievements of these Phase-II-components.

c) UNICEF

Based on the 'Nutrition Friendly School (NFS) Framework', developed 2009 by WHO, and on strategic nutrition frameworks in BiH (Nutrition Policies adopted in RS 2012, in FBiH in 2013) with its corresponding guidelines, UNICEF has supported the implementation process at entity levels (trainings with broad stakeholders) and started to support selected kindergartens (through individual workshops with teachers and cooks). Handbooks, manuals and cookbooks are available (also online) and the plan is to scale up NFS to more kindergartens and later to primary schools.

The RHRF-project should profit of UNICEF's experiences made till now, e.g. when LAGs envisage healthy food actions at kindergartens or schools. A closer exchange and collaboration between SDC and UNICEF would be appreciated by UNICEF, and would benefit LAG-coalitions working on nutrition if more regular and formal links could be established.

[11] *MZs are community governance units at village or city quarter level*

A preliminary logframe Proposal for Phase II

On the basis of this first logframe, further work on Phase II of the RHRF-project can be launched, final outcomes and outputs defined.

In the opinion of the mission team, a level of health impact cannot be reached by this project – or if certain behavioural changes and reforms really can be obtained during the time-frame of phase II, the proof of corresponding health outcomes is beyond the reach of the project. For this reason, this preliminary logframe is limited to outcomes of the four project components, where indicators on outputs, process and progress can realistically be defined and found.

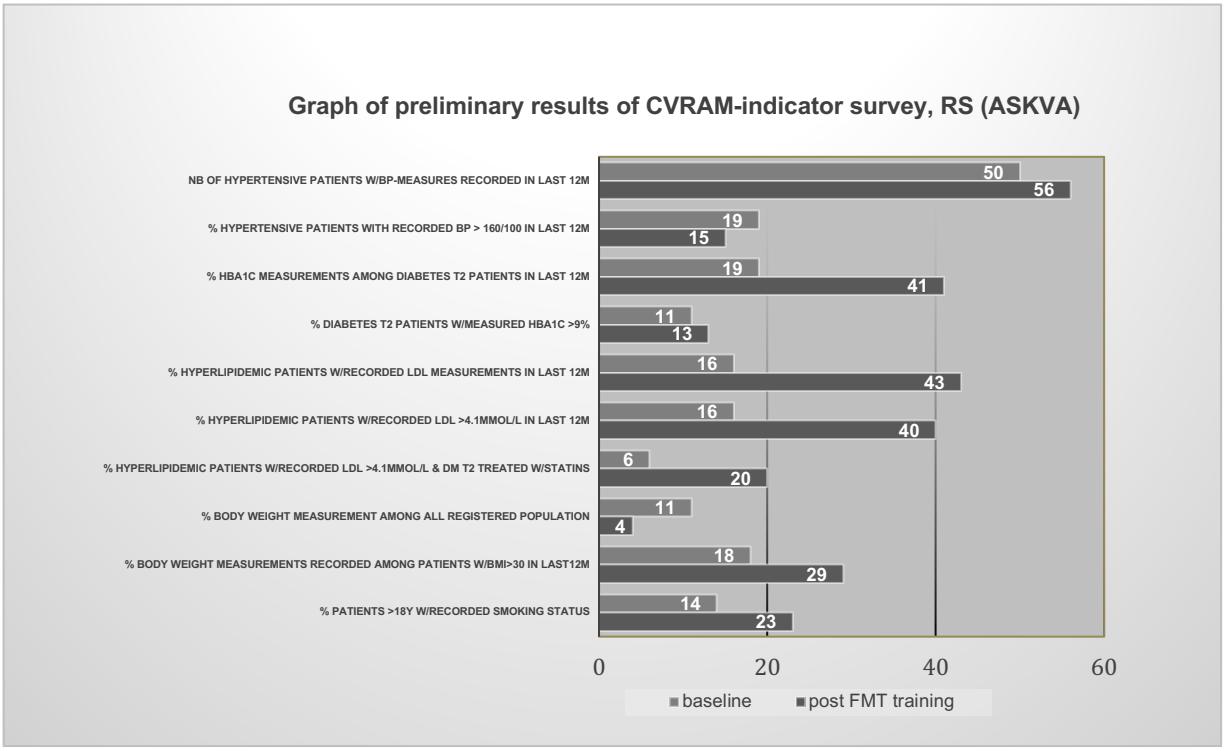
Project structure and components			Outcomes	Indicators	Source of indicators
Overall goal			**The awareness has increased on the importance of Health Risks Reduction among authorities in general and in the project municipalities, and more (young) people adopt healthy behaviours** **FMTs are increasingly enabled to apply correctly the protocols on CVD-treatment, prevention and healthy life-style promotion**	Attitude and behavioural-change indicators Core indicators from of FM-reform process	Surveys at municipality level, at schools or population samples; Reports from FMT Quality assessments
Intersectoral Arm 1	Component CMH	A1-CMH cont.	Pilot municipalities have reached a level of community mobilization that is sustainable, with reiterated actions promoting healthier life-styles	Sustainability indicators Life-style indicators	Reports; Surveys
		A1-CMH new	New municipalities have engaged in community action for healthier life-styles through training and motivation of government, stakeholder and volunteers	Output, process, progress indicators	Reports; (Surveys)
	Component SGS		Progress has been made in implementation of Action Plans and enforcement of laws relevant for the reduction of health risks among the population	Indicators on SDC contributions to activities reducing health risks, at state or entity level.	Reports of inspectors; Target population surveys; Media
Sectoral Arm 2	Component AWC		Reasons impeding correct CVRAM-work of FMTs are identified, causes analysed and solutions proposed to the respective authorities, as a contribution to broader PH-reform efforts	Output and progress indicators	Study results; Proposal with reform options
	Component TSA		A scientifically sound and sustained assessment method exists, with the corresponding resources, to demonstrate quality and progress in the application of CVRAM-protocols in FM-practice	Indication of improved, computerized and centralized data management	Output, process indicators; Reports of the Accreditation Agencies

