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Review of the Mental Health Project in Bosnia and Herzegovina: Phase 2

Maudsley International Review Team:
Professor Nick Bouras
Ms. Silvia Davey

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2 Acronyms and abbreviations

AA	Alcoholic Anonymous
AKAZ FBiH	Agency for Quality and Accreditation of the Health System of the Federation of Bosnia and Herzegovina
ASKVA RS	Agency for Certification, Accreditation and Health Care Improvement of the Republika Srpska
BD BiH	Brcko District of Bosnia and Herzegovina
BiH	Bosnia and Herzegovina
CBT	Cognitive Behavioural Therapy
CHF	Swiss franc
CMD	Common Mental Disorder
CMHC	Community Mental Health Centre
DALYs	Disability Adjusted Life Years
EU	European Union
F	Female
FBiH	Federation of Bosnia and Herzegovina
FM	Family Medicine (teams)
FMoH	Federation Ministry of Health
GDP	Gross Domestic Product
GNI	Gross National Income
HIF	Health Insurance Fund
HIS	Health Information System
Logframe	Logical Framework
M	Male
MH	Mental Health
MI	Maudsley International
PHI	(Entity) Public Health Institue
Project / MHP	Mental Health Project in Bosnia and Herzegovina
MoH	(Entity) Ministry of Health
M&E	Monitoring & Evaluation
NCD	Non-communicable Diseases
NGO	Non-Governmental Organisations
OT	Occupational Therapy
PHC	Primary Health Care
RS	Republika Srpska
SMD	Serious Mental Disorder
SDC	Swiss Development and Cooperation Agency
ToR	Terms of Reference
WHO	World Health Organization

3 Executive summary

3.1 Purpose of the review

Maudsley International (MI) was commissioned by the Swiss Development and Cooperation Agency (SDC) to undertake a review of the Mental Health Project (Project) in Bosnia and Herzegovina (BiH), to produce evidence-based recommendations for the Project phasing out (Phase 3). The review aims to provide information and make recommendations that will allow informed decisions to be made in relation to the rest of Phase 2, and the exit strategy to be taken in Phase 3.

3.2 Review methodology

The MI review team acted as external consultants in the undertaking the review and writing the report. The review methods included: undertaking a background desktop review of relevant documents; field visits in BiH and interviews with relevant stakeholders and integrating the information obtained in order to formulate Review findings and recommendations.

The Review findings and recommendations are based on the DAC Criteria for Evaluating Development Assistance, which include Relevance, Effectiveness, Efficiency, Impact and Sustainability. The “know how transfer” from the Swiss Cantons, and the best practices that could be “capitalized on and replicated” were also reviewed. Issues around equity and inclusion were also considered.

3.3 Review findings

The Project has had an important role in facilitating the ongoing mental health reform in Bosnia and Herzegovina, and has significantly influenced the country’s shift towards community focused mental health services. This is in line with international mental health and human rights policies. Overall, the Project has met its objectives in a timely, effective and efficient way, and has had a significant impact on its target population.

The Project has helped increase the skills and capacities of mental health and other health professionals to provide appropriate interventions to service users. It has increased the capacity and influence of service user associations that now have a stronger voice in decision-making processes. It has also helped increase mental health awareness within BiH’s population and decreased levels of stigma and discrimination against people with mental disorders. It has contributed to increasing and helping maintain the quality of services delivered in Community Mental Health Centres (CMHCs), in addition to developing a Health Information System (HIS) for mental health within CMHCs, which was missing. The Project has therefore contributed to the development of a more equitable and inclusive mental health system in BiH, contributing to maintain the levels of social cohesion within the country.

However, there are a number of issues still present within the mental health system, which could be addressed during the Project’s exit phase (Phase 3). It was observed that the mental health system in BiH is not fully integrated and that stronger levels of coordination and collaboration between community-based and hospital-based services are still needed. In addition, a closer collaboration between mental health services and other services such as social services should be fostered, although this is not directly within the Project’s remit. There also appears to have been low uptake of the HIS developed by the Project and it is considered administratively burdensome. Additionally, the Monitoring & Evaluation data provided by the HIS developed by the Project does not appear to be fully used for decision-making and funding processes.

3.4 Recommendations

Following the review of the Project' activities, outcomes and impact, the MI Review Team proposes that a number of Recommendations be taken into consideration when planning the Project's exit phase (Phase 3). Recommendations have been formulated in the following areas:

A. General Project Recommendations
B. Service delivery and improvement: Funding systems and Accreditation
C. Service delivery and improvement: Health Information System
D. Service delivery and improvement: Integrated, effective and efficient services
E. Increasing service quality and scope: training and capacity building
F. Decreasing stigma and discrimination

The detailed Recommendations can be found from p.31 of this report.

