# Final Report

## Health Portfolio Review (2022)

## on behalf of the Swiss Embassy (SCO), Sarajevo

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# Abbreviations

| | |
|---|---|
| AKAZ | Agency for Quality & Accreditation in Healthcare (Federation of Bosnia & Herzegovina) |
| AQH | “Accessible Quality Healthcare” project, implemented in Kosovo |
| AZKVA | Agency for Certification, Accreditation & Health Care Improvement (Republic of Srpska ) |
| BiH | Bosnia and Herzegovina |
| CMHC | Community Mental Health Centre |
| CSO | Community Organisation |
| DPC | Disease Prevention Centre |
| DPF | Development Project Financing (World Bank) |
| EP | Extension Phase |
| EU | European Union |
| FBiH | Federation of Bosnia and Herzegovina |
| GESI | Gender Equality and Social Inclusion |
| HIF | Health Insurance Fund |
| HRH | Human Resources for Health |
| HUG | University Hospital of Geneva |
| IA | Implementing Agency |
| IPD | Institute for Population and Development |
| IPF | Investment Project Financing (World Bank) |
| KM | Convertible Mark (monetary currency of BiH) |
| MDTF | Multi-Donor Trust Fund |
| MHP | ~~The~~ Mental Health Project in Bosnia and Herzegovina |
| MoH | Ministry of Health |
| NCDs | Non-Communicable Diseases |
| NGO | Non-Government Organisation |
| PEN | Package of Essential NCD Interventions (developed by WHO) |
| PBP | Performance Based Payments |
| PHC | Primary Health Care |
| PHI FBiH | Institute for Public Health of Federation of BiH |
| PHI RS | ~~The~~ Republic of Srpska Institute for Public Health |
| RCSBiH | Red Cross Society of BiH |
| RHRF | The Reducing Health Risk Factors Project implemented in BiH |
| RS | Republic of Srpska |
| SCM | Supply Chain Management |
| SDC | Swiss Agency for International Development and Cooperation |
| SOP | Standard Operating Procedure |
| SRC | Swiss Red Cross |
| SWAp | Sector-Wide Approach |
| ToR | Terms of Reference |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| WB | World Bank |
| WHO | World Health Organisation |
| YMI | Young Men Initiative |

# 1. Introduction

An SDC Health Portfolio Review was carried out in 2022.

The **specific objective** of the Review was "*to assess the relevance and effectiveness of the Swiss cooperation in the field of health from a portfolio perspective and to provide strategic mid- to long-term recommendations for the future orientation and focus of the SDC health portfolio*".

## 1.1. Deliverables

The **main deliverables** from this review are

- The Strategic Review report provides an assessment of the relevance, main strengths, limitations and challenges of the **Swiss health portfolio** in relation to the current most important country needs, together with recommendations for future orientations.
- A series of short concepts with an abstract, main purpose, intervention strategy, recommended partners and setup, one for each of the 4-5 **identified new project ideas** ~~should be elaborated~~. This ~~should~~ include~~s~~ an outline of the main options to be considered when developing new projects towards an increased use of country system.
- The **proposal for a new Swiss-supported public health project** developed by the Institute of Population Development (IPD) in discussion with the MoHs critically assessed based on the conclusions of the strategic review.
- main options to be considered when developing new projects towards an increased use of country system

## 1.2. Disclaimer

This is an external and independent Portfolio Review and this report presents the opinion of the authors.

# 2. Background and Methodology

The Swiss Agency for Development and Cooperation (SDC), acting through The Embassy of Switzerland in BiH, contracted two consultants, Peter Campbell (international) and Emina Pasic (national) to undertake a review of the Swiss Health Portfolio for Bosnia and Herzegovina (BiH).

The review was carried out over **2 missions**. The first mission was for one week from 27 June - 2 July 2022, and the second was for two weeks from 19 September - 3 October 2022. In the second mission the two consultants were complemented by Chantal Nicod, SDC Regional Adviser for Health, to help guide on strategic aspects from an SDC perspective.

### 2.1.1. Interviewed Actors

In total, about 40 people were interviewed during this time including at the Ministry of Health (MoH) level, health institutes and agencies, Non-Government Organisations (NGOs), Community Sector Organisations (CSOs), Development Partners (DPs) and healthcare workers particularly at Primary Health Care (PHC) level and staff of the Embassy of Switzerland (see Annex 2 for the two mission schedules).

### 2.1.2. Limitations

There are a number of **limitations in conducting this Review**. This Review is carried out taking a "forward-looking" approach. Hence the consultants have not spent a high proportion of time or effort on analysing the current functioning of the entire health system, nor on assessing the current health needs of the country, nor on conducting a detailed evaluation of the performance of past or ongoing Swiss-funded health projects. Information on relevant aspects are taken from available documentation - reviewed during desk study by the consultants - most notably comprising the WB[1] and EU[2] assessments and from project reports: the findings from these are not repeated here in any detail.

During the nineteen working days of the two field trips, the main focus was on interviewing key partners and stakeholders to gain their insights and ideas on the role (past, present and future) of Swiss cooperation and how this can best meet the needs of BiH. All quotations are anonymous: informants were guaranteed this at the start of any meeting and some of the issues dealt with are sensitive especially if related to political topics.

By the final week of the Review, when sufficient information and understanding of the BiH health situation had been obtained, a number of potential future project concepts were developed (described in Section 3). These were presented to the SDC team on 29 September 2022, but this left insufficient time to check with the various potential implementers/workforce whether they could confirm the suggested implementation arrangements would be feasible. Depending on which of the proposals are selected, further work would be needed to ascertain whether - and how - the projects could best be established.

Using remaining time, as available, the "Healthy Communities in BiH" project - with a core focus on NCDs - was reviewed and relevant people interviewed. The consultants were not able to visit and assess how such a project would function at facility level, nor to assess in any depth the capacity of the proposed to lead, guide and monitor the implementation. This was the same for the elucidation of future project concepts (described in Section 3): these are developed on the assumption that, of those that are selected for more serious consideration, relevant experts will be deployed to evaluate the ideas in more detail.

A variety of questions are posed within the ToR, and these are used as the basis for the discussions and research carried out in the course of this Review. However, it was agreed with the Embassy of Switzerland that the findings would not be presented in relation to each question but would be written up using a clear set of overall headings derived from the original main goal of the review and according to other verbal clarifications that have been given.

[1] Health Systems Improvement Project, WB PAD3988, 2021

[2] Annual Action Programme for Bosnia and Herzegovina for the year 2018, EU Support to BH Health Sector Reform

# 3. Strategic Review

## 3.1. Background and context

The main purpose of this review is to explore the relevance of the current strategic orientation of the Swiss Health Portfolio for BiH in relation to the current and developing context.

The Review is carried out taking into consideration the **priorities of the latest Swiss Cooperation Programme** Bosnia and Herzegovina 2021–24. The overall objective of the Programme is to ensure that women and men demand, and benefit from, high-quality primary healthcare and live healthier lives. Two key desired outcomes linked to this are that (1) the primary healthcare (PHC) system sustainably provides access to gender sensitive services of improved quality, focusing on the prevention of non-communicable diseases (NCDs) and leaving no one behind and that (2) communities actively engage in creating health-promoting conditions and women, men, and youth in particular, adopt healthier lifestyles.

In addition, the Review is carried out on the understanding that future potential projects will be budgeted to a similar level to what has been allocated previously, taking as a rough estimate the CHF 11 million planned over a 4-year period 2021-2024 mentioned in the ToR for this Review.

In line with the Swiss Programme, five **Swiss-funded projects** are ongoing at the time of this Review while Swiss support to one of the flagship projects, the long-term reform of mental health, is coming to an end. However, a new project to address healthy lifestyle issues and prevention of NCDs (Communities that Care) is in the process of planning, as is a planned contribution to the World Bank-led Multi-Donor Trust Fund (Change Management Trust Fund).

This Trust Fund will be linked to the implementation of a large Investment Project Financing (IPF) loan that is currently being negotiated with the state entities – the Federation of Bosnia and Herzegovina (FBiH) and the Republika Srpska (RS). The future of the Swiss Health Portfolio needs to be seen in the light of this planned **World Bank (WB) $75 million Health Systems Improvement Project**.

Although a few other development partners (DPs) are also involved in health projects, they are relatively small scale or focused on specific short-term goals (e.g., UNICEF supports childhood vaccinations, early development and nutrition; UNDP supported specific COVID-19 response measures; USAID had a focus on health education in schools linked to COVID-19 immunisation). In contrast, the planned WB project will be more in-depth and take a robust health system reform approach, including many aspects that overlap with current - or future - topic areas covered by the Swiss Portfolio. Taken from the PAD3988, the breadth of topics include disease data collection/analysis, e-records for patients, NCD patient pathways, day surgery in out-patient departments, human resources for health (HRH) planning, hospital finance & supply chain management (SCM), quality management data and performance-based payments (PBP), and health insurance accounting.

The planned WB project had an initial expected approval date of 22 January 2021 and, at the time of writing, the WB Team Lead confirmed that project approval had been received at the state level in the third quarter of 2022, but was not yet approved by each of the entities. In addition, there is the potential for new leaders as a result of the national election process - planned for early October 2022 – that could lead to further delays in project approval.

The general **context of the BiH health system** is summarized in the 2020 functional review conducted by the WB. This highlighted numerous deficiencies, pointing to five main constraint categories to be addressed in both entities: (1) weak preventive and primary care, (2) inefficiencies in the in-hospital care, (3) lack of effective financial controls, (4) weak incentives and accountability and (5) under-funded health care system. The population of the country is also noted to be ageing, so that by 2060 it is estimated that more than 30% of persons will be older than 65 years, likely putting an increased strain on services related to Non-Communicable Diseases (NCDs) and elderly care in general.

Interviews with the general public (from a 2016 survey mentioned on p. 73 of WB Health Functional Review) have shown dissatisfaction with quality of care across a number of dimensions including long waiting times, unnecessary duplication of diagnostic tests and procedures, and unhelpful attitudes of health professionals and lack of information for patients on available services. There is also evidence of significant geographic variability in terms of access to care and productivity in the Federation.

In addition, according to the evidence gathered by the consultants, the **COVID-19 pandemic** impacted the health system, putting important reforms on hold but also revealing important weaknesses. The COVID-19

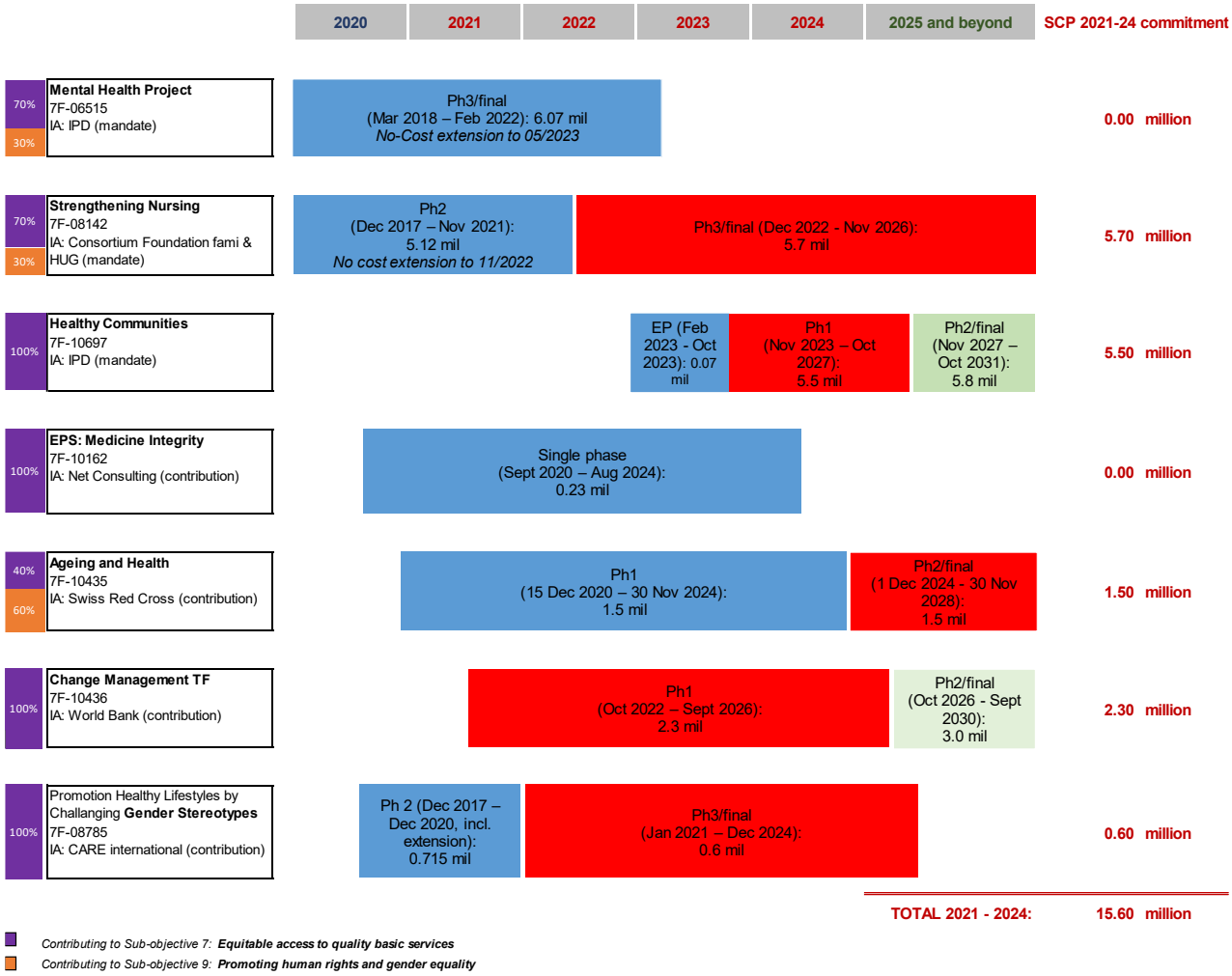
pandemic has severely strained health and public health systems in areas including rapid procurement of needed equipment and supplies to handle COVID-19 cases, dissemination of consistent clinical guidelines, supply chain management issues, availability of emergency funds. Measures to contain its spread have resulted in an economic slowdown and threaten the economic security of many of the country's citizens, particularly those with low incomes (EU 2022). For example, the pandemic has significantly contributed to the drop in the coverage of routine immunization and it will be difficult to reach universal vaccination coverage given the widespread anti-vaccine sentiments. The pandemic has also underscored the importance of having a strong, effective and crisis-resilient system of primary health care (to identify and reduce NCD risk factors that have been shown to be key to reducing COVID-19 morbidity and mortality, and to reduce the workload placed on the hospital system). It has also shown how new digital tools have proven invaluable (and will be important to build on in all the projects of the sector), allowing efficient communication between actors and enhancing access to needed information and educational materials.

## 3.2. Current Health Portfolio: mapping, relevance, strengths and limitations

### 3.2.1. Mapping

The **current portfolio**[3] consists of five main projects: the Mental Health Project, Strengthening Nursing, Medicine Integrity, Ageing and Health, and Promoting Healthy Lifestyles by Challenging Gender Stereotypes. These are shown using a timeline format in the figure below, together with the planned multi-donor Trust Fund and the Healthy Communities in BiH project targeting NCDs.

**Figure 1: Current Swiss Health Portfolio with timelines**




Of these initiatives, the **Mental Health project** implemented through the Institute of Population Development (IPD) - formerly Association XY - is preeminent. It has operated as a mandate since 1996, when a network of 70

[3] Taken from SDC MSExcel sheet entitled: "Health Domain: Portfolio SDC/OZA Commitment Planning" updated 8.12.2022

Community-based Mental Health Centres (CMHCs) was established, providing services to the whole population of BiH. The centres employ multi-disciplinary teams composed of psychiatrists, psychologists, social workers and nurses. Swiss expert support has meant that the services provided are well recognised and trusted by all, and this is seen as something that both health staff and the population are proud to benefit from. The project is well integrated into the health care system, and support from Switzerland is planned to end in early 2023. Other countries are learning lessons from this model, and its multi-disciplinary nature is also influencing the thinking of healthcare leaders and managers so that multi-disciplinary care at the PHC level is now being incorporated into the design of the new Healthy Communities in BiH Project. Some issues of sustainability linger, in particular the ongoing professional development of the staff, and their continued motivation to continue working in this field.

The **Strengthening Nursing project**, implemented as a mandate by the NGO Fami together with the University Hospital of Geneva (HUG), is now in its second phase. The first phase ran from 2011 to 2017, followed by a second phase that runs until November 2022 and should be extended into a third phase until 2026. The goal of the project is to support the country system in the comprehensive development of nursing by improving nursing regulation and university education of nurses, and by introducing Community Nursing (CN) services. By the end of this second phase, revision of the curricula at all eight public nursing faculties will be finalised ensuring proper clinical skills training and mentoring for the graduated nurses. A future issue of growing importance is the position and salary such highly qualified nurses will be given, and how this will differ from the nurses who have not undertaken this level of training.