ANNEXES

Annex 1:

Set of agreed CVRAM performance / quality indicators;
to be monitored and evaluated among FMTs which participated in CVRAM training: prior and post training

1) existence of registry of patients with hypertension in FMT;
2) percentage of hypertensive patients with blood pressure measurements recorded within the last 12 months;
3) percentage of patients with hypertension with recorded value of blood pressure over 160/100 in last 12 months;
4) existence of registry of patients with diabetes mellitus type 2;
5) percentage of HbA1C measurements among DM type 2 patients in last 12 months;
6) percentage of patients with DM type 2 with measured HBA1C level above 9,0%,
7) existence of registry of patients with elevated LDL cholesterol level (over 3 mmol/L);
8) percentage of patients with hyperlipidaemia with recorded LHL cholesterol measurement the last 12 months;
9) percentage of patients with hyperlipidaemia with recorded LDL cholesterol greater than 4,1 mmol/l in the last 12 months;
10) percentage of patients with recorded LDL cholesterol greater than 4,1 mmol/l and diabetes type 2 that are treated with statins;
11) percentage of body weight measurements among all registered population;
12) percentage of body weight measurements recorded in the last 12 months with obese patients (BMI over 30)
13) percentage of patients older than 18 with recorded smoker's status.



Annex 2:

Program of the RHRF-review Mission 16-26 September 2018: Matthias Kerker and Jan Zlatan Kulenovic
(Accompanied by interpreters Bjanka Pratellesi and Amela Kurtović)

Sunday, 16th September 2018: Sarajevo

Time	Programme	Comment
9:15	Matthias – arrival to Sarajevo LX 2548 (from Zurich)	Taxi to the hotel (should cost around 15 KM) Hotel Colors Inn, address: Koševo 8
	Matthias - overnight in Hotel Colors Inn, Sarajevo	www.hotelcolorsinnsarajevo.com *Price of overnight with breakfast 142.80 KM*