4 Background of the review and mission

4.1 Project context

4.1.1 National context

Bosnia and Herzegovina (BiH) is an upper middle-income country with an area of 51,210 km2 (World Bank, 2017). In 2013, the total population was of 3.531.159 (50.9% female) (Agency for Statistics of Bosnia and Herzegovina, 2016). Following the Dayton peace agreement which ended the Bosnian war, BiH is composed of two entities: the Federation of Bosnia and Herzegovina (FBiH) divided into 10 cantons (total population: 2.219.220), the Republika Srpska (RS) (total population: 1.228.423) and Brcko District (BD BiH) (total population: 83.516), which is a self-governing administrative unit (see Figure 1) (Agency for Statistics of Bosnia and Herzegovina, 2016). BiH is divided in 141 municipalities, 79 of which are in FBiH, 62 in RS, and BD counts as a single municipality.

Each entity has its own constitution, president, government, parliament, police and other bodies. A central Bosnian government has a rotating presidency (BBC, 2016). The Chair of the Presidency rotates every eight months in the 4-year term between a Serb, a Bosniak and a Croat president; the responsibilities of the presidency lie largely in foreign policy (BBC, 2016a). The three members of the Presidency are elected directly by the people with FiBH voters voting for the Bosniak and the Croat president, and the RS voters for the Serb president. The Prime Minister (Chairman of the Council of Ministers) coordinates ministers, is nominated by the Presidency and approved by the House of Representatives. In 2015, the Council of Ministers of Bosnia and Herzegovina, the Government of RS, and Government of the FiBH adopted a joint program of structural reforms, known as the Reform Agenda (World Bank, 2017), potentially leading to significant changes in BiH's political context. In 2016, BiH made a formal application to join the European Union (EU).

Figure 1: Administrative map of Bosnia and Herzegovina (taken from: Zaric, 2017)

4.1.2 Socioeconomic context

BiH's main ethnic groups are Bosniaks (50.1%), Serbs (30.8%) and Croat (15.8%). These populations are unevenly distributed throughout BiH; the majority of the population (70.4%) in FBiH is Bosniak, whilst the majority of the population in RS is Serb (81.5%). 3.4% of BiH's population is classified as "Other", which includes more than 17 different minority groups.

The majority (50.7%) of the population in BiH is Muslim, 30.7% is Orthodox, 15.2% is Catholic, 0.8% is Atheist and 0.3% is Agnostic (Agency for Statistics of Bosnia and Herzegovina, 2016). BiH's official languages are Bosnian, Croatian and Serbian.

4.8% of females aged 10 or over in BiH are illiterate, whilst 0.8% of males are illiterate. In 2013, 51.1% of BiH's population had completed secondary education, and 13.4% had completed tertiary education (Agency for Statistics of Bosnia and Herzegovina, 2016). In 2011, 17.9% of the population was at the national poverty line (World Bank, 2017). In 2014, 27.9% of the total labour force (that is available for and seeking employment) was unemployed (World Bank, 2017), which was significantly higher rate than the unemployment rate in the EU in 2013 (10.8%) (Eurostat, 2013). Youth unemployment rate is at 62.8%, 53.4% of BiH's population lives rurally, and the percentage of population living in urban areas increased following the Bosnian war form 39.9% (1992) to 46.6% presently (World Bank, 2017).

BiH's Gross National Income (GNI) in 2015 was of 40,708,500,706 US$, and its Gross Domestic Product (GDP) in 2015 was of 16,191,716,214 US$ (4,802 US$ per capita), with an annual growth of 3%, which represents a better than expected economic growth (World Bank, 2017). The World Bank (2017) projects that economic growth will be strengthened to above 3% in the medium term, via improved business environments, implementation of the Reform Agenda, and investments in the energy and tourism sectors.

4.1.3 The Bosnian war

The Bosnian war was an armed conflict that took place from 1992 and 1995. An estimated 104,000 people were killed in the war, and around 7,000 people are currently still reported missing. 2.2. million people fled from their pre-war homes, constituting more than half of the pre-war population. 1.2 million people asked for refugee protection internationally, whilst around 1 million people were internally displaced. The consequences of the war still affect BiH's population; at present, there are 84,500 internally displaced people, and 7,200 people are still residing in collective accommodation (Zaric, 2017). 2.3% of the BiH's territory still consists of mine affected fields (Zaric, 2017).

4.1.4 Public health

The life expectancy at birth in BiH in 2015 was of 76.0 years in males and 81.8 in females (IHME, 2017); the median age in 2013 was 40 years (WHO, 2015). In 2014, the fertility rate was 1.3 and there was a negative annual population growth rate (-0.2%), meaning that there is a declining population (World Bank, 2017). Similar to the shift that has been observed globally towards non-communicable diseases, non-communicable diseases currently present the biggest burden of disease in BiH, with neuropsychiatric conditions being the third biggest cause of Disability Adjusted Life Years (DALYs), following cardiovascular diseases, diabetes and cancer (WHO, 2015).