The third initiative, **Medicine Integrity**, a single phase that ends in mid-2024, is implemented by NET Consulting in collaboration with the Association of Innovative Drug Producers in BiH (including Roche). It aims to support health authorities and related institutions in achieving high standards of integrity in establishing lists of medicines and to assist patients in raising understanding of their rights and capacities (holding health authorities accountable concerning access to medicines). This project faces the challenge of requiring high level agreements to make procedures more transparent for allowing medications to be funded by the Health Insurance Funds (HIF).

A fourth initiative, **Ageing and Health**, builds on work already carried out since 2013 by the Swiss Red Cross to enable the Red Cross Society of BiH (RCSBiH) to establish an affordable model of home care for the elderly. In Phase 1 - supported by SDC from 2020 until 2024 - home based care and active ageing will be scaled up to five new municipalities, while the already introduced services in the five existing municipalities will be further strengthened. New municipalities will be selected based on an open call to the municipal Red Cross branches. Selection criteria will include clearly expressed willingness of the respective local governments to financially contribute to the project. In addition, the institutional capacities of RCSBiH to sustainably manage the ageing and health services will be further strengthened and embedded within the social welfare systems in the country. This project appears to be effective and sustainable in those municipalities that have chosen to contribute, but progress is slow with only 5 new municipalities included every 4-5 years (out of 143 municipalities in total).

Fifth, SDC are supporting CARE international with the **Challenging Gender Stereotypes** project to systematically support the development of school curriculums, textbooks, and teaching materials to make sure that they exclude bias, prejudices and gender stereotypes. This intervention is in line with the Swiss FDFA Strategy on Gender Equality and Women's Rights, as it addresses the importance of the role of men and boys in promoting gender equality. The project introduces life skills education, developing soft skills for peaceful conflict resolution, dealing with anger, negotiation and communication, and the prevention of violence in schools. Since 2014, SDC supports the CARE International Young Men Initiative (YMI) - implemented throughout the Western Balkans - to engage young men and women in the promotion of healthy lifestyles and the prevention of violence in partnership. In Phase 3 of this support from 2021 to 2024, CARE continue to work with trusted local partner NGOs from Sarajevo (IDP), Banja Luka (Perpetuum Mobile) and Mostar (Youth Power). They build on the accomplishments of the first two phases and focus on producing tangible, long-term systemic solutions. In this last phase, the focus is on the integration of the project's educational tools into the compulsory curricula throughout most of BiH and it is planned that this curriculum will continue to be taught long after the project funding has ceased.

Two more projects to be supported by SDC are in the final stages of planning.

Phase 1 of a new **Communities that Care project** addressing the risk factors of relevant NCDs using a community-level approach is due to commence in mid-2023 and run for four years. In its current design (taken from the Pre-final concept paper dated 16 September 2022), it will be organized through IDP and managed by the MoH and Public Health Institutes. Key implementing bodies will include Community Health Advisory

Councils, Disease Prevention Centers based at the Primary Health Care level, and local non-governmental organizations/citizens' associations/user associations. The focus will be on (1) strengthening of the Public Health Institutes (PHIs), health facilities and educational institutions in undertaking joint activities for better health and disease prevention of citizens, to (2) empower local governments to create an enabling environment for the improvement of the health of citizens at the community level, and to (3) increase health literacy of citizens and empower them to more meaningfully participate in promotional and prevention activities. The design of this project is still at an early stage, and critical comments on this are provided in Section 4 of this Review.

SDC have agreed to contribute, together with the European Union (EU), towards Phase 1 (originally planned from 2021- 2025) and a follow-on Phase 2 of a **Multi-Donor Trust Fund** which focuses on policy, research, and analysis for health reforms linked to the planned implementation of the large WB loan project "Health Systems Improvement Project". The Trust Fund, implemented by the WB, aims to evaluate a number of areas including weak preventive and primary care, inefficiencies in hospital care, lack of effective financial controls, weak incentives/accountability and health care systems' under-funding. However, implementation of the Trust Fund is on-hold, awaiting final approval of the larger WB loan project by the Entities. By contributing to it, SDC co-leads in guiding the direction of the Trust Fund, and this in turn may guide the policy recommendations and direction of the health reforms affected by the WB loan project.

In addition to the above projects in which SDC is directly involved, there are **other projects funded by development partners**. These are summarized together, with outline timeframes, in the table below:

**Table 1: Overview of major development funders of health-related projects in BiH with timelines**

| Major Funder | Program/ Project (Implementer) | Topic | Timeframe | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 |
| **SDC** | Mental Health Project | Community Mental Health Teams | ■ | ■ | ■ | | | | | | |
| | Strengthening Nursing (Fami NGO) | Nurses professional environment (regulatory, Asscociations) | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | |
| | | Community Nursing Models | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | |
| | | Secondary Nursing Education | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | |
| | Public Health NCD Project (Communities that Care) | NCD prevention/ promotion | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | Medicine Integrity (NET Consulting/Roche/ Assoc) | Transparency of medication procurement planning | ■ | ■ | ■ | ■ | | | | | |
| | Ageing and Health (SRC with RCSBiH) | Home based care of elderly | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| | Change Management MDTF (contributing with WB/EU) | Policy, research, analysis for health reforms | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | Challenging Gender Stereotypes (CARE) | Youth education | ■ | ■ | ■ | ■ | | | | | |
| **WB** | Health Systems Improvement Project | Disease data collection/ analysis | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | E-Records for patients | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | NCD patient pathways | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | Day surgery in OPDs | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | HRH planning | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | Hospital finance & SCM | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | Quality management data & PBP | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | Health Insurance accounting | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| **EU** | Multi-Donor Support | Tobacco | ■ | | | | | | | | |
| | EU4Health | COVID-19 vaccines/ eqpt | ■ | ■ | | | | | | | |
| | Change Management MDTF (activities implemented by WHO/WB/Unicef) | Policy, research, analysis for health reforms | ■ | ■ | | | | | | | |
| **UNDP** | Multi-Donor Support vs COVID | Diagnosis and treatment equipment/ supplies | ■ | ■ | | | | | | | |
| **UNICEF** | Unicef & EU Support to BiH Health Reform | Childhood Immunisation | ■ | ■ | ■ | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | EU Support to BiH Health Reform | Nutrition | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | EU Support to BiH Health Reform | Early Child Development | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| | | Policy and Data | | | | ▨ | ▨ | ▨ | ▨ | ▨ | ▨ |
| **USAID** | Strengthening Social & Health Protection vs Covid-19 (UNICEF) | School education outcomes | | ■ | ■ | ■ | | | | | |
| | | Support COVID vaccinations | | ■ | ■ | ■ | | | | | |
| | | Cold Chain review | ■ | | | | | | | | |
| | (WHO) | Reporting systems vaccine coverage | | ■ | ■ | ■ | | | | | |

Key

| | |
|---|---|
| ■ | Conducted or agreed |
| ▨ | In planning |

The table above highlights how Swiss involvement plays a large role in supporting the BiH government to reform and improve the services provided by the health system. The CHF 15.6 million allocated by Switzerland (2021-2024) is by far the biggest contribution of any bilateral donor towards improving health care services in BiH. Apart from the delayed WB Health Systems Improvement Project, the inputs of other major development partner funders (EU, UNDP, UNICEF, USAID) can be seen to cover very few health areas (UNICEF and USAID[4] have a particular focus on children), and some (UNDP, EU) have mainly become involved in meeting urgent COVID-19 needs. WHO is included here as an implementer (e.g working with EU and USAID funds), but not as a major funder.

### 3.2.2. Relevance of Swiss Health Portfolio engagement

As described above, SDC is a major contributor to health development in BiH, especially since few other development partners are engaged in this sector. A number of the development partners have stated that they do not consider the **health sector as a priority** for support. However, this does not mean that the health system is satisfactory, nor that it is fully meeting the needs of the population. This is highlighted by the fact that both the recent WB and EU evaluations of the health system highlight numerous serious shortcomings, both in terms of services that are delivered and in the efficient use of resources. This has led both the WB and the EU to assign budgets and develop plans to address many of these issues, in a field in which the SDC is already fully engaged.

Of those development partners that are engaged in the health sector, some have become involved on a short-term basis in order to combat the emergency threat posed by the pandemic (e.g., EU, USAID, UNDP) while others have a clear focus on their areas of expertise (e.g., UNICEF's focus on children). By contrast, SDC has taken a broad approach to address areas identified as needing **comprehensive reform** that require taking time and care to be effectively changed. Hence, SDC has provided major support to the development of community-level mental health care services, to reforms of the nurse-education system and also for the transparent selection of health package medicines/supplies. These are fundamental health system reforms, and on completion of each the population of BiH should experience tangible improvement in the health services they receive.

In view of the **changing population demographics** with a predicted increase in the proportion of the elderly (by 2060, more than 30% of people will be older than 65 years of age) and expected rise in NCDs (a high proportion of NCD-related deaths occur between the ages of 30 and 69 years[5]), the Ageing and Health project led by the SRC and the planned NCD-focused Healthy Communities in BiH project are able to address relevant needs at the community level. Such changing demographics also mean that there will be a higher proportion of people requiring end-of-life care, and lack of sufficient services both in terms of quantity and quality has been mentioned as a priority issue to both the SDC team and to the Reviewers by several parties including representatives of the MoH.

The **efficiency of the health system** has been shown to be lacking, not only in terms of use of resources but also in terms of organisation of services, which are generally more aligned towards meeting the demands of the system and following historical (bureaucratic) practices than meeting the needs of the patient and understanding the issues from their perspective. SDC is already the main contributing partner in an initiative that will improve efficient use of resources through the Medicine Integrity project. In addition, the planned WB "Health Systems Improvement Project" seeks to address numerous efficiency issues, and SDC is aligning itself with this project through the Multi-Donor Trust Fund. This will be used to research and assess aspects related to policy and practice, including providing in-depth country situation analyses regarding identified topics, cost-analyses and recommended next steps. SDC's on-the-ground knowledge and experience in this sector may prove valuable in guiding the analyses and actions planned under the loan.

With its primary **focus on the PHC level**, SDC health policy is promoting efficient delivery of health care services. This is the level most often geographically closest to the population, making access fast and relatively inexpensive. It is also the level at which there is the opportunity to identify risk factors of NCDs, provide effective health counselling and be on hand for easy follow-up. The effectiveness of the Community Mental Health Centres in meeting patient needs is an excellent example of this, as are the services provided to the ageing through the Red Cross Society branches (Ageing in Health project). Also, the Strengthening Nursing project has shown clear benefits for patients as a result of Community Nursing interventions, particularly in the

[4] https://www.usaid.gov/bosnia/newsroom/key-documents

[5] https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

four first-round sites (Zenica, Vitez, Derwenta and Pmjavor). (ProSes Annual Progress Report 1 Dec 2020 - 30 Nov 2021).

### 3.2.3. Strengths of Swiss Health Portfolio engagement

From document reviews, observations and interviews with numerous stakeholders, a number of strengths of the Swiss Health Portfolio are evident.

First and foremost is the **long-term approach** taken to project design and implementation. All the current or planned projects have multiple phases, often each with a duration of about four years (with the exception of the Medicine Integrity project, which has only one phase). An implementing partner made the comments; "*It feels a great responsibility to deliver results, since it has taken a long time to set things up with such a long-term perspective. This makes it a meaningful project and this has helped us to exceed many of the goals/indicators*". A comment from an MoH representative states, "*Over the next 5 years, even up to 15 years, this project needs to happen and long-term support will be needed: we need to establish this as a routine work so that it becomes fully accepted*".

What these comments demonstrate is that, in contrast to many other development partners, SDC allows the possibility to build effective, long-term system-changes where goals may be exceeded and promote sustainability until the point is reached when certain standards or ways of working are accepted as normal. One specific example was the effort made to introduce "*Occupational Therapy measures for every aspect of functionality of people, including setting short- and long-term goals. Professionals were initially very resistant to this way of documenting their work, and now after many years see the value of it and cannot imagine doing it in any other way*". Another comment made to the Reviewers was that "*some results of the project regarding legal aspects were considered so valuable they are now integrated into RS healthcare law".*

Secondly, SDC are known as one "*most desirable partners from the development perspective*" because the projects they fund do not impose interventions but rather seek to enhance and support initiatives that have **foundations within the existing system and are sustainable**, with assigned human resources and budgetary commitment. SDC projects generally rely on existing strategies, and implementers are asked to closely collaborate with partners to design and implement the changes to improve practice or legal framework or develop missing elements of the system. Sustainability is further enhanced by allowing many projects to have a close-out phase to further integrate changes into the system.

Such a long-term perspective that cares for the sustainability of the intervention also **promotes respect** among the authorities. SDC are seen as a "*trusted and valued partner*" by authorities, who recognize that supported interventions are not simply seen as tick-box exercises that meet the donor criteria, but rather aim at bringing about real benefits at the level of the recipients of health care. This also allows SDC leadership to engage in debate with the authorities over policy changes that are needed in order to allow projects to reach their goals. This is recently exemplified by the sensitive discussions ongoing related to the Medicine Integrity project, where open discussions and disagreements have recently taken place that have apparently allowed strong opposing opinions to be aired in a way that has led to immediate agreement to take defined steps forward. SDC leadership has catalysed other policy changes too to support development and sustainability of other projects, in particular the Strengthening Nursing project (e.g., involvement in obtaining consensus for establishing a Bachelor's degree) and the Mental Health project (e.g., ensuring integration within the PHC services). SDC thus appears to be able to collaborate closely to support needs and requests of the authorities, while at the same time managing to argue and debate with them effectively to shape policy.

A number of implementing partners interviewed have explained how the on-the-ground presence of SDC leadership is highly appreciated for their ability and openness to listen to and **understand viewpoints and obstacles faced by implementers**. Each partner meets regularly with SDC staff to discuss ongoing progress and issues and the open, listening attitude allows implementers to feel themselves open to share difficulties they face and to work through the issues in partnership. A quote from one source highlights this, "*Bureaucracy is much reduced because the SDC staff are available on speed-dial, on a first name basis. The local SDC coordinator knows their own domain and what is not within their responsibility or what would not be allowed".*

This is in contrast to some projects known to the Reviewer, where implementers fear the response of donors and cover-up issues to avoid negative repercussions. In the end, this latter approach often leads to manipulation of monitoring data/analysis and, ultimately, may result in ineffective projects that appear to succeed to

outsiders, but are known to be performing poorly by those working on them or directly affected by them. The opposite is therefore likely to be true for SDC-funded projects with accurate data likely to be reported and problems quickly highlighted and able to be resolved, not hidden, leading in the end to what one partner has called "meaningful" projects that those involved believe in.

This recognized partnership approach has shown itself during the COVID-19 pandemic. A number of the SDC-supported projects experienced severe obstacles from restricted travel and inability to contact beneficiaries face-to-face, procurement or supply delays, reduced spending and lack of achievement of expected targets. However, throughout the pandemic, SDC staff have been readily available to discuss the issues with the partners and to **work flexibly with the partners** on how to make adjustments to the project activities (e.g., teaching conducted online, setup of equipment for this purpose), expected timelines and indicators, realigning estimated outputs and outcomes. One example of this was the development of contingency plans in agreement with SDC to reallocate project funds to fight the COVID-19 pandemic with Community Nurses asked to switch from planned community work activities to instead provide urgent support for affected patients and provided with the necessary Personal Protection Equipment.

SDC insist that the implementing partners are "*all on the same side, cooperating with local authorities on all levels"*. SDC projects "*do not impose, but share and **collaborate and develop concepts together with partners***". This fosters a sense of equality and empowers the local partners to take on their responsibilities. Somebody commented that SDC lead from the front in this, setting an example so that "*SDC works to collaborate with the implementing partner*".

This approach has also engendered **loyalty among the partners** and over the past few years there have been few changes in personnel across the various project staff, a known indicator for good managerial practices. In an interview with a national member of staff working for one of the partners in a leadership role, it was made clear that this approach has led them to be prepared to take on more responsibility about which they have less experience and confidence, because they feel they will get the support they need as the project progresses. This is a form of development, both on an individual level and, ultimately, building the human resource capacity of the country.

### 3.2.4. Limitations of Swiss Health Portfolio engagement

Following on from the strengths, which are many and deep, limitations of the Health Portfolio engagement identified during this Review are relatively minor and can best be described in two categories: processes and impact.

#### Processes

A few informants mentioned their frustration with **SDC bureaucratic processes**, especially those associated with seeking approval to take next steps forward or to make adjustments to planned workplans. However, some felt this was normal when dealing with a bilateral organisation, and others with more experience said that such processes were far less than other agencies they had dealt with. It was also stated that the longer the project ran, the more these processes were adjusted for - and methods found - to take account of them without affecting the project outcomes.

One informant pointed out that, early on in a project, SDC had paid special attention to the project managers following all procedures accurately and monitored this closely. However, as the project continued, and the project management were trusted more, so SDC took a less hands-on and more relaxed approach that built on and developed trust with the partner. This latter example highlights a type of leadership practice known as Situational Leadership as described by Paul Hersey and Ken Blanchard in the early 1970s. In this there are four leadership styles named Telling, Selling, Participating and Delegating and the example given follows this pattern of moving, over time, from an attitude of telling the project managers how to work to moving towards delegating the managers to do the job expected of them. This is in no way a limitation of the management of the Portfolio, but rather a logical approach that may be frustrating for the partner in the early stages but becomes appreciated by them later on.