Monday, 17th September 2018: Sarajevo

Time	Programme	Address, contact details & link to the project/topics
8:15	Transport to the Embassy	Driver (Bane +387 61 167 307) will wait for Matthias in front of the hotel
8:30	Briefing at the Swiss Embassy - Barbara Dätwyler Scheuer, Director of Cooperation - Maja Zarić, Programme Officer for Health	Swiss Embassy Address: Zmaja od Bosne 11
11:00	Meeting WHO – introduction / project briefing - Boris Rebac, Project Manager	Address: UN House, Zmaja od Bosne
13:00	Lunch with Maja	Aquarius
14:30	Meeting with the World Bank team – introduction / project briefing - Lorena Kostallari, Task Team Leader (video link) - Darko Paranos, Project Coordinator	World Bank office, UNITIC
	Matthias - overnight in Hotel Colors Inn, Sarajevo	

Tuesday, 18th September 2018: Sarajevo

Time	Programme	Address, contact details & link to the project/topics
9:00	Ministry of Health of Federation BiH - Dragana Galić, Advisor to the Minister / project contact person for WHO - Ferid Huseinbegović, Sector for Project Implementation / WB component on community mobilisation	Ministry of Health of Federation BiH, Higijensko - overall public health and NCDs strategy and priorities - processes, results, challenges, lessons learnt related to the project
11:30	Agency for Accreditation and Quality in Health of Federation BiH - Mr Ahmed Novo, Director - Dženana Fazlić, Expert Associate for International Cooperation and Projects - Alhijad Hajro, Expert Associate for Finances	Agency for Accreditation and Quality in Health (TBD) Dr. Mustafe Pintola 1 (Dom zdravlja Ilidža) Tel. Ahmed Novo, 061 165 101 - accreditation of FM teams for NCDs prevention (WHO component)
13:00	Lunch	
14:30	Public Health Institute of the Federation BiH - Davor Pehar, Director - Team of the Institute involved in the project / WHO component	Public Health Institute, Higijensko - overall public health and NCDs strategy and priorities of the Institute, its role and cooperation with the project
	Matthias - overnight in Hotel Colors Inn, Sarajevo	

Wednesday, 19th September 2018: Sarajevo *(Jan not available on this date)*

Time	Programme	Address, contact details & link to the project/topics
9:00	Federation BiH: Primary Health Centers and Family Medicine Cathedra - Representatives of FM departments, quality coordinators, trainers Educators: Zaim Jatic, Amela Keco, Emina Bajramovic and Advija custovic Quality control: Smiljana Viteskic and Milan Miokovic	Primary Health Care institution of Canton Sarajevo: Dom zdravlja Kantona Sarajevo, Vrazova 11, 2nd floor - WHO component
11:00	Republika Srpska: Primary Health Centers and Family Medicine cathedra - Representatives of FM departments, quality coordinators, trainers Srebrenka Kusmuk (Sokolac), Nebojsa Matic (East Sarajevo), Igor Tesovic (Foca), Nedeljka Ivkovic (Foca) and Goran Bircakovic (Zvornik)	Swiss Embassy - WHO component
13:00	Lunch	
14:00	Follow-up meeting with the WHO team (Boris Rebac, Mirza Palo, Sanid Vlajcic)	UN House
15:00	UNICEF - Geetanjali Narayan, Representative - Fatima Čengić, Health and Nutrition Specialist	UN House, Room 105 - Activities and tools available for promoting healthy nutrition for children, potential synergies and cooperation with the project in the future
	Matthias - overnight in Hotel Colors Inn, Sarajevo	

Thursday, 20th September 2018: Sarajevo – Zenica – Zvornik

Time	Programme	Address, contact details & link to the project/topics
	Matthias – hotel check out	
7:30	Trip to Zenica (1 h)	Departure in front of the Hotel Colors Inn (Matthias, Jan, Bjanka); driver Amer +387 61 979 142
9:00 – 15:30	Meetings with local partners and stakeholders of the community-based program: • 8:30-9:30 City administration Zenica (Zijad Softić, Sumea Mujkanović, Maida Mujanović) • 9:30-10:30 Local Action Group representatives (Zijad Softić and others) • 10:30-11:30 Cantonal Public Health Institute representative (Elma Kuduzović) • 11:30-12:30 Primary Healthcare Center (Selvedina Spahić Sarajlić) and Pedagogical Institute (Neira Jusufović) • 12:30-13:30 Lunch break • 13:30-14:30 Advocacy Group representative (Jasmina Gasal) • 14:30-15:30 Local media representatives (Maida Mujanović, Alma Husaković – RTV Zenica)	Društveni centar (mjesna zajednica Brist), Fakultetska 36 (preko puta Rektorata, odnosno Ekonomskog i Pravnog fakulteta) Kontakt: Mirza Škrgo 062 708 842 - WB component
16:00	Trip to Zvornik (3 h)	
	Overnight in Hotel 'Kod Novaka', Zvornik	Karakaj, Zvornik www.hotel-novak.com *Price per person for overnight with breakfast 50 KM*