The probability of dying between ages 30 and 70 years from the 4 NCDs that cause the highest mortality (cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) is 18%, with the major risk factors including alcohol and tobacco consumption, which are consumed by a higher percentage of males than females (WHO, 2014). Other risk factors include obesity, raised blood

glucose and raised blood pressure (WHO 2015). In 2015, self-harm was the 13th leading cause of premature death, descending from being the 7th leading cause of premature death in 2005; self-harm as a cause of premature mortality was significantly lower in BiH than the group mean of comparison locations (IHME, 2017).

Amongst health problems that caused the most disability in BiH 2010, major depressive disorders ranked 8th, alcohol use disorders ranked 9th, self-harm ranked 10th and anxiety disorders ranked 15th (IHME, 2010); the number of DALYs contributed by these disorders has decreased since 1990 (IHME, 2010). In terms of the leading causes of death and disability combined, depressive disorders ranked eighth in 2015 (IHME, 2017).

4.1.5 Population mental health

Little information is available about the prevalence of mental disorders in the general population of BiH. Following the Bosnian war, a number of studies have been undertaken on the impact of the war on the mental health of Bosnian refugees, particularly focusing on post-traumatic stress disorder (Priebe et al., 2010). It is clear that BiH's population continues to be highly traumatized.

Broers et al. (2006) undertook survey on 1285 adult patients attending over 50 primary health care centres in the FBiH and RS, and found that over a quarter of all respondents were suffering from at least one mental health problem. 16.1% of respondents experienced somatisation disorder, 15.5% experienced anxiety syndromes, 13.7% experienced panic syndrome, and 10.1% experienced major depression syndrome (Broers et al., 2006). Eating disorders were experienced by 4.7% of respondents and 5% of respondents had alcohol abuse disorder (Broers et al., 2006). The prevalence of common mental health problems is similar to those of European countries, including ones who have not experienced a recent conflict (Wittchen et al., 2011).

However, recent surveys have shown that there is an increasing prevalence of mental health disorders such as depression, abuse of psychoactive substances, anxiety and stress related disorders (Paranos, 2014). In 2007, in the RS the number of mental health in-patients was of 7,037 (M 4,522, F 2,515) and the number of suicides was 252 (M 178, F 74) (Paranos, 2014). In the FBiH, the number of suicides in 2012 was 146, and the most prevalent diseases include neurotic, stress related and somatoform disorders, followed by affective, schizotypal and delusional disorders (Paranos, 2014).

4.1.6 Health care services and health financing system

BiH's healthcare reform started in 1996, consisting of a shift from an intervention-focused and specialist based system, to a system of care focused on prevention and promotion at the community level, resulting in the development of Primary Health Care services (PHC). Family Medicine (FM) teams, who provide their services within PHC, are the main contact point for the entirety of BiH's population in 141 municipalities, with 1 FM team serving around 2,500 people. However, it has been reported that PHC are understaffed and lack capacity, in part due to extensive workforce migration to EU countries (Zaric, 2017). In addition, one of the main issues with the health system that has been put in place by the reform is that it is inefficient and has low cost-effectiveness (Zaric, 2017). Public sector providers constitute 85% of all providers, whilst private for profit sector constitute 15% (Zaric, 2017).

In 2014, 9.6% of BiH's GDP was spent on health (463.6 current US$); 14.1% of BiH's government expenditure was on health (World Bank, 2017). In 2014, the majority of funding (71.2%) for the health sector came from compulsory social health insurance paid by employers and voluntary social

health insurance paid by unemployed (Zaric, 2017). BiH's social health insurance is compulsory for employers, and covers employed people and their families, those who are officially unemployed, victims and veterans of war, people with disabilities, children under the age of 18, students under the age of 26 and those over the age of 65. The health insurance covers around 63%-97% of BiH's population (Zaric, 2017). On the other hand, out-of-pocket health expenditure was 27.9% of BiH's total health expenditure, the majority of which was spent on private healthcare (Zaric, 2017). Around 0.04% of BiH's population is covered by a private health insurance (World Bank, 2017). Budget of governmental entities contribute around 1-2%.

The responsibility for the organisation, financing and provision of healthcare lies with 13 different Ministries of Health: the RS and FBiH entities, the 10 autonomous cantons in FBiH and BD BiH (as shown in Figure 2). The Ministry if Civil affairs has a coordinating role of these 13 health subsystems, mainly focused in compiling data for international reporting and harmonizing BiH's legislation with that of the EU.

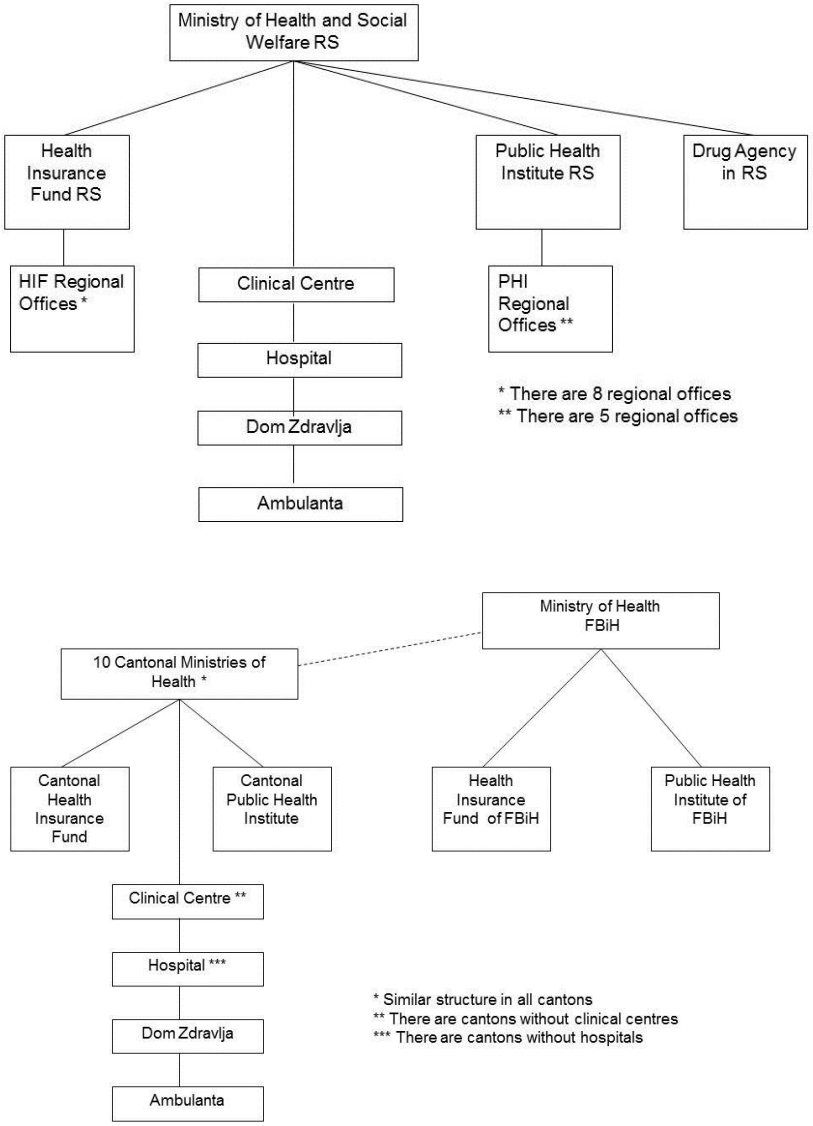

Figure 2: Organisation, financing and provision of healthcare in RS and FBiH (adapted from: Zaric, 2017)

4.1.7 Mental health services

Following the 1996 Mental Health Care Reform in BiH, mental health services have shifted from a tertiary model of care, based on the hospitalisation of a person with mental health problems, to a primary and community-based model, in which individuals are supported in their communities and families. A network of Community-Based Mental Health Centres (CMHCs) was therefore set up, to provide alternative care to the already existing hospital psychiatric services.

In the FBiH, secondary and tertiary mental health care services are provided at the University Hospitals in Sarajevo, Tuzla and Mostar, and in 10 psychiatric wards of general hospitals in major cities, which provide a total of 694 beds (Paranos, 2014).

In RS, secondary and tertiary mental health services are provided by the: Psychiatric Clinic of the Banja Luka Clinical Centre; Sokolac Psychiatric Clinic, Chronic Mental Patient Treatment, Rehabilitation and Social Protection Institute in Modrica; and 5 psychiatric wards of the General Hospitals such as Prijedor, Doboj, Trebinje and Gradiska. BD BiH has one psychiatric ward in a general hospital (Paranos, 2014).

Similar to other health services, psychiatric hospitals directly receive their funding from the HIF, which is usually based on a contract negotiated by the hospital's directors.

There are also a number of long-stay institutions for the treatment, rehabilitation and social welfare of people with chronic mental disorders, 20 day care centres (3 in FBiH and 17 in RS), in addition to a number of mobile crisis intervention teams (Paranos, 2014).

There is currently a network of 74 community based mental health centres (CMHCs), with 45 in FBiH, 28 in RS and 1 BD BiH (Paranos, 2014). CMHCs are organised as units that are legally, administratively and financially embedded within PHC centres, and consist of