**Data monitoring and reporting** is required according to the project design, and usually follows the rationale of a Logical Framework. This can make things complicated for a partner who already implements other non-SDC funded activities in the country, and has their own data collection and reporting system. If the partner's original

data monitoring system cannot easily be aligned with the SDC monitoring version, it can create a sense of collecting data for data's sake, rather than for improvement's sake. This carries the danger of putting off valued partners from being involved in further or additional activities, because of what may be considered additional, unnecessary administrative/monitoring burdens. It is recommended that, when working with partners already implementing projects in the country, the Logframe monitoring tool should be adjusted to be as compatible as possible with any existing data collection tool.

**Coordination of health sector activities among the development partners** is done in many countries through one of the major development organisations. This can take the form of information-sharing, regularly updating all parties on latest activities, issues and plans. Alternatively, it can take the form of full coordination of activities and project planning, sharing out tasks and coordinating activities in unity to avoid duplication and to maximise synergies, similar to what is done in a Sector Wide Approach (SWAp). In general, WHO often convenes such meetings but other agencies are known to do this, for example, the Ministry of Health itself (especially in a SWAp), the EU Delegation or UNDP etc.

In BiH there is no Sector-Wide Approach, and the number of actors in the health sector are relatively few. There is a high-level Ministerial Conference on Health convened by the State Ministry of Civil Affairs that meets regularly with Ministers of Health for each Entity to coordinate all health reform initiatives including those supported through the Development Partners. WHO are invited to these meetings and, on occasion when their participation is deemed to be relevant, larger development partners such as the WB. While this would be an ideal setting for all development partners to participate, be informed, and coordinate activities, until today such a scope of objectives is not shared by the Ministries. It is recommended to continue to encourage and promote donor coordination through the leadership of the two entities.

However, a number of both development partners and implementing partners stated how useful it had been to have information sharing on activities which, on occasion, had prevented any unnecessary duplication or had reduced effort needed for project planning situation analysis. Although no longer the case, until a few years ago, the Head of Health for SDC took on the role of holding regular information-sharing meetings, and it was then discussed that WHO would take on this role. However, this has not happened. Instead, meetings are held sporadically on an "as-needed" basis in order to share on specific topics of interest and/or urgency. Some people who were spoken to felt this is sufficient in view of the few key actors/initiatives in the health sector, but that this situation will change if/when the new WB Health Systems Reform Project commences. When it does, the parallel WB-led Multi-Donor Trust Fund will also commence, as will the specific EU-funded projects involving the WHO, UNICEF and the WB. Coordinating the numerous interventions will be complicated as there will be potential for significant overlap of responsibilities so it may be wise to reinstitute, at least, the information-sharing meetings in order to keep key stakeholders updated on developments and, as a major actor in the Health Sector, SDC could consider taking on this role as before or sharing it on alternating occasions with others e.g., WHO and/or the WB. In addition, and with the potential WB loan project touching so many aspects of the health system, the Ministry of Civil Affairs could be approached to consider inviting all the development partners at least annually (preferably bi-annually) to participate in the Ministerial Conference on Health.

The **capacity of staff members in the SDC office** located in the Embassy of Switzerland BiH to manage all the health initiatives puts them under strain. The five ongoing projects, carried out in the ways described above in Section 2.2.1 (Strengths) require substantial stamina of the SDC team. Their responsibilities include to conduct regular meetings with the partners, respond to urgent issues of which there have been many due to the COVID-19 pandemic over the past couple of years, engage in policy dialogue on sensitive issues in a country of the complexity of BiH where there are the equivalent of 13 Ministries of Health to deal with in order to take broader health reform initiatives forward, plus all the regular administrative work including project reports to be read and responded to and the development of new project pipelines. The staff, from all accounts, have handled themselves in an exemplary manner this past couple of pandemic-affected years, but the Reviewers note from conversations and observation that they are at the limit of their capacity, and this should be borne in mind when planning new projects that require sufficient time for policy dialogue, field visits etc.

### Impact

As a consequence of the objectives outlined in the Swiss Cooperation Programme BiH 2021–24, there is a sharp **focus on the PHC level**. This dictates the scope of SDC health projects and, together with the emphasis on addressing NCDs, tends to push all new projects in these directions. It could be argued that this is too constraining, since the patient journey is not limited to PHC but may require referral to the secondary or tertiary level. For example, the CMHCs provide an excellent service for patients attending at the PHC level but, since

little support has been given to enhance the services at secondary level, the Reviewers heard (anecdotally) that because some secondary centers do not provide a sufficient level of mental health services to those attending, they send their patients to the CMHCs for care. This highlights the lack of depth of such expertise at higher levels in the system, and this will remain neglected if the focus of the government on topics of SDC focus remains only on the PHC level.

This will also be a question when the new Healthy Communities in BiH project becomes operational, since it is possible that the planned PHC-based Centers for Disease Prevention may offer more reliable tests and counselling of patients than those at secondary level. This can create an imbalance, leading to negative (envious) feelings towards the PHC level from those at the referral level and, related to this, may promote division of health care services with those at the referral level following different guidelines/diagnostic criteria and offering conflicting advice to patients.

## 3.3. Future Swiss Health Portfolio directions: opportunities, challenges, principles

This section summarises general ideas concerning future directions, while in Section 3 the focus is on specific future options to be considered.

### 3.3.1. Opportunities and challenges for the Health Portfolio

In Bosnia and Herzegovina, SDC plays a major role in the reform and development of the health sector, where it is recognised for its long term, impactful projects to-date and appreciated for its understanding and respectful approach to problem solving. Having matured to this level, SDC is in a strong **position to further influence reforms** in the country that may require deep systemic changes while touching on areas of sensitivity. Such influence may be either direct, through projects it supports and the policy dialogue via the Embassy or indirect, through involvement with other initiatives - in particular the planned WB Health Systems Improvement loan project.

The approaching commencement of the large **WB loan project** is significant because many inefficiencies in the health system are expected to be addressed. SDC has committed itself to collaborate through the MDTF, and it is understood that SDC is already fully engaged in its design, being one of the few other development partners to take this position of influence seriously. Involvement in the MDTF puts SDC - and its deep knowledge and experience of the health sector context - at the heart of the policy-development process that should ultimately guide the implementation of the loan project. This should be a win-win situation, but transparency and a willingness of the WB team actioning the Trust Fund (and, in parallel, the loan project) to be engaged and open to ideas that may be critical of some approaches will be required.

**Informing, coordinating and guiding development partner interventions** needs to be efficiently organized, especially if the WB loan project and other parallel interventions, including the MDTF, eventually commence. There are 3 main aspects of these relevant to future SDC inputs described below, and each has its own purpose, mode of operation and issues to be aware of.

a. <u>Information Sharing</u>
   **Purpose & mode:** In order to plan ahead, all development partners working in the health sector should ideally be well informed about each other's activities and plans. This can be carried out purely through the use of various forms of media, including regular email/Social media (eg Facebook, Whatsapp, LinkedIn etc) newsletters, or through regular face-to face meetings of relevant personnel.

   **Issues:** Sending out newsletter-type updates can be done individually by each organisation, either as a specific newsletter targeted for the partners, or as a regular three- or six-monthly report that is developed as part of its regular reporting process and which is permitted to be sent out to the partners as is, or else adapted slightly.

   Sending out the regular report is the simplest process, since it requires little extra work on the part of the organisation (perhaps minimal editing). However, a regular report aimed at each implementers funders may not be very readable or understandable for partners in the country since it may be long and detailed and cover areas less useful for other partners to know about. There is therefore also a high chance that such reports will not be read by everyone, although the information will be readily available should other partners feel that they need to know how the landscape is looking, especially if new

projects or directions are planned. If such reports are published on each partner's website, there does not even need to be a process of sending them out, but simply an updating list of relevant websites.

It can also be done by one coordinating person/agency who collates information from each partner and puts it together into a package of some sort (a single newsletter, a combination of news items etc). While this may ensure that the information is more coherent and attractive, tailored to the interests of the other partners, it requires a responsible person or agency to take on a role that is often not included in any one agency's ToR, and who is competent to collate and summarise the information. This makes it very unlikely that anyone will take the time to do such work.

Holding regular (e.g., monthly) face-to-face meetings to share information requires much less preparation, but does require someone to take responsibility, agree on a date, send out the invitations, arrange a venue preferably with a supply of tea/coffee, set the agenda and manage the meeting (and perhaps produce minutes of the meeting). The other issue is that there will always be people who are unable to attend for various reasons, so that important information may be either not shared at the meeting, or not received by those not attending. Minutes of the meeting will reduce the latter risk, while asking people to share a summary of key activities beforehand could address the former risk. The rationale for such meetings should be kept clearly in mind, since for each project to share everything they are doing each time the meeting is held can becoming very boring for those who attend regularly. It may be better to focus on sharing aspects that are new, and it can be a very attractive idea to have 1-2 partners be given 15-30 minutes to present on a topic of particular interest early on in the meeting, before sharing general updates. This can turn the meeting into a type of Continuing Professional Development for those attending, and may draw in more attendees.

The consultant understands that recently the WHO have taken responsibility to arrange such meetings.

b. <u>Coordination of Interventions</u>

**Purpose & mode:** In order to coordinate the planning and implementation of activities between partners and, preferably, with the authorities, regular face-to-face (or online) meetings should be organized with the relevant stakeholders. Coordination can ensure that there is minimal duplication of activities, that projects can maintain consistency in what is taught and how health service delivery/monitoring is provided and organized, and to share results that can lead to further improvement of planned inputs. Coordination meetings, done properly, should allow plenty of time for discussion, for representatives to have time to discuss, clarify and respond to each other's plans and proposals, and even to develop joint planning activities.

**Issues:** As described above under (a) Information Sharing, the same risks apply for holding face-to-face meetings in terms of intentional organisational planning, people missing meetings, and the necessity to have a clear focus and interesting agenda. Such meetings should therefore be planned well in advance to allow representatives to plan it into their diaries and held not more frequently than every 6-months to allow for at least a one full-day meeting or longer.

This corresponds to what is already happening when the Ministry of Civil Affairs invites key Development Partners 1-2 times per year for (or in parallel to) the Ministerial Conference of Health.

c. <u>Project Guidance (e.g. Advisory Board/Steering Committee of MDTF)</u>

**Purpose & mode:** Once the planned WB Health Systems Improvement Project commences - together with the accompanying initiatives (the MDTF and the linked EU-funded support) - there will be a specific need to advise and steer the planning and activities on a regular basis. This can be carried out using both the above modes. Firstly, sending out regular information summaries/reports to all stakeholders in order to update everyone on progress. Secondly, for the key stakeholders to be involved in planning and decision-making about how the project and related initiatives (MDTF, EU-funded activities, other affect ted projects) move forward in order to work in a synergistic manner with minimal duplications and maximal coherent impact. This second aspect will be more effective if conducted face-to-face (perhaps online) to enable sharing of ideas and deep discussions for planning purposes. Sufficient time should therefore be allocated for deeper discussions and joint planning - meaning holding less frequent meetings.

**Issues:** In order to collate informational materials on progress and plans, there needs to be agreement on who will do so and how it will be done (type of information to be output, frequency, target audience). Similar can be said for organizing face-to-face meetings, with decisions to be made on who will convene them, and the focus, agenda and timeframe of the meetings.

From the documents seen by the reviewers, the WB will oversee management of the Health Systems Improvement Project and will also oversee the day-to-day management of the MDTF, with advice and guidance offered by the other contributing partners (SDC being a major partner in the MDTF). Assuming that the WB team will be very occupied by the demands of managing the projects, especially in the early phases when planning and processes will need to be established, there could be reticence on their part to coordinate such meetings and time pressure to keep the meetings short. But the meetings will be necessary should be planned with sufficient time allocated to deal with issues that arise and SDC should be at the forefront in promoting this. However, there is the real danger that SDC health-related staff will end up spending all their time attending frequent meetings, with little additional time left over to provide the usual day-to-day inputs to support the various SDC-funded projects.

There are several **proposed options for a way forward,** each with the aim of keeping informational/ coordination activities manageable, but still effective.

Knowing that SDC is taking on more commitments both in terms of the new project(s) combined with the MDTF, it would be wise to review the responsibilities of each team member and to consider ways in which to reduce the burden on the staff by, for example, taking on more full-time junior staff to handle day-to-day project activities while freeing up more senior staff to fulfil the coordination responsibilities. It could also be that some team member responsibilities are reduced and, perhaps, given away to others (e.g. any regional responsibilities).

Informational materials will be expanded to comprise regular updates on the WB project and accompanying measures in addition to preparing materials on what other projects are doing.

It could also be good to combine the various partner meetings and focus them around the WB project and its accompanying interventions, simply because this will outweigh all other initiatives in the country. For face-to-face coordination purposes, it could be wise to include the WB-related interventions in the regular WHO-led coordination meetings rather than as a separate series of Advisory Board/Steering Committee meetings, using the opportunity to bring aboard the relevant MoH/PIU leaders (perhaps online). Advisory Board/Steering Committee meetings could be held less frequently, not more frequently than every 6-months, but with plenty of time allocated on those days to discuss issues in detail and resolve them properly.

If it is decided to hold the Advisory Board/Steering Committee meetings more frequently eg every 2-months, then there should be a reduction in the frequency of WHO-led coordination meetings, and perhaps there could be open invitation to the partners to attend this meeting instead, particularly if the agenda encompasses aspects relevant to particular partners.

For the MDTF, SDC could promote the idea of a coordinator whose main role is to summarise the progress of the various aspects and send out regular updates to keep all stakeholders informed of the plans and developments. That person could also arrange the regular coordination meetings, take minutes and send them out, if this is separated from the WHO-led general partner meetings.

In terms of the Ministry of Civil Affairs meetings, the WB-funded and related interventions will likely be a priority area and this could be a good opportunity for SDC to attend (perhaps requesting WB to support this idea) and advise on steering and policy issues. But again, the SDC representative(s) should be in a position to devote sufficient time to this important coordination/steering role.

The health system of BiH is still facing many issues and, looking into the future, as the proportion of the elderly is set to rise there is a growing need to develop effective strategies and programmes for the **prevention and management of NCDs**. SDC is already moving forward to address this with a long-term, partner-oriented approach in the design of the new Healthy Communities in BiH project and also through the Strengthening Nursing project with the emphasis on training of Community Nurses. In a future phase, the Nursing Project could also become more deeply involved in vocational education of nurses.

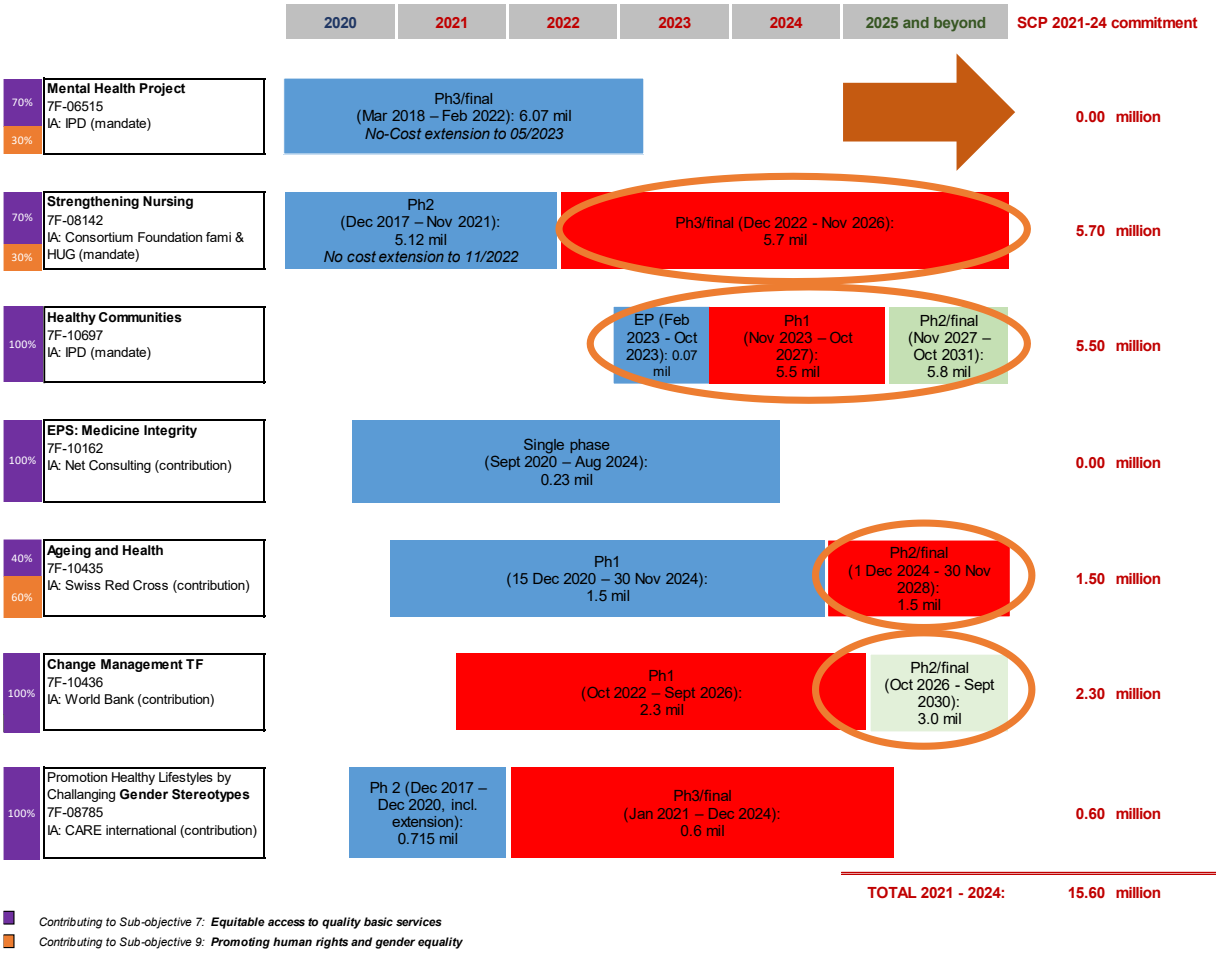
However, NCD prevention and management are topic areas that highlight the **functioning of the entire health system**. First, from a horizontal perspective, how well is each level of the health system set up to perform? This touches on the effectiveness of training of staff and monitoring performance; coordination of teams to offer satisfactory health promotion, accurate/accessible diagnosis and valid/affordable treatment; supply chain management including sufficient funding for long-term prescriptions of preventive and treatment medications (anti-hypertensives, anti-cholesterol, anti-glycaemic medications). Second, from a vertical perspective through the entire health system, NCD prevention and management requires good communication from community work to PHC facilities and on up when referral is needed to hospital level; and downwards with relevant and useful IEC materials designed, produced and disbursed to support the work of the health care teams combined

with policy-level commitments to address the social-cultural-political issues. A third aspect is the scope of the needs, since there are multiple types of NCDs (heart disease, stroke, cancer, diabetes and chronic lung disease etc) and, with them, comes the question of, "Where to begin to focus"? The Healthy Communities in BiH project - currently being designed - appears to have a clear focus to commence at the community level, linking with the PHC services through the development of multi-disciplinary community centers for disease prevention and health promotion. Based on this design, all these other health system aspects will need to be considered, and care will be needed to keep the project clearly focused on making tangible improvements to the system that can scale-up and be developed for more NCD topics over time.

Since NCDs touch upon the vertical nature of a health system, it is also a question as to how much the project (or other SDC-supported initiatives) should encompass the **secondary or even tertiary hospital levels of care**. While these may not be the priority recipients of SDC support, increasing their awareness of the project inputs and aims (e.g., through professional development meetings/discussions accompanied with provision of relevant health IEC materials/guidelines) may support the overall reform changes at least in geographic project areas supported by SDC. When the Healthy Communities in BiH project commences and implementation plans become clearer, existing projects funded by SDC should be involved in a combined workshop to consider how they touch upon topics that will be covered by the Healthy Communities in BiH project, and to what extent they too may work in synergy especially if there is potential to develop further awareness related to NCDs.

There are a number of other areas/scope where SDC could provide future support to the health system of BiH, and some examples of these developed during this Review are described in Section 3 below. However, a challenge for the future in developing the health portfolio is to consider the number of projects and their scope in the light of the **capacity of the SDC country health team**. As shown in the figure below, from 2025 onwards four projects will be operational and requiring oversight: the Strengthening Nursing project, the new Healthy Communities in BiH project, the Ageing and Health project, and the Change Management MDTF project. Addition of too many new projects to this mix runs the risk of reducing the quality of support that the SDC team can provide, and in turn this may lead to ineffective implementation and, ultimately, to wasted effort and funds. Options to address this include to keep the number of new projects to a minimum, or to consider how to increase the staffing level and capacity of the SDC team.

**Figure 2: Swiss Health Portfolio highlighting post-2024 period**



# 4. Potential future directions for BiH health reforms - supported by SDC

## 4.1. Palliative (End-of Life) Care

### 4.1.1. Description

According to the WHO[6], palliative care improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social or spiritual. The quality of life of caregivers improves as well.

Palliative care is a resource for anyone living with an end-of-life illness, such as end-stage heart failure, chronic obstructive pulmonary disease, cancer, dementia, Parkinson's disease, and many others. Once the criteria for end-of-life stage are met, palliative care is best to be planned and provided as early on as possible. Palliative care may include escalating levels of pain relief, oxygen therapy and other medicines to reduce suffering or contain ongoing disease or ease symptoms (such as itching, heartburn, headaches) prevention of bed sores, basic hygiene care, and mental health care counselling including religious support.

In addition to improving quality of life and helping with symptoms, palliative care can help patients understand their choices for medical treatment.

Ideally, a palliative care team is made up of multiple different professionals selected according to the needs of the patient. They work with the patient, family, and the patient's other doctors to provide medical, social, emotional, and practical support. The team may comprise palliative care specialist doctors and nurses, and can include others such as counsellors, social workers, nutritionists, and if appropriate, religious functionaries.

Palliative care can be provided in hospitals, nursing homes, outpatient palliative care clinics and certain other specialized clinics, or at home. At community (PHC) level, the main objective would be to care for patients at home but with multidisciplinary support closely coordinated with the local PHC facility. In addition to supporting the health care workers, support could also be considered to be provided to the informal caregivers (family, relatives, friends) and how they can be integrated/ supported in view of a holistic perspective.

It would also need to align services with any available referral palliative care units or hospice centers, such as the one at Gradiska (Republika Srpska), Tuzla or Ljubinje (Federation BiH). Such centers should also receive support and training to ensure all service provision is aligned, appropriate and consistent guidelines are developed, and any necessary equipment and supplies (e.g., syringe pumps for pain relief, pulse oximeters, oxygen equipment, pain/symptom-relieving medications) are coordinated.

There is a legal basis for palliative care in the country[7], and services can be funded through the HIF to reimburse care, but the provision and amount may vary according to Canton in FBiH or in RS. There are also limited government funds that may be accessible to support close relatives who are deemed to have to provide full time end-of-life care.

### 4.1.2. Rationale

Palliative care should be considered an area for future intervention for a number of reasons.

First and foremost, it has been highlighted as a need during this review by the Ministry of Health of RS, Department of Health of Brcko District, Health Care Facility of Zenica, and by several development partners including UNDP and NGOs (IPD, Think Pink) and mentioned previously as a priority of the FBiH MoH to SDC staff. Demographic studies show that there is an increasing proportion of the population

[6] https://www.who.int/news-room/fact-sheets/detail/palliative-care

[7] (1) The Primary Health Care Strategy of the Republika Srpska, BiH
http://www.vladars.net/sr-SP-Cyrl/Vlada/Ministarstva/MZSZ/Documents/Primarna%20zastita%20Brosura.pdf
(2) The Primary Health Care Strategy of the Federation of Bosnia and Herzegovina.
http://www.fmoh.gov.ba/images/federalno_ministarstvo_zdravstva/zakoni_i_strategije/strategije_i_politike/dokumenti/strategija_razvoja_PZZ.pdf
(3) Law on health protection of the Republika Srpska, BiH, Article 36. http://www.vladars.net/sr-SP-Cyrl/Vlada/Ministarstva/MZSZ/Documents _106_09.pdf
(4) Law on health protection of the Federation of Bosnia and Herzegovina, Article 93. http://www.fmoh.gov.ba/index.php/zakoni-i-strategije/zakoni/zakon-o-zdravstvenoj-zastiti

who are elderly and who will require palliative support especially home-based and, combined with so many youth emigrating, this means that palliative care support from the health system will be in high demand. Currently there are very few palliative care centers in the entire BiH, with one under consideration for development in Brcko, and few staff are properly trained in this area.

Second, palliative care is something that can be supported at the level of PHC, one of the key areas of focus of SDC. In fact, it is already included as a module in the education curriculum of Community Nurses supported by the SDC-funded Strengthening Nursing in BiH program.

Third, Switzerland has recognized expertise in this area, with Swiss experts already having provided some training on this topic to the Nursing Program.

Fourth, it is not covered in any depth by any other Development Partner programmes.

And fifth, the topic aligns easily with the ongoing thematic areas of nursing, the teamwork concepts at PHC level developed through the CMHC initiative, and the Swiss Red Cross-led programme supported by SDC to provide local community support for the ageing[8].

### 4.1.3. Implementation Options

Palliative care could be supported by different mechanisms. Support could be provided as an **add-on to an existing SDC program.**

This could be to further enhance the work of the Community Nurses trained under the **Strengthening Nursing project**. This might be logical since the Strengthening Nursing Program (led by Fami/HUG) already has a module of nurse training on Palliative Care and HUG has assigned additional support for this initiative. However, the broad primary objectives of the program, which is currently in planning for the next phase, may not allow enough planning time nor resources to be devoted to ensuring palliative care in the community is sufficiently promoted and coordinated with interdisciplinary teams. On discussion with the Fami-led project, there are currently no plans to provide home-based mentoring support for palliative care by the community nurses being trained, but this is something that could be considered.

From a mid-term perspective and, taking into account continuity of reform processes, it would make a lot of sense to go for a **newly designed Nursing-End of Life (Palliative) Care project** (nursing with focus on palliative care). In terms of systemic approaches and institutionalization, this would help to further strengthen the nursing reform and anchor the reform changes within the system. This is especially relevant given the fact that the BiH health authorities are adamant that there should be continuation of the nursing reform beyond the lifespan of the current nursing project.

Alternatively, it could be an added responsibility for the **local RCSBiH teams**, who work with the ageing population. These teams are trained to work with the elderly in the community, especially those who need more intensive forms of help at home. However, these are all volunteers, and not all of them are medically qualified. Their ability and availability to support palliative care may mean they are not able to carry this out.

Another way could be to integrate it with the **Communities that Care** intervention (currently in the process of being designed) as an expected function for the Disease Prevention Center at PHC level. This makes sense if it can be designed into the project clearly from the start and, at the time of this review, there may be time for this to happen. But including it as a topic for this intervention - when there are many other pressing issues for prevention - is perhaps expecting too much.

It could be established as an extra role for the **CMHC teams at the PHC centers**, particularly when dealing with cases of severe dementia when nearing the end-of life. The CMHC staff are familiar with - and have been well trained in - working with interdisciplinary teams, and expansion of this role to include end-of-life care in the community is a possibility. But this is an added responsibility and covers many more areas

[8] ESPC (European Social Policy Network) 2019: Investment is essential if BiH wants to ensure a decent life for all persons in need of care. Extensive measures are needed to address the current situation in terms of: 1) raising care allowance levels; 2) improving the capacity and affordability of residential facilities; 3) expanding home care and community-based services; 4) integrating health and social care services; 5) providing support to informal carers; and 6) developing prevention and rehabilitation measures for active ageing.

than mental health, and the staff would need further training and should be motivated to carry out this work. Also, as the funding support from SDC for the CMHCs comes to an end, it is not clear whether the staffing capacity of the CMHCs will be sufficient to allow staff to take on such a role, if some start to move away and are not replaced.

Consideration could also be given to **establishing robust coordination** between any (perhaps, preferably, two only) or all of the above partners to take on this role. Clear division and sharing of responsibilities would reduce the burden on any one of the partners. However, establishing such coordination may be extremely challenging to achieve and sustain.

Whichever partner is chosen to implement, they would be expected to collaborate with the other partners in areas of expertise and interest.

Another option would be to **intervene as a new project** to enhance end-of-life palliative care throughout the country.

A clear focus could be on developing teamwork at PHC level to identify and care for the needs of patients, using already existing mechanisms of support from the Community Nurses at PHC level, the CMHC also at PHC level, the Disease Prevention Teams under current consideration for funding, and the Ageing and Health Program implemented by local teams of the Red Cross Society of BiH with SRC technical support.

A focused program would ensure that this topic is developed in a comprehensive and effective manner, not treated as a second priority if added to another project. However, administrative and management costs to implement may be higher, with a specific team needed to implement. But this could possibly be put into the hands of a local palliative care unit(s) or department(s) who could be supported by an external partner. Setup time could take longer and additional SDC human resources may be required, but institutionalization will be more assured.

There is also potential for a **Public Private Partnership** to support this model.

For example, to cooperate with the existing private clinic for pain relief in Brcko or elsewhere for study visits and sharing of experience and skills. This could maximise utilization of in-country expertise, promoting further development and expertise of such a local facility. Since it is not within the government system, cooperation may be problematic to be achieved and there is an argument that such a facility benefits the wealthier population which is not a priority for SDC support. For these reasons, it is unlikely that this can be considered as a stand-alone project, but it could eventually be an activity in existing projects (nursing or aging project)

Institutionalization of Palliative Care can be promoted in a number of ways. First, by ensuring that costs of services to be provided are met by the participating municipalities or for some aspects to be funded through the HIFs. Second, by collaborating closely with the Strengthening Nursing program (Fami) to integrate relevant Palliative Care training modules widely into other relevant medical staff curricula (eg undergraduate teaching of doctors, post-graduate training of specialists). Also, by working closely with existing Palliative Care units.

### 4.1.4. Overall risks with regard to a Palliative Care intervention

Insufficient available funds for the services in local municipality or HIF budgets. In principle, such services can be funded, but there is a risk that there could be a lack of political will to provide the additional funds needed to manage these services to a higher level than at present.

There could be overburdening of Community Nurses, or Mental Health Nurses or others, especially in the context of sub-optimal staffing levels. This could lead to poor coverage and a lack of quality of service provision.

Lack of motivation (particularly remuneration) among involved carers to take on such extra responsibilities if no additional staff are taken on.

Lack of capacity for coordination between the members of the multi-disciplinary teams and with social service providers.

## 4.2. Patient-Oriented PHC Organisation

### 4.2.1. Description

Currently, the health care services of BiH (both at PHC and Hospital level) are often organized according to the needs of the system, not those of the patients. Hence, patients, who are viewed in business/marketing industries as clients for whom satisfaction with the product is vital, have instead to navigate their way through the health system sometimes with little clear guidance or support. This is especially relevant if their case is a little complicated, for example if they are affected by disability and cannot climb stairs to reach a medical service, or if their care needs referral to another canton, or filling out the required paperwork that requires substantial time and effort to do so with numerous clinician signatures needed, or to identify where to go for getting the needed service.

### 4.2.2. Rationale

This non-patient focused approach places a great burden on patients and their families or friends who require lots of time, effort, and perseverance to navigate through the health care system. Time and effort also translate into costs for the patient - unseen uncountable costs - due to transport and time lost from work. Patients have to identify and reach the right medical facilities and the relevant medical staff, fill out the correct medical or social welfare forms such as sickness forms, some of which may have to be repeatedly filled out even when the disease may be recognized as chronic and perhaps irreversible.

However, if the health system is non-patient focused, there are also increased burdens on medical facilities and staff: patients arriving for appointments that are with the wrong facility or medical specialist, staff filling out forms that may be unnecessary or duplicating, explanations given to patients to guide them to the right step in seeking health services, staff dealing with frustrated and angry patients who are frustrated by the opaqueness of the system. This also contributes to the medical staff becoming frustrated and can contribute to the reaction that sees patients as a burden to be dealt with, perhaps harshly, and using as little precious staff time as possible.

Patient satisfaction has been shown to be low[9] despite the increase in medical staff salaries. Such factors are strong contributors to this, and many could be addressed.

Beginning with a bottom-up focus on PHC level, an SDC-supported program could work to support the appropriate assigned health partner to analyse the issues faced by patients in a number of representative facilities, using existing patient complaints/surveys as relevant and interviews with both patients and staff and relevant associations. From this, ideas could be generated, prioritizing those that are simplest to resolve, then moving to more complex issues over time. Some issues may be addressed by simple patient-flow changes within a clinic, or by producing simple guidelines, instructions, signs or SOPs. Other issues may be more complicated, such as reviewing and revising patient forms, mechanisms for medical staff to communicate with each other including telemedicine to gain expert opinions on conditions, or systems of referral and updating databases of health providers. Issues of ethics and compliance with regulations may also be identified, and suitable responses developed.

Issues that are able to be resolved at one facility could be relevant for other facilities to be emulated or adapted, and the planned SDC-supported program could develop ways to spread ideas of innovation management across the system - as a sustainable knowledge management mechanism such as through peer groups of clinical staff - either in large entity-level steps working with the authorities to bring the changes, or smaller ones area by area within the system, wherever possible cooperating with relevant partners along the way.

Relevant Associations (eg patient groups, professional groups) could be interested to be involved in promoting the ideas and engaging them in implementation.

The initiative could be complimentary with the planned WB health loan project, identifying issues in implementation of the WB reforms at ground-level and seeking realistic solutions that please both staff and patients.

[9] Annual Action Programme for Bosnia and Herzegovina for the year 2018. EU Support to BH Health Sector Reform. 2018

### 4.2.3. Implementation Options

The project could comprise several main components. (1) To identify issues and find ways to address them, enhancing quality of care for patients and efficiency in the system. Also, (2) to support better information for patients through close work with Associations - such as those that represent the voice of the patients (and not forgetting the opinions of the medical staff). (3) To ensure patient feedback better reaches the relevant service provider/authority to build more trust in the system, with appropriate (checked) feedback published and addressed more transparently. Guided by ideas from patients and medical staff, information materials and official forms could be defined, developed and tested using mechanisms that are replicable and sustainable over the long term.

Peer networks could be developed around certain identified issues, and cooperation would be sought to support them to address the problems, and this could be combined with one of the other implementation options. This could be funded through a small grants program or even promoted as a normal expected activity by the authorities.

One mechanism for implementation would be to identify the **appropriate authorised health partner**.

The **agencies responsible for quality (AZKVA, AKAZ) are ideally placed** to further develop their capacities and take on a bigger role to bring about patient-centered improvements across the system. From the meetings during the Review mission they come across clearly as agents of change with great knowledge of the issues and high levels of enthusiasm to see improvements in the functioning and results achieved by the health system. SDC funding should support them, including backing them with a project structure/contracted partner, to fulfil their vision and ideas and let them be in the driving seat.

These are both agencies who have been given the legal remit to improve quality through almost all means possible including developing standards of care and management, managing certification and accreditation processes, education of staff on quality issues and spread of innovation. They work with specified quality coordinators in every facility and operate through hundreds of qualified assessors spread throughout the country. They hold annual Quality Days meetings with these staff, and encourage patient representatives to join in too, and collect enormous amounts of data that could be used to guide improvement efforts. However, the staff employed are already working at maximum capacity to achieve their current aims. Also, the majority of their funding originates from paid activities and they are currently unable to extend their roles to encompass more facility-level improvements. This last aspect brings up the issue of a conflict of interest, with the agencies facing potential pressure from the facilities to grade them well, since they are paying for the process. Both agencies have a number of internal mechanisms to reduce this possibility and, until now, no hospitals are facing any grave sanctions for non-compliance.

Unless there is government commitment from the outset, new staff would need to be hired and trained through project funds to promote better services for patients, and sustainable funding for this work would be in question. Although the agencies may be able to exert some influence over the policy-makers, they do not have regulatory power to enforce improvement ideas, and may face resistance from facility managers and staff.

It could also be implemented directly through the **health authorities at Canton level,** perhaps sharing responsibilities with the Canton Institute of Public Health, overseen by entity level MoH managers.

The MoH staff would have more authority to promote improvements in the facilities and, through the project, would benefit from training and support for the principles of quality management. But substantial training and support may be required, and there is the risk that - as with other project initiatives - with changes in the political situation, key staff may change position making the program less sustainable.

Another mechanism would be to **develop existing SDC programs** that could incorporate this strategy into the next phase of their project:

For example, the **Strengthening Nursing project** could integrate quality improvement into its training and develop teams at facilities to promote improvement. The ongoing program could integrate the concepts at an early stage in the system through the nurse training programs, and then develop a

system to support improvements. New project administrative system costs would be low. The Nursing project is able to consider to include these ideas in a future phase.

However, obtaining good system-wide information to analyse and plan improvements may not be so easy (but connections could be made with ASKVA and AKAZ and perhaps the HIFs). Sustainability could be an issue if new systems and structure (new teams) are required to be established, and funding for them is not planned within the system.

#### 4.2.4. Risks

Such a strategy may be seen to be critical of the existing services, and both authorities and medical staff may feel threatened and push back or not cooperate with the suggested innovations.

Some issues may prove difficult to resolve, requiring perhaps regular high level agreement to changes to patient flow patterns, guidelines and protocols, or official reporting or application forms.

If AKAZ/AZSKVA are selected for implementation, there is the risk that the support is unsustainable since they are mostly self-financing and such additional activities may not be sufficiently funded. These organisations are also viewed with some scepticism and distrust by the facility staff, who may reject their assistance.

There may be legal or policy hurdles to resolve depending on the types of intervention identified.

### 4.3. Ageing and Health in BiH

#### 4.3.1. Description

This is an existing SDC-funded program implemented by the Red Cross Society of BiH and its local branches with technical support from the Swiss Red Cross. Phase 1 of this project, from Dec 2020 to Dec 2024, covers five Municipalities and builds on work that has been done previously without SDC support. This is planned to be followed until 2028 by Phase 2, with a focus on five more Municipalities. The objectives are to provide home-based care and active ageing initiatives through volunteers working with the Red Cross branches. New municipalities are selected based on an open call to the municipal Red Cross branches. Selection criteria will include clearly expressed willingness of the respective local governments to financially contribute to the project. In addition, the institutional capacities of RCSBiH to sustainably manage the ageing and health services will be further strengthened and embedded within the social welfare systems in the country.

An option for the future is simply to expand the funding for this effective initiative, and to scale up the geographical scope of the project to encompass as many municipalities as quickly as possible, without losing quality of care on the way. This may mean a clear focus on strengthening the capacity of existing or new implementing organisations such as the SRC and the RCSBiH in terms of administering the program. It may entail building a bigger group of implementers by initially training/mentoring more trainers and experts and enabling them to identify, encourage take-up and implement in more municipalities with a view to covering as much of the entire country as is feasible.

#### 4.3.2. Rationale

The project has proved itself effective and is building sustainability in its strategy and actions, with ten implementing partners co-financed by their local governments. In the five new partner branches, the local governments cover between 10-18% of the service costs. In 2021, 906 older people (66% women and 34% men: difference most likely due to women having a longer life-span) received home-base care services and 15 additional active healthy ageing groups established themselves. The 50 active healthy ageing groups and the cantonal Active Ageing Network provided platforms for community engagement, advocacy initiatives and policy dialogue and 1522 people (67% women, 33% men) actively engaged as members of these groups.

Demographic studies show that there is an increasing proportion of the population who are elderly, so this is an area in which the needs of the elderly are growing.

Various actors have stated that ageing is a growing issue.

This initiative has a clear focus on the vulnerable and focuses at community (PHC) level.

### 4.3.3. Implementation Options

To contribute substantially more funding to the existing SDC-supported **Swiss Red Cross Ageing and Health** program to enable the future phases to expand to many more municipalities with an aim to reach the majority of the population over an agreed period of time. Other NGOs that wish to emulate these mechanisms could also be involved, including for example Hilfswerk International who replicated significant elements of the Swiss Red Cross model in organising home-based care in Sarajevo

This model is already working successfully, and plans are in place for some scale-up. However, to scale up faster, very specific capacity development is required that may require some time and cooperation to be developed.

Alternatively, it could be implemented with a technical support structure, to directly contribute **small grants to RCSBiH local branches** to develop Ageing Health programs using the existing model. Technical support would need to be provided, perhaps from existing trainers (SRC) or from new identified contractors.

This mechanism promotes the autonomy of the RCSBiH branches and could promote sustainability as one branch helps another. However, coordination of the activities and getting buy-in from branches could be very complex to arrange, and capacity building of trainers to a sufficient quality may take time.

### 4.3.4. Risks

SRC is unwilling to expand their activities further

There is insufficient capacity of implementing leaders to expand the activities wider and faster

Insufficient Municipalities are willing to be involved and co-fund the activities

If Municipalities change leadership on election day, will they cease their co-financing of the RCSBiH. But even if there is a change, there is usually a lag time of 1-2 years before previous funded activities may be stopped.

## 4.4. Cancer Screening

### 4.4.1. Description

Some types of cancer can be cured if detectable signs are picked up early-on in the disease. The classic ones include breast cancer that can be detected accurately with mammography, cervical cancer that can be detected with a smear test, prostate cancer that can be picked up with a blood test and colon cancer that can be detected using colonoscopy.

Breast cancer could be the first to be targeted since there is already some screening going on, it is non-invasive, and focuses on women's health. But any of the other cancers could also be considered as a priority. As a potential starting point it requires, first and foremost, a comprehensive system of screening matched with extensive and effective awareness raising of the population. Mammography equipment is available in some areas, and more can be procured if the needs become more well recognized and demanded.

### 4.4.2. Rationale

Detecting and averting cancers early can reduce tremendous suffering and also save costs on treatment when cases are detected late. This is counted as a form of NCD by the WHO, with PEN protocols developed for Breast and Cervical Cancers[10].

During this Review, several informants including the FBiH MoH, the Zenica-Doboj Canton Minister of Health and medical staff at the Zenica PHC Outpatients Clinic, have highlighted the need to better organize screening for early detectable cancers especially for breast cancers. They have explained that management of the process is the key issue to be addressed, and guiding expertise from external experts is needed to establish effective mechanisms.

[10] https://www.who.int/publications/i/item/9789240009226

For breast cancer, the means of detection are available in some places, and machines are able to be purchased or rented. There is a project supported by an Italian NGO in Zenica-Doboj Canton that is helping to carry out mammography screening in the Canton. The Think Pink NGO is also promoting its use more comprehensively across the country. A particular benefit is that they had digitalized the system, so the interpretation of the screening images is done by the first available radiologist at the cantonal level, as the IT system automatically recognizes the first available slot in their schedules. This also optimizes the utilisation of the human resources and available expertise that is, in general, lacking.

Switzerland has an established breast screening system that is developing over time[11] and can offer expertise in this area.

This is a project that promotes gender equality and takes into account the vulnerable population if services can be offered at no direct cost to those participating.

### 4.4.3. Implementation Options

Screening for breast cancer could be carried out as part of the planned NCD-focused **"Healthy Communities in BiH"** project with a clear task given to community nurses and communities to raise the level of awareness among women to undergo mammograms, giving clear information packages perhaps in association with an NGO such as Think Pink.

The planned programme still has time to take this into consideration for planning, and community nurses (who are mostly female) could easily support the education and awareness raising strategy. However, the government authorities may not see this as a priority disease in comparison with others that are under consideration for the project.

### 4.4.4. Risks

That there are insufficient mammograms functioning or accessible for the population.

The population cannot be convinced to undergo (breast) screening for historical, cultural or religious reasons.

That the HIFs will not fund such a screening system over the long term.

## 4.5. Modular Trainings - Emergency First-Responder

### 4.5.1. Description

Doctors, nurses and medical technicians working in the Ambulance and Emergency units of hospitals and who provide first response treatment to emergency cases require training in the basics of emergency case-management. Currently this is run as a 3-month course in the FBiH by only 2 centers that are licensed to do so: Sarajevo and Mostar. However, many Cantonal health facilities cannot afford to send their staff to attend for two main reasons. First, because of the prohibitive costs of the course (1500KM excluding including travel, accommodation). Second, because there is a need to find replacement staff for the 3 months that they are away training. And third, due to the considerable cost of the training, it is felt not worthwhile if the trained member of staff then moves location or position.

Hence, there is an idea to analyse the training course and to look at ways to repackage it into short modules that cover certain key topics that can add up, over time, to a complete qualification, but which is much more acceptable for the facilities to send their staff to both in terms of replacing them and financially. A longer-term training may also encourage staff to remain longer with the facility. Some modules might be able to be adapted to be online, so that no travel costs whatever are incurred by the facility and minimal replacement time is required.

The principles established in adapting such a course could possibly also be developed for other current face-to-face training courses, such as the current Family Medicine training programme or others.

[11] https://www.unisante.ch/sites/default/files/inline-files/SwissMoni2010-18Report_final.pdf

### 4.5.2. Rationale

Several informants have mentioned the problem and costs of training staff over the course of the Review.

Training in emergency care is a form of Primary Health Care, and therefore relevant for consideration by SDC and the Swiss Health programme.

Reforming clinical training curricula are a specific expertise of Swiss experts, as exemplified in the Nursing and MH programmes in BiH, and in other programmes internationally (e.g., Kosovo and Tajikistan, as known to the Reviewer).

### 4.5.3. Implementation Options

It could be an add-on to the current **Strengthening Nursing** project or carried out in collaboration with the **Swiss Red Cross** or other agency with expertise in this field.

### 4.5.4. Risks

Centers with the license for teaching are unwilling to make the course available in short modules.

Since the courses will still have to be funded by facilities, there is no guarantee that staff will be funded to attend. To mitigate this, one module could be developed and tested initially to test acceptance and uptake.

Depending on the implementation mode chosen, if it is decided to have 2 projects working together (beyond synergies and coordination) this may need a lot of coordination time from the Embassy, which they may not be able to offer given the current constraints.

# 5. Potential and options for increased use of the country system and structures for future project implementation

This section offers a brief analysis of "options for intervention modalities and project setups as steps towards increased use of the country system".

Each of the existing SDC projects cooperates and collaborates with the country system to differing extents. These aspects were not analysed in any great detail during the Review, which was planned to be more forward-looking as opposed to assessing the functioning of existing projects. However, some reflections based on what has been read, observed and heard can be made.

- The IPD-led **Mental Health Project** has worked extremely effectively with the Primary Health Care centers to establish the CMHCs, to the extent that these are now a recognized part of the health system. The IPD itself is a national organisation, and its capacity has been built up to become recognized as a very capable implementing agency, with the wise plan to make full use of its potential as a lead implementer in the upcoming Healthy Communities in BiH.
- The **Strengthening Nursing Project**, led by FAMI together with the University Hospital of Geneva, has worked to strengthen a number of national organisations. These include entity-level nurses' organisations, enabling them to become the voice of nurses in decision making processes and protectors of the profession. The project has also collaborated with representatives of patients' Associations in identifying obstacles in access to care, voicing their needs, and participating in the design of the services. In addition, Entity and cantonal Ministries of Education (MoE) have become key partners in improving the education of nurses.

  Each of these national organisations has grown in capacity during the project phases and their strengths could be further harnessed in upcoming initiatives. For example, the nurses' Associations could become involved in supporting development of further skill sets such as for the proposed Palliative End-of-Life Care initiative; Entity and cantonal Ministries of Education (MoE) could become involved in health curriculum development such as for Emergency Care; and patient Associations could become involved in supporting the proposed Patient-Oriented PHC Organisation proposal.
- The single-phase **Medicine Integrity Project** has worked closely with the Association of Innovative Drug Producers in BiH to identify key issues and bring them to the table with top decision-makers. It is to be hoped that this Association may continue to play such a useful role in resolving other pharmaceutical issues on behalf of patients.
- The **Ageing and Health Project** led by the Swiss Red Cross has built up the capacity of numerous local branches of the Red Cross Society of BiH (RCSBiH) to establish an affordable model of home care for the elderly. These branches may, in time, become a recognized part of the fabric of the health care services and fully integrated, and could in future cooperate with potential SDC projects such as those proposed in Section 4 for "Ageing and Health" and, possibly, for "Palliative End-of Life Care".
- The **Challenging Gender Stereotypes Project** cooperates closely with local partner NGOs from Sarajevo (IDP), Banja Luka (Perpetuum Mobile) and Mostar (Youth Power) to enhance their capacity to reach out to the youth in their areas, which should hopefully continue long after the project funding is over.

A key feature of interventions supported by SDC is the desire and effort to promote sustainability. This is demonstrated by the longer-term perspective given to develop chosen topics such as the Community Mental Health, Strengthening Nursing programs and scaling up existing projects like Ageing and Health. It is also emphasized by allowing close-out phases to further ensure sustainability aspects.

However, even with these approaches, it is still best to build sustainability into the interventions from the beginning, and the following points should be taken into consideration in designing and implementation.

**A.** **Institutionalization**: Despite finding existing country organisations and systems to be weak, it is important to make strenuous efforts to listen to the leadership and to work through these organisations from the commencement of the intervention, developing their capacity at every opportunity to ensure enhanced use of country systems. This may take more time to negotiate and organize in the early stages but will likely reap rewards later when funding is reduced and the national organisation is still able to stand on its own feet, funded through national budgets and accepted as a normal part of the system. If this

institutionalisation is not prioritized early on, even a late handover after development of inputs may not be sufficient for an "outsider" intervention to be able to continue.

Having said that, there should be realistic expectations of what can be provided from the side of the Ministries of Health - whose limited human resources are stretched - to oversee and coordinate the growing number of health initiatives (SDC, WB, WHO, Unicef etc.) in addition to their usual government tasks.

There is a critical elaboration of such intervention modalities in Section 4 (described above) which offers a number of directions for making increased use of the country system in five potential future SDC-funded projects. For each of these, under their third headings "*Implementation Options*", there are descriptions of various implementation modalities which include, where it seems feasible and with some critical analysis, the idea to make better use of existing country systems. These country mechanisms are summarized below:

- **Palliative (End-of Life) Care** proposal could be implemented as an extra role for the CMHC teams at the PHC centers. These CMHCs are now well established and funded through the system, meaning that they are part of the current health system structure. Involving them in providing end-of-life care may be a way to both make use of this system and to strengthen it thorough increasing the capacity of the CMHC staff to provide at least some aspect of supportive end-of-life services perhaps more liked to the mental health care needs of those in their final phase of life.

  Nurturing a public-private partnership is another option, with at least one known private clinic (Brcko) offering some end-of-life services. Again, such a strategy would be to work with the existing services (which, because they function alongside the public system, can be said to be a part of the entire health system) and could be a means to strengthen them, ensuring up-to-date training and care protocols are promoted and supported.
- **Patient-Oriented PHC Organisation** proposal could be implemented through the existing agencies responsible for quality, namely AZKVA and AKAZ. A detailed and critical analysis is given in Section 4.2.3 of the issues to be considered if choosing to make use of this option. They are both active organisations, integrated into the health system and with a positive record of achievement. However, they face conflicts of interest from receiving payments for the facilities they assess and lack staff to further expand their responsibilities.

  Another option described is to work through the health authorities at Canton level, perhaps sharing responsibilities with the Canton Institute of Public Health, overseen by entity level MoH managers. They would possess the requisite authority to push for improvements, but would require substantial training and support. They would also face a significant conflict of interest threat, since being critical of the performance of facilities under their jurisdiction is tantamount to claiming responsibility for their underperformance.
- **Ageing and Health in BiH** proposal could potentially be implemented through grants given to the local RCSBiH branches which, once established, could be said to become stakeholders of the local health system. Strengthening their role strengthens the role of local organisations.
- **Cancer Screening** proposal would need to work with the close cooperation of community nurses and communities to raise the level of awareness among women to undergo cancer screening (e.g, mammography). Such cooperation would be making use of existing country system, strengthening it in terms of empowering both staff and community members to improve their care for the population.
- For the **Modular Trainings - Emergency First-Responder** proposal the suggestions are to cooperate with medical trainers familiar with modern training methods, for example those trained through the SDC nursing program. These trained trainers could become involved in developing the training modules using a modern adult-learning techniques, and their involvement - probably under supervision by international experts - should strengthen their capacity to develop such programs, leading to the possibility of modernising other educational topics in the future. This national involvement could strengthen development of the teaching curriculum, in cooperation with existing national Emergency Care specialists**.**

Other detailed suggestions for using the country system for the design of the Healthy Communities in BiH are covered in Section 6 below, including to work closely with existing government agencies including the relevant Ministries of Health and Public Health Institutes, under the coordination of the IPD.

**B.** **Existing instruments** should be used whenever possible rather than creating new ones. Often, development partner-supported interventions are under time pressure to show results and, therefore, implementers may be tempted to introduce new systems. For example, a monitoring system may be established that is in parallel to existing systems, or diagnostic tests conducted using outside contractors, equipment etc. in order to measure and demonstrate rapid success. The time and effort needed to work with existing systems to assure sustainability may appear to reduce the expected level of achievement in terms of fulfilling Logframe indicator-targets, and this needs to be taken into consideration by the implementing agency through open discourse.

**C.** Whenever possible, **experts from the diaspora** - who have developed relevant knowledge and skills and who are accepted from a cultural-political perspective - could be sought out and involved, even intermittently. Examples of individuals who are being invited by the entity Ministries of Health, sometimes through the medium of video-conferences, were provided during the review mission. They may be able to share their insights for training, skills development and critical thinking especially with regard to management and organisation of services. Their knowledge of the context, culture and language - combined with an outside perspective of what can be achieved - may be an invaluable contribution.

**D.** It should be noted that, although there may be excellent interventions developed internationally, it is not always the case that such ideas can be copied directly into the BiH context. Such **models should be tested and adapted** to ensure the suitability to the local situation, and flexibility to allow for this should be designed into the design and implementation stages.

# 6. Healthy Communities in BiH - Concept Paper

## 6.1. Introduction

The Review team studied the pre-final concept paper dated 16 September 2022 with the working title, "Healthy Communities in BiH" (Mobilization of community resources with the aim of improving the health and prevention of NCDs at the individual, family, and community levels).

In addition to reading the document in detail, the consultants also spoke to relevant stakeholders to find out more about their ideas, interest and commitment to the project concept. However, as described in the paragraph on limitations in Section 1 above, other aspects of the Review were considered of higher priority, and there has not been time to look in great depth at how the project could be designed and integrated into the health system and/or other sectors. A general analysis is made, and suggestions are offered that may support the successful planning and development of this project.

## 6.2. Critical Assessment in view of this Strategic Review

Healthy Communities in BiH conforms with **desires of both Entity Ministries** to focus on prevention of NCDs combined with promotion of healthy lifestyles and the project has been developed with high level involvement of the Entity Ministries from the start. This means that SDC are being pulled to support the government initiative, rather than trying to convince and push the government into agreeing. This augurs well for a successful programme.

It makes sense to **focus on NCDs** because it has become clear – especially highlighted by COVID-19 with its propensity to cause more severe disease in those with high risk factors - how important they are to be addressed. Prevention always costs less than cure, hence it also makes economic sense in the light of the long-standing budget difficulties faced by the Entities, highlighted by the need for adjustment and support proposed in the planned WB Health System Reform Project loans. One research paper[12] analysed six interventions targeted at adolescent tobacco smoking, heavy episodic drinking and obesity and that were supported by effectiveness and cost-effectiveness evidence. Based on a population-level cohort of adolescents in 70 representative countries, the global mortality consequences of fully implementing these interventions over 2020–2070 using the potential impact fraction approach was calculated. This showed that for every $1 of public money invested, $5 are gained in increased human capital.

The proposed project also aligns in terms of its emphasis on running key aspects of the project through the existing **government agencies**, with outside technical support provided as needed through the IDP. This approach is one that builds capacity of the health system and is more likely to ensure sustainability over the long term.

Working to **involve the community** and promote their participation also fits with the approach proposed in this Strategic Review, continuing the long-term focus of Swiss involvement at the PHC level, where the needs of the highest proportion of the population are met.

If the project is able to ensure more accurate collection of data of those with NCD risk factors, especially if it catalyses **effective digitalization** innovations and promotes compliance with reporting requirements, this is also an aspect that aligns with the Strategic Review findings.

With its main focus on the community, working in collaboration with Associations that represent various patient groups, the project may be able to influence the health system, at least at the **PHC level**, to become more patient oriented in the domain of clear, rational patient pathways for awareness raising, diagnosis, treatment and follow-up.

The "Healthy Communities in BiH " approach is taken from Canada, and it is recommended there should be an analysis of this approach and flexibility built into the project to learn from and **adapt as necessary**, perhaps even Municipality by Municipality. This is because models developed elsewhere may not easily be replicable in the context of BiH.

[12] Watkins D, Hale J, Hutchinson B, et al. Investing in non-communicable disease risk factor control among adolescents worldwide: a modelling study. BMJ Global Health 2019; 4:e001335.

## 6.3. Issues identified in the Pre-Final Concept Paper

The project rationale is described in detail and at length, and the overall expected outcomes appear to be logical and are highly ambitious. The Consultant has identified a number of issues that should be addressed that may help to clarify the design and ensure successful, sustainable implementation.

1. The project is entitled "Healthy Communities in BiH " and this is taken from an approach **developed in Canada**. However, there is no reference to this approach - nor its history, impact, or costs - in the document.
2. At the PHC level, it is mentioned that diagnosis of risk factors and management of them will be undertaken. However, it is not clear **how PHCs will be organized** to do this (role of PHC staff: doctors, nurses, others), what resources will be needed in terms of personnel (who are most likely limited in number), equipment and supplies and any required changes to the structure of patient flow within the facility.
3. The **leadership role** of IPD in the management of the project is not clearly described. The key involvement of MoH and the PHIs is mentioned, but the division of responsibilities is not elaborated in any detail. But it is vital to explain the roles of these 3 actors, in order develop a realistic appreciation of who will do what, leading to a clear idea of what sort of capacities and logistics and organisational setup will be required.

   Linked to this, there is no clear logistical concept about how the PHC facilities and community work will be established and supervised. What effort will it take to establish a Disease Prevention Center, who will oversee it, how many visits are needed? Once established, who will supervise, how often will they visit and what training and support is needed for these supervisors? Such detailed planning is not required for all sites, but an overall concept would help considerably to understand the feasibility of the proposal.
4. What are the ways in which health promotion/prevention be carried out in the **Disease Prevention Center**? Will it be through handing out relevant information brochures, posters on the walls, video teaching slots shown on a television in the Center and Waiting Area, personal counselling etc.
5. For longer term sustainability, it is not clearly described **how such services will be resourced** - at PHC level and in the community - including staff salaries, equipment and ongoing purchase of supplies/ IEC materials, and transport costs to reach the community if needed. From where will the staff come who will take on these responsibilities? The worst case scenario is that, if the PHC facilities feel compelled to establish the Disease Prevention Center, they will reassign staff from departments where they are needed, and patient care is diminished in those departments.

## 6.4. Suggestions to address the issues

1. Include a section in the paper to explain the **origin and history of this "Healthy Communities in BiH "** approach, its key features including how it was organized at the community level (who did what?), its impact - preferably over the longer term, and some idea of the costs required and how it was financed.

   Understanding the original context and development may help guide the current program in identifying the key principles, and then to find ways to adapt them for the BiH situation (or build into the design some room/flexibility that allows for the model to be adapted as the project progresses).

2. Develop a clear **logistical concept** to explain how the Disease Prevention Center will be developed. This needs to be done using the experience gained from visiting several different types of PHC facilities (eg urban/rural, large municipality/small municipality). The role of primary care in controlling NCDs at PHC-level is more than a first point of care; it is the core process of a health system. It is accessible to all patients and can undertake the management of early stages of NCDs when it moves from delivering an episode of care to providing an integrated approach that includes prevention, diagnosis, treatment, and palliative care for all conditions and over time[13].

   Examples of how this could look are given below.

[13] Varghese C et al. Better health and wellbeing for billion more people: integrating non-communicable diseases in primary care. BMJ 2019; 364 :l327 doi:10.1136/bmj.l327. Accessed at https://www.bmj.com/content/364/bmj.l327

Figure 3 illustrates a patient flow diagram showing the option for a doctor to refer relevant patients to the DPC when they think it is justified. Patients may then be sent home by the DPC staff, or else referred back to the doctor for further tests or counselling if required.

International experience of screening for NCD risk factors varies between countries. In England, family doctors working in PHC clinics (General Practices) are monitored by the Quality Outcomes Framework (QOF), in which are a number of indicators for aspects of care related to identification and management of the NCD risk factors. All the clinics have digital patient record systems and strict records are kept of each patient for monitoring the factors, including for body mass index, diabetes, hypertension, cholesterol and more.

According to the QOF, doctors are paid a moderate proportion of their earnings according to how well they control the risk factors in their patients. It takes considerable time to keep the records updated, and extra nurses are employed to manage the process to ensure targets are hit. Such a digitalized system is expensive to maintain (including all the resources needed to analyse the data and make the commensurate payments), requires high levels of funding for initial setup and, hence, may not be very applicable for BiH. It has also led to a lowering of morale among doctors, who feel that medicine has become too tick-box, bureaucratic and too little patient-focused. However, if the DPCs are established in each clinic and run by assigned nursing personnel, monitoring systems can be set up to ensure data of patients seen in these centers are consistently recorded and then used to help improve the services provided. This could be done without additional financial reimbursement, instead providing effective feedback of the analysed data direct to the clinic staff to guide them in their work: it will, however, require an effective data collection, analysis and feedback system across the participating facilities that could be the responsibility of the PHIs, or perhaps under the Quality Assurance system (AKAZ, AZKVA).

The SDC-supported AQH project in Kosovo has established the PHC Health Resource Centres[14] where motivational counselling is offered to patients and those otherwise identified for management of NCD risk factors.

**Figure 3: Example of patient flow diagram showing option for doctor to refer relevant patients to DPC**

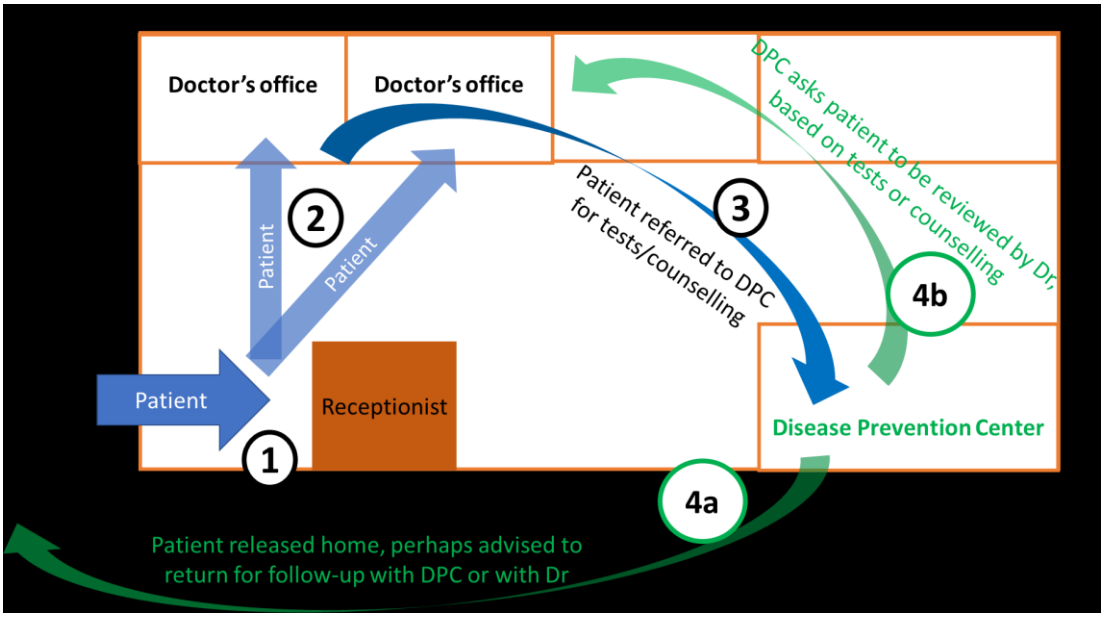


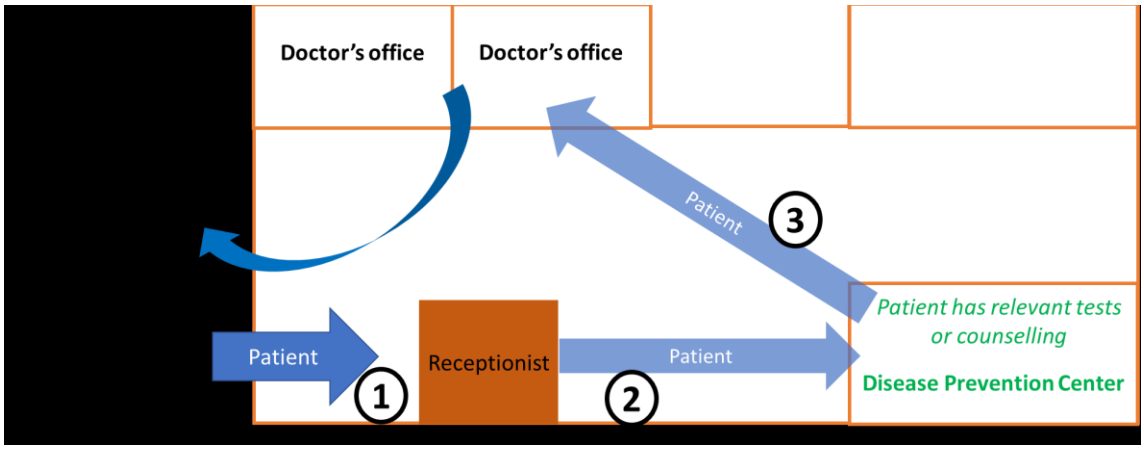

Figure 4 below is an alternative patient flow mechanism, in which patients are first "triaged" through the DPC for basic screening of risk factors (body mass index, blood pressure, glucose, smoking etc) and may then proceed on to be consulted by the doctor. This ensures a higher proportion of patients are comprehensively

[14] AQH Project. Motivational Counselling to combat Non-Communicable Diseases in Kosovo. 2022. Accessible at https://aqhproject.org/motivational-counselling-to-combat-non-communicable-diseases-in-kosovo-2/

screened for risk factors, but this also creates a "bottleneck" and may result in delays to see the doctor depending on the capacity of the DPC in terms of staffing, equipment and space.

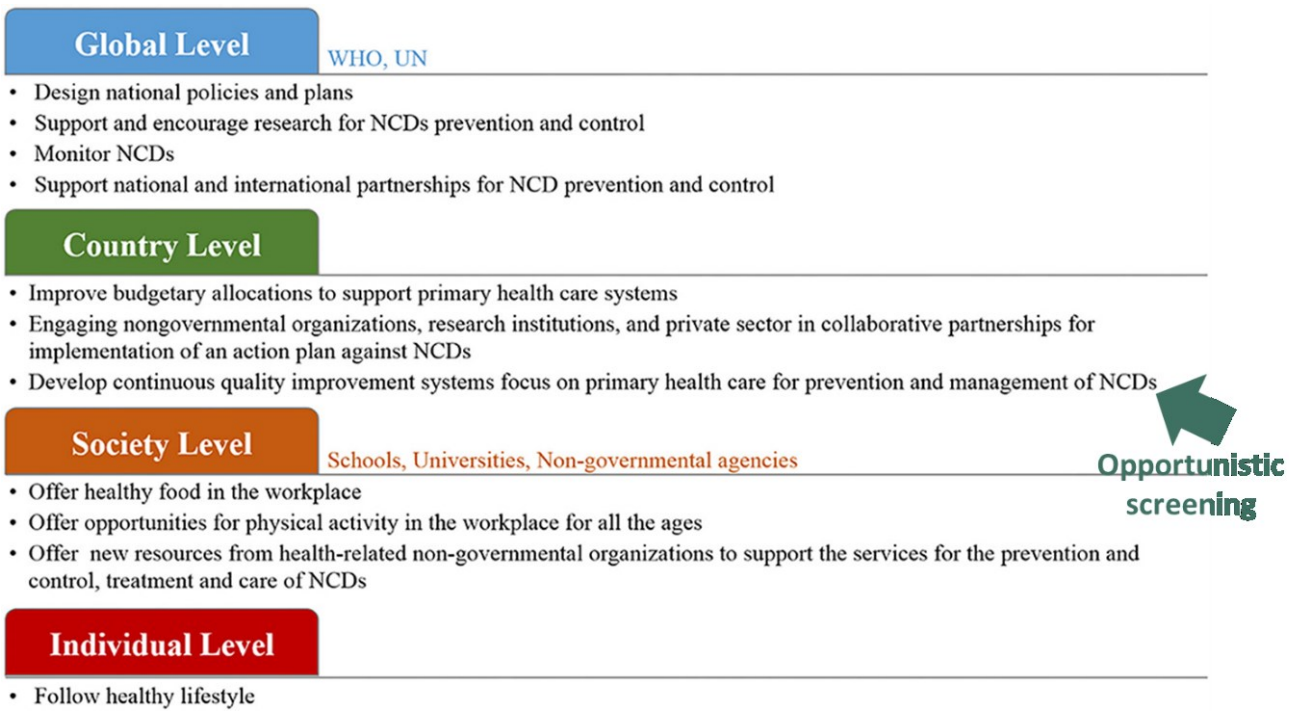
The advantage is that it should enable more comprehensive monitoring of NCD risk factors with less reliance on doctors to "refer" patients to the DPC. This is a system used in Kyrgyzstan, where PEN protocols are being implemented through in a number of WHO pilot health facilities[15].

**Figure 4: Example of patient flow diagram showing option for DPC to check patients prior to doctor**




Both the above examples illustrate how **opportunistic screening** can be carried out, "catching" patients who turn up at PHCs for their perceived health issues and, if possible, bringing in others from community outreach activities. This is a very efficient mechanism for identifying those with risk factors, since they are attending the clinic of their own volition and using their own resources. This level of activity at the PHC facilities is highlighted in Figure 5 below, which shows such activities in the overall context of other potential levels of intervention[16].

**Figure 5: Proposed prevention management of NCDs with small and large-scale human cooperation**



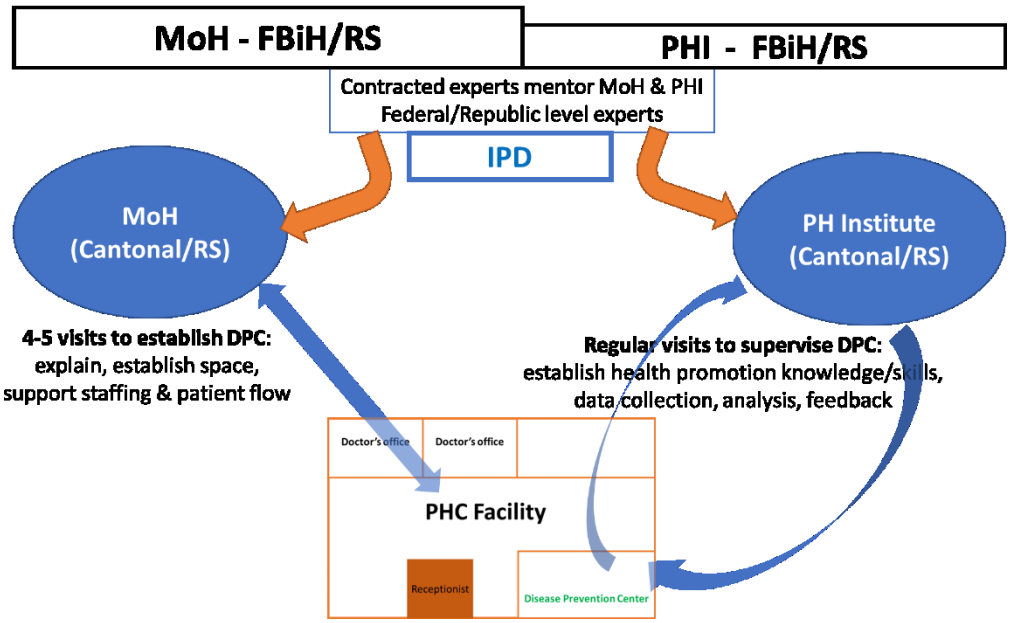

[15] Collins D et al. Improving the implementation of a package of essential noncommunicable (PEN) disease interventions in Kyrgyzstan: mixed methods service evaluation of pilot health centres.WHO 2017. Accessible at https://www.euro.who.int/__data/assets/pdf_file/0011/355961/PEN-implementation.pdf

[16] Budreviciute A. et al. (2020) Management and Prevention Strategies for Non-communicable Diseases (NCDs) and Their Risk Factors. Frontiers in Public Health. 8:574111. doi: 10.3389/fpubh.2020.574111. Accessible at https://www.frontiersin.org/articles/10.3389/fpubh.2020.574111/full

3. The **leadership roles** of the MoHs and PHIs and initial concepts of how they are supported by the IPD should be considered and explained in the paper, giving a perspective of their capacities at various levels of the system.

An example of how this could be illustrated is given in Figure 5 below, but this needs to be adjusted based on the findings/reality from assessing a representative sample of the municipalities.

**Figure 6: Example of organisational setup to establish and supervise the DPCs**




This organisational setup is important to conceptualise, in order to understand how the capacity for travel and support that those in the MoH and PHIs will need to establish well-functioning DPCs. Developing too many, too quickly with insufficient support will lead to demotivation of the staff, poor perception by the population and, ultimately, ineffectiveness of the initiative and failure to impact the health of the population.

4. Some more detail should be given about specific **types of NCD prevention and health promotion** activities that are envisaged and how they are introduced to the population.

PEN protocols are developed by the WHO which focus on some of the key NCDs. They have accompanying guidelines and materials that can be used to guide clinic staff in each step of the process. In order to implement, certain tests are required that are specific for each type of risk factor (weighing scale and height measure for BMI, blood pressure cuffs, glucose testing kits, cholesterol tests, etc). Setup of this aspect of disease prevention requires knowledge, skills and leadership that works with the facility to find the right way

A stepwise approach focusing on one priority topic at a time would allow training materials to be developed, tested and taught in a way that best ensures their effectiveness, and simultaneously population IEC materials can be developed and perhaps introduced on a special "National Day to Prevent…" National or local media could advertise the event, and DPC staff would be trained, equipped and prepared to offer tests and counselling as needed.

As has been done in other NCD projects in low-middle income countries, DPC staff should be supported to develop their skills and capacity one topic at a time, perhaps beginning with the risk factors for cardiovascular disease: this gives time to develop systems of training, mentorship and PHC organisational mechanisms adapted best to the local situation.

With respect to reaching relevant types of people, different strategies can be used. Opportunistic screening of allcomers to the PHC clinics is an extremely efficient approach that has a higher likelihood of identifying those with risk factors and provides a natural environment for sharing information on health issues.

In terms of community-level interventions, studies show that many approaches are used depending on local circumstances and possibilities. In a systematic review[17] using controlled before-after studies of 36 relevant community programs to address cardiovascular disease that took place from 1970 - 2008, there was demonstrable net reduction in 10-year CVD risk. These programs were multifaceted interventions including a media-based approach, with combinations of radio, television, and printed material to communicate heart health messages. Many programs also included screening interventions, individual and group counseling, and environmental changes. Health departments, local health committees, voluntary organizations, and community volunteers had roles in program delivery, and interventions were delivered in a variety of settings, including workplaces and schools.

For BiH, this means that children can be reached through community staff visiting their homes or when they attend school (ideal to build health messages into the school curriculum, opportunities to improve fitness, healthy meals), men and women can be reached in their workplaces either by changes to the work environment (fitness promotion, healthy food) or though media that they have access to (radio, TV messages) or directly by outreach visits by community workers/volunteers.

5. Some understanding of **how the various actors will be funded/staff assigned** is also needed and will be vital in any pre-commencement negotiations with the authorities.

This will help to assure that any proposed mechanisms are feasible, preferably with precedent, and not just spoken casually, delegating the payments to local budgets of lower-level institutions who, in reality, may be unable to fund the additional activities.

For example, it could be explained by officials that health promotion materials will be paid for from existing the PHC budget-line but, even if such a budget line exists, it may well be used in most facilities for other priority issues. Another example would be that travel by vehicle to the facilities by PHI staff will be paid out of the PHI budget: but if their budget is not increased for this purpose, when implementation starts there may be no available funds to allow this to happen.

The same is true for allocation of staff to the DPC. Once it is clear what their role will be, the number of patients they may see (depending on the type of patient-flow model selected and the amount of community-related activities they will be expected to perform) needs to be gauged through visits to a small proportion of facilities to find out where such staff could come from, and how – if at all – their reassignment from another department might affect that department.

Suggestions to address potential mismatches between theoretical/actual funding and staffing availability include (1) to do an analysis of some PHC facilities to understand their current PHC budget lines to clarify what is allocated for public health activities and how it is currently being used and to consider how such funds may be ear-marked for these activities without reducing other aspects of care (2) to similarly assess the PHC staffing levels at these sites and assess how the DPCs can best be staffed without affecting other departments.

If solutions are found during these assessments, this carries the benefit of confirming that the initiative is feasible without relying on higher level changes or commitments. In parallel, (3) a study of these aspects could be made of existing similar initiatives, such as the DPC set up recently in RS, to ascertain how funding and staffing was established and how replicable and sustainable this is at other sites.

Depending on what is found, the next step could be to (4) begin discussions with relevant authorities to resolve any bottlenecks in the system that prevent sufficient funding or staffing levels for the DPCs.

[17] Pennant M et al. Community Programs for the Prevention of Cardiovascular Disease: A Systematic Review, American Journal of Epidemiology, Volume 172, Issue 5, 1 September 2010, Pages 501–516, https://doi.org/10.1093/aje/kwq171

# 7. Summary of Key Recommendations from the Review

Recommendations are taken from the main body of the Review and are summarized and reworded here, ordered according to the section from which they are taken.

## From Section 3.1 (Background)

i. The pandemic has underscored the importance of SDC keeping a key focus on having a strong, effective and crisis-resilient system of primary health care (to identify and reduce NCD risk factors that have been shown to be key to reducing COVID-19 morbidity and mortality, and to reduce the workload placed on the hospital system).

ii. It has also shown how new digital tools have proven invaluable (and will be important for SDC to consider to build on in all the projects of the sector), allowing efficient communication between actors and enhancing access to needed information and educational materials.

## From Section 3.2.2 (Relevance)

iii. Changing demographics (increasing proportion of elderly) mean that there will be a higher proportion of people requiring end-of-life care, and lack of sufficient services both in terms of quantity and quality has been mentioned as a priority issue to be considered for future projects by both the SDC team and to the Reviewers by several parties including representatives of the MoH.

iv. The planned WB "Health Systems Improvement Project" seeks to address numerous efficiency issues, and SDC is aligning itself with this project through the Multi-Donor Trust Fund. SDC's on-the-ground knowledge and experience in this sector should be used to the maximum to guide the analyses and actions planned under the loan.

## From Section 3.2.3 (Strengths)

v. In contrast to many other development partners, SDC's long-term approach allows the possibility to build effective, long-term system-changes where goals may be exceeded and promote sustainability until the point is reached when certain standards or ways of working are accepted as normal. For sustainability reasons, this should be continued.

vi. SDC projects seek to enhance and support initiatives that have foundations within the existing system and are sustainable. For sustainability reasons, this should be continued.

vii. The "on-the-ground" presence of SDC leadership is highly appreciated and their ability and openness to listen to and understand viewpoints and obstacles faced by implementers should continue to be supported and promoted

viii. Availability of SDC staff to discuss issues with the implementing partners and to work flexibly with them to make appropriate adjustments to the project activities should also continue to be encouraged

## From Section 3.2.4 (Limitations)

ix. The SDC leadership style, closely monitoring procedures in the early project stages but later taking a more relaxed and trusting approach as implementing project managers become more familiar with their responsibilities is a commendable approach and should be continued.

x. When working with partners already implementing projects in the country, the Logframe monitoring tool should be adjusted to be as compatible as possible with any existing data collection tool.

xi. For coordination purposes, (1) the Ministry of Civil Affairs could be approached to consider inviting all the development partners at least annually (preferably bi-annually) to participate in the Ministerial Conference on Health, especially with the commencement of the broad WB loan project. (2) More regular meetings could be organized (preferably by the WHO, with SDC involvement as a major contributor in health) to update representatives of development partners on project progress and activities.

xii. Staff in the SDC office are at the limit of their abilities and time, and if additional tasks or projects are planned, support should be offered to ensure there is capacity when planning new projects that require sufficient time for policy dialogue, field visits etc.

xiii. While keeping the focus on PHC level, SDC projects should also be allowed some scope to consider how they may promote some degree of balance with higher levels of the system. This could, for example, include awareness raising with higher level facility staff of the implemented activities, sharing guidelines, giving access to aspects of the training courses.

## From Section 3.3.1 (Opportunities/Challenges)

xiv. Information sharing: all SDC project are already developing at least 6-monthly progress reports. These can be adapted with little effort to be made available to partners (and, eventually, the public) in order to update everyone to support collaboration and planning of activities. Face-to-face meetings for information exchange are currently being organised by WHO, and the purpose of these meetings needs to be very clear and reflected in the meeting agenda in order to keep the meetings effective and interesting.

xv. Coordination of Interventions: Such meetings (such as those held by the Ministry of Civil Affairs) should be infrequent and require significant advance planning allowing sufficient time to hold deep discussions for effective coordination of planning and activities.

xvi. Project Guidance: this refers in particular to the MDTF. How this is arranged in relation to other coordination meetings is important in order not to spend an inordinate amount of SDC staff time only in meetings. Several options are proposed to try to limit the overall number of meetings, including to review the roles and staffing numbers of SDC personnel.

## From Section 4 (Potential future directions)

xvii. 5 project ideas are proposed, each with a description of its purpose, the rationale for implementation, a critical explanation of possible implementation modalities, and overall risks. SDC must consider these options and, once one or more of these are agreed upon as potential candidates, further research and analysis is required to determine which ones will be promoted for funding and implementation.

## From Section 5 (Use of country system)

xviii.

xix. It is important to make strenuous efforts to work through existing country organisations, listening to their leadership from the commencement of an intervention, developing their capacity at every opportunity to ensure enhanced use of country systems

xx. Existing tools (such as monitoring or diagnostic systems) should be used (or adapted) whenever possible, rather than creating new ones

xxi. Excellent interventions developed internationally, should be tested and adapted to ensure the suitability to the local BiH situation, and flexibility to allow for this should be designed into the design and implementation stages.

## From Section 6 (Healthy Communities in BiH)

Detailed options and recommendations for planning and implementation of the project are given.

# Annex 1: Mission 1 Schedule June- July 2022 - internal only

# Annex 2: Mission 2 Schedule Oct – Nov 2022 - internal only

# Annex 3: Terms of Reference for Health Portfolio Review

# Health Portfolio Review

## Terms of Reference (TOR)
## Swiss Embassy (SCO), Sarajevo

### 1. Context of the review

Health outcomes in Bosnia and Herzegovina (BiH) are among the worst in the region and Europe. BiH is spending more than it can afford - almost 10% of GDP - on health, but the health system is not financially sustainable and at risk to collapse. Even though formally committed to reforms and EU accession, BiH lacks the financial and technical ability to undertake and implement demanding reform processes. According to the Global Competitiveness Index, BiH is among the top ten countries with the highest brain drain, with particularly medical professionals increasingly leaving the country. The population of Bosnia and Herzegovina (BiH) is rapidly ageing. Currently 18% of it is older than 65, while life expectancy is 77. It is estimated that in 2060 there will be more than 30% of persons older than 65 in BiH.

Reflecting BiH's complex constitution, health care insurance and services are highly fragmented. The health sector is expensive, inefficient, and suffering from poor service quality, limited skills and accountability. Insufficiently defined standards for medical treatment and profession lead to unnecessary duplication of services and cost increase. The patients' care and quality of services remain inadequate, especially for those suffering from complex or chronic health problems such as NCDs (non-communicable diseases)[18]. Poorly planned services and weak governance negatively impact the quality of care. Citizens do not trust the health care system, its quality and ability to respond to their needs and ask for urgent reforms[19]. During the COVID-19 outbreak, increased pressure on the health care system revealed long-term inefficiency and outdated approaches to the organisation of the service provision. This further contributed to citizens' perception of not having access to adequate health care[20].

In 2020, the WB conducted a functional review of the Bosnian health system. Main findings highlighted numerous deficiencies, pointing to five key constraints to be addressed in both entities: (1) weak preventive and primary care, (2) inefficiencies in the in-hospital care, (3) lack of effective financial controls, (4) weak incentives and accountability and (5) under-funded health care system.

In the Health sector (where SDC plan to spend about CHF 11 Mio over the period 21-24), Switzerland has supported health authorities by improving accessibility, quality and safety of primary healthcare. Special attention was given to strengthening health promotion and disease prevention as cost-effective investments in improving the health of the population. Thanks to Swiss support, BiH citizens have now increased access to **standardised, gender-sensitive services for the prevention of cardiovascular diseases**. Significant contributions have been made to improve the framework conditions for reducing health risk factors in the country, including tobacco control. **Affordable and sustainable models of primary healthcare** were developed in the areas of **nursing, home-based care for the elderly and mental health**, and these have a strong potential to be scaled up. The relevance and effectiveness of these models were also proven during the COVID-19 pandemic, as they enabled continued service provision for the most vulnerable populations, despite the crisis-related restrictions.

Swiss support also contributed to improve the access to health for socially excluded persons who increasingly benefit for example from **community nursing services** and also **home-based care for elderly** people. **Young people were also reached through health education** sessions aimed at promoting healthy lifestyles and fighting health-related gender stereotypes. Four municipalities embraced a **community health promotion model**, based on multi-sectoral cooperation and the promotion of healthy lifestyles. A **care coordination model was introduced in mental health facilities** across the country and improved the quality of life for people with severe mental disorders and for their families. The hospital referral rate of patients with mental disorders has significantly decreased due to improved services at the primary healthcare level, generating important savings for the health system. Switzerland

[18] NCDs account for 80% of the country's annual deaths (highest in the region), with a high hospitalization rate.

[19] World Bank poll conducted in 2019

[20] App. 20 % of BiH population remain without any kind of health insurance

took also an important role in bringing together development partners for concerted policy influencing and pushing for reform in the health sector.

The ministers of health of both entities have developed concrete ideas of support in terms of health promotion and disease prevention that are crucial for ensuring better health outcomes and reducing the burden of disease for the population. These are building on some achievements reached within the Swiss health portfolio in the past years in particular the **closed Reducing Health Risk Factors (RHRF) project** and the **Mental Health project** which is currently phasing out. As this proposal came also with a demand to partner with a national NGOs - the Institute for development and population (IPD) - for engaging in this endeavor, SDC encouraged IPD to further develop the initial proposal in dialogue with both MoHs, in view of developing a coherent and relevant Public Health Project.

## 2. Objectives of review

The main goal of the review is to assess the relevance and effectiveness of the Swiss cooperation in the field of health from a portfolio perspective and to provide strategic mid-to longer-term recommendations for the future orientation and focus of the SDC health portfolio.

### Strategic review

The review is to address the following strategic questions:

1. What are the main lessons learned regarding the reforms in the health sector the last 4-5 years and what can be learned from the Covid-19 pandemic? What should be the future strategic orientation of the portfolio? What aspects should be prioritized in the mid-to longer term for Swiss support to the health sector in BiH?
2. What are the main mid-to long-term scenarios (5-7years) in the field of health reform, what are the main current and future risks and opportunities? What are the opportunities and limitations for more use-of-country systems, strengthened governance of reforms and stronger institution building? (develop options and scenarios regarding portfolio development and a corresponding overview of risk/opportunity matrix)
3. How can the strategic coherence and relevance of the Swiss health portfolio be strengthened given the needs and challenges faced by the country? Which Swiss expertise would be of particular interest in the current context of BiH in the health sector? Develop a coherent narrative of the Swiss support to the health sector in BiH based on a revisited rationale for continued support in the health sector and highlighting Switzerland's added values/ comparative advantages in relation to the needs for reforms, institutional strengthening and external support by other international actors. What is the scope for increasing the coherence of the Swiss health sector engagement with the other sectors of the Cooperation Programme?
4. Is the portfolio mix appropriate in terms of synergies and complementarities between projects? Is the balance between results at the systemic level vs. at people's level adequate? How should Switzerland strengthen its contribution to policy dialogue and development actors coordination at entity (cantonal) level? Is the partner-mix in the portfolio well-balanced and appropriate in the current context? Explore possibilities and relevance of Switzerland supporting private sector involvement in the health sector. Does Switzerland sufficiently empower local partners and sustainably build capacities at country level while avoiding substitution?
5. Recommendations should be elaborated for the engagement of Switzerland in health for the next 5-7 years. What are the main topics and issues on which Switzerland should put emphasis in supporting the health sector, what needs to be further strengthened and what are possibly new strategic directions to be considered. In line with these recommendations, 4-5 concrete project ideas (pipelines of projects starting 2023 and later) should be proposed and described for a strategic Swiss engagement in health, which would make the portfolio develop to better address the present day and foreseeable future realities and health related needs in BiH. Each of these proposals should identify clear entry points, main objectives, outline of possible intervention strategy, suitable partners and possible setup.
   These new project ideas should in particular strengthen the coherence within the portfolio and within the overall Cooperation Programme. They should possibly use the expertise of Switzerland in health sector (in country expertise) and take into account the available resources (financial and

personnel) at the Embassy. Furthermore, the proposed projects should be in line with the Swiss International Cooperation Strategy 2021-2024 and the Swiss Cooperation Programme in BiH 2021-2024 and be complementary with other donors' interventions in the sector.

6. The proposal for a new Swiss-supported public health project developed by IPD (in discussion with MoHs) should be critically assessed based on the conclusions of the strategic review. Support should be provided to improve the proposal (prodoc), address the main identified weaknesses and integrate the recommendations.
7. Develop a set of concrete options for intervention modalities and project setups as steps towards increased use of the country system[21] based on exploratory discussions during the fieldwork. This should include a critical review of modalities used in current Swiss supported projects. The note should describe possible options and combinations with their possibilities, potential strengths and weaknesses.

## 3. Methodology

Work methods of the experts include, but are not limited to:

- A desk study of key documents: health project documents, evaluation reports, policy papers, strategies, etc.
- Elaboration of an inception paper (maximum 3 pages) that summarizes the main findings of the desk study and ensures a broad understanding of the context and of the TOR. This inception paper should highlight the limits and/or the major issues of the consultancy.[22]
- Briefing with the Embassy of Switzerland in Sarajevo with the Head of Cooperation, the Head of Health Domain and the National Program Officer at the beginning of the mission.
- Field visits in Swiss funded project areas and non-Swiss project areas.
- Interviews with key actors in the health sector including state and non-state institutions: MoH of entities, health facilities, public health institute, health insurance fund, private sector actors in health, donors, international organizations, SDC implementing partners in health.
- Interviews or discussion with representatives from different development actors in health including WHO, EU, World Bank.
- Meeting with relevant NGOs/CSOs active in health and patients/ citizens.
- Workshop with the main stakeholders for testing / validating findings and options for strategic directions.
- Debriefing with the Embassy of Switzerland in Sarajevo (discussing key findings).
- Preparation of i) the strategic review report on the relevance, main achievements, limitations and challenges of the Swiss health portfolio together with recommendations for new strategic orientations; ii) 4-5 concepts for new project based on the review recommendations; iii) the note on possibilities and options for increased engagement in working with the country system in the health portfolio;.

## 4. Organization of the consultancy team and required profiles

An international team leader will be responsible for the preparation and organization of the consultancy process, and preparation of the draft and final deliverables of this mandate.

In order to select the international expert, several consultants will be invited by the Embassy of Switzerland in BiH to express their interest in this mandate. The international expert will be chosen by the Embassy based on his/her professional experience relevant to the mandate, combined with the quality of the technical offer (max 3 pages), and the competitiveness of the financial offer.

[21] For SDC using country system doesn't reduce to budget support as opposed to project based aid. A whole range of modalities/ set up aiming at developing government capacities, facilitating reform processes but also involving CSOs are considered steps toward strengthening the country system.

[22] The objective of the Inception paper is to inform the Client about the understanding of the context and the mandate and major issues that will be addressed during the field mission. It is an opportunity to clear up misunderstandings and/or ask for clarification of specific aspects mentioned in the Inception paper before the field mission.

The international expert should be free from any conflict of interest related to this consultancy.

A national consultant will support the team leader by providing relevant context-related information, particularly related to the administrative structure of BiH, the health system in BiH and division of responsibilities between the institutions, its governance system, organising the programme and logistics during the field visits and interviews. The national consultant will be selected by the Embassy of Switzerland. The national consultant should be free from any conflict of interest related to this consultancy.

**Required profile of the international team leader:**

- At least MA degree in public health, health system management or related field
- Substantial experience in the field of public health, health system strengthening, health promotion and related topics
- Good knowledge of the context in BiH
- Professional relevant experience
- Willingness to contribute to a team effort and to manage and coordinate the work with the national consultant
- Experience in working in complex settings
- Excellent analytical skills
- Excellent communication and written English skills
- Previous work experience in BiH or in the region is considered an advantage

**Required profile of the national consultant:**

- Degree in public health, health management or social sciences
- Experience in the field of health sector and related topics in BiH
- Strong knowledge of the health context and governance in BiH
- Good understanding of assessment processes and methodologies
- Excellent communication and written English skills

## 5. Timetable

| Activity | Period / Deadline | Workdays | |
|---|---|---|---|
| | | International Team leader | National consultant |
| **Preparation** | | | |
| • Desk study<br>• Inception paper<br>• Communication with the Swiss Embassy in Sarajevo<br>• Preparation of the field mission | tbd | 4 | 6 |
| **Field mission in BiH (main assessment)** | | | |
| • Travel to and from BiH<br>• Briefing and debriefing with the Swiss Embassy in Sarajevo<br>• Field visits and interviews<br>• Support to IPD for proposal review and improvement | tbd | 14 | 13 |
| **Reporting** | | | |
| • Sending the draft review report, to the Swiss Embassy | tbd | 8 | 7 |
| • Finalizing the review report based on the Embassy's comments | tbd | 4 | 4 |
| **TOTAL** | | **30** | **30** |

## 6. Requirements of the consultancy deliverables

(i) The Strategic review report should provide an assessment of the relevance, main strengths, limitations and challenges of the Swiss health portfolio in relation to the current most important country needs, together with recommendations for future orientations. It should not be longer than 20 pages (excluding executive summary and annexes).

(ii) A series of short concept (2-3 pages) with an abstract, main purpose, intervention strategy, recommended partners and setup, one for each of the 4-5 identified new project ideas (pipelines of projects starting 2023 and later) should be elaborated.

(iii) A short practical note of 5 pages based on consultation during fieldwork should map out the main options to be consider when developing new projects towards an increased use of country system.

All deliverables shall be written in English. The Embassy of Switzerland in BiH reserves the right to request changes in the structure of deliverables or the inclusion of additional information. Draft reports to be submitted electronically within 20 working days after the mission to BiH to the SCO in BiH.

## 7. Contract and logistics

The international team leader and national consultant will sign a contract with the Swiss Embassy in BiH. Transportation in BiH for the contracted services and interpretation will be organized by the Embassy for the field mission in the country.

# Annex 4: Desk study documents reviewed

### A. Directly related to SDC Projects


EU Support to BH Health Sector Reform. 2018. Annual Action Programme for Bosnia and Herzegovina for the year 2018.

Hinic M. for Swiss Red Cross. 2021. Ageing and Health 412925 Annual report. Dec 15, 2020- Dec 31, 2021

IBRD Project Appraisal Document on a Proposed Loan in the Amount of US$ 75 Million to Bosnia and Herzegovina for a Health Systems Improvement Project. Submitted to SECPO on 4 March 2021.

IBRD/ World Bank. 2020. Bosnia and Herzegovina Functional Review of the Health Sector.

Institute for Population and Development. April 2022. Eighth Progress Report 1 March 2021 – 28 February 2022 (V.1) of Mental Health Project in Bosnia and Herzegovina (Project), Phase III.

Katic-Vrdoljak I. for Fami Foundation. ProSes Phase 2 Annual Progress Report 1 Dec – 30 Nov 2021

Kerker M (healthFORUM) 2018. 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.

NET Consulting 2022. Semi-Annual Report: Improving the Integrity of Processes of Establishing Medicine Lists in Bosnia and Herzegovina. Sept 2021 to February 2022.

SDC. Domains Spreadsheet - SDC Porfolio Planning 2021-2024 (771.221-41). 2022

SDC. Swiss Cooperation Programme Bosnia and Herzegovina 2021–24. www. sdc.admin.ch/publications. Bern 2021.

SDC. Pre-final concept paper. Communities that care: Mobilization of community resources with the aim of improving the health and prevention of NCDs at the individual, family, and community levels. 16 September 2022

SDC BiH. Reduction of Health Risk Factors II PHASE. The Logical Framework. Nov 2020

SDC. Draft Project Document for Phase 2 of the Reducing Health Risk Factors Project in Bosnia and Herzegovina (7F-04362.02, phase duration: 2021 – 31.08.2025). Nov 2020

SDC (TANAL/FEH). Credit Proposal. Promoting Healthy Lifestyles and Gender-equitable Attitudes among Young Men and Women (Contribution to Young Men Initiative by CARE International). Phase 3: 1 January 2021 – 31 December 2023. (7F-08785.03). Nov 2020.

SDC (ZARMA/DBA). Credit Proposal. Mental Health Project in Bosnia and Herzegovina. Phase 3: 1 March 2018 – 28 February 2022 (7F-06515.03). Jan 2018

SDC (ZARMA/DBA). Credit Proposal. Strengthening Nursing in Bosnia and Herzegovina. Phase 2: 1 December 2017 - 30 November 2021 (7F-08142.02). Oct 2017

SDC (ZARMA/DBA). Single Phase Credit Proposal. Improving the Integrity of Processes of Establishing Medicine Lists in Bosnia and Herzegovina. Single phase: 1 March 2020 – 29 February 2024. (7F-10162.01). Feb 2020

SDC (ZARMA/DBA). Entry cum Credit Proposal. Ageing and Health in Bosnia and Herzegovina (7F-10435.01). Nov 2020

World Bank. 2022. Strengthening Transparency and Accountability in Public Financial Management in the Bosnia and Herzegovina's Health Systems – Pilot Study of Sarajevo and Tuzla Cantons. © World Bank.

World Bank. 2022. Strengthening Transparency, Integrity and Accountability in Public Procurement in the Bosnia and Herzegovina's Health Systems – Pilot Study of Sarajevo and Tuzla Cantons. © World Bank.

World Bank. 2020. Proposal for a Multi-Donor Trust Fund. Health Sector Strengthening in Bosnia and Herzegovina.

World Bank. 2020. Annex: Proposed WB Assistance to Deal with Debts and Improve Performance of Health Care Systems in the Federation of Bosnia And Herzegovina. October 2020

WHO 2021. Roadmap for Health and Well-being in the Western Balkans (2021–2025): Summary: European Programme of Work (2020–2025) – "United Action for Better Health" Document number: WHO/EURO:2021-3437-43196-60510

World Bank 2016. Reducing Health Risk Factors in Bosnia and Herzegovina Project (Revised project concept)

Zaric M, Rebac B (WHO), Kostallari L (World Bank). July 2022. End of Phase Report 2012 – 2019 for Reducing Health Risk Factors in BiH. (7F-04362.01)

### B. Background research on topics related to planned SDC Projects

Aebischer Perone et al. Addressing the needs of terminally-ill patients in Bosnia-Herzegovina: patients' perceptions and expectations BMC Palliative Care (2018) 17:123. https://doi.org/10.1186/s12904-018-0377-2

Buck D. et al. A vision for population health Towards a healthier future. The Kings Fund. November 2018

Budreviciute A. Management and Prevention Strategies for Non-communicable Diseases (NCDs) and Their Risk Factors. Frontiers in Public Health. doi: 10.3389/fpubh.2020.574111. 26 November 2020

Koracin V. Current Status of Newborn Screening in Southeastern Europe. Front. Pediatrics, Sec. Neonatology. https://doi.org/10.3389/fped.2021.648939. 07 May 2021.

Lönnberg, L. 2022. Lifestyle counselling in primary health care for patients with high cardiovascular risk. Aspects of a 1-year structured lifestyle programme promoting healthier lifestyle habits to reduce future risk of cardiovascular disease. Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine 1849. 92 pp. Uppsala: Acta Universitatis Upsaliensis. ISBN 978-91-513-1530-0.

Social Impact Assessment of COVID-19 in Bosnia and Herzegovina. Prepared by Prism Research & Consulting for Unicef and UNDP. 2020

UNDP in BiH. The SDGs Framework in Bosnia and Herzegovina. December 2020.

Varghese C. Better health and wellbeing for a billion more people: integrating non-communicable diseases in primary care. BMJ 2019; 364:kl327. http://dx.doi.org/10.1136/bmj.l327

WHO 2014. Health in All Policies (HiAP) - Framework for Country Action. January 2014

WHO 2017. Promoting health: Guide to national implementation of the Shanghai Declaration. (WHO/NMH/PND/18.2). Licence: CC BY-NC-SA 3.0 IGO.