Friday, 21st September 2018: Zvornik – Sarajevo

Time	Programme	Address, contact details & link to the project/topics
	Hotel check out	
8:30	Meeting with FM teams: dr Goran Bircaković	Primary Healthcare Center Zvornik - WHO component
9:30 – 17:00	Meetings with local partners and stakeholders of the community-based program (city administration, local action group, advocacy group, schools, participants of education from schools, primary healthcare center and city administration) – *detailed program will follow*	- WB component
17:00	Trip to Sarajevo (3.5 h)	
	Matthias - overnight in Hotel Colors Inn, Sarajevo	

Saturday, 22nd September 2018: Sarajevo

Time	Programme	Address, contact details & link to the project/topics
	Report writing / meeting with Maja (to be confirmed)	
	Matthias - overnight in Hotel Colors Inn, Sarajevo	

Sunday, 23rd September 2018: Sarajevo – Banja Luka

Time	Programme	Address, contact details & link to the project/topics
	Matthias – hotel check out	
15:00	Trip to Banja Luka (3.5 h)	Departure in front of the hotel Colors Inn (Matthias, Jan, interpreter Amela Kurtović); driver Amer +387 61 979 142
	Overnight in Banja Luka, Hotel Talija	Srpska 9, Banja Luka *www.hoteltalija.com*

Monday, 24th September 2018: Banja Luka – Doboj

Time	Programme	Address, contact details & link to the project/topics
	Hotel check out	
09:00	Ministry of Health and Social Welfare of Republika Srpska - Siniša Janjetović, Assistant Minister / contact person for the WB component - Dr Amela Lolic, Assistant Minister / contact person for the WHO component	Ministry of Health and Social Welfare of Republika Srpska Address: Zgrada Vlade RS, Trg Republike Srpske 1 - overall public health and NCDs strategy and priorities - processes, results, challenges, lessons learnt related to the project
12:00	Public Health Institute of Republika Srpska - Miodrag Marjanović, Director - Dragan Obradović, Assistant Director - Dragana Stojisavljević - Biljana Mijović	Public Health Institute, Jovana Dučića 1 Contact: Dijana Štrkić 051/491-638 - overall public health and NCDs strategy and priorities, role and cooperation with the project (both WHO and WB components)
13:30	Lunch	
15:00	Agency for Accreditation and Quality in Health of Republika Srpska - Mr Siniša Stević, Director	Agency for Accreditation and Quality in Health of RS Address: Vladike Platona bb, I sprat

		Dr Stevic 065 927 540 https://www.askva.org/en/agency.html - accreditation of FM teams for NCDs prevention (WHO component)
	Trip to Doboj (1.5 h) Overnight in Hotel Park, Doboj	Kneza Lazara 2, Doboj www.hotelparkdoboj.com *Price per person for overnight with breakfast 93.5 KM*

Tuesday, 25th September 2018: Doboj- Sarajevo

Time	Programme	Address, contact details & link to the project/topics
	Hotel check out	
9:00 – 16:00	Meetings with local partners and stakeholders of the community-based program (city administration, local action group, advocacy group, schools, participants of education from schools, primary healthcare center and city administration) – *detailed program will follow*	- WB component
16:00	Trip to Sarajevo (2 h) ; Matthias - overnight in Hotel Colors inn, Sarajevo	

Wednesday, 26th September 2018: Sarajevo *(Jan not available on this date)*

Time	Programme	Address, contact details & link to the project/topics
8:30	Debriefing in the Swiss Embassy - Mrs Barbara Dätwyler Scheuer, Director of Cooperation - Mrs Maja Zaric, Programme Officer for Health	Swiss Embassy
11:00	Wrap-up with the Federal Ministry of Health - Vildana Doder, Sector for Project Implementation	Interpreter Bjanka Pratellesi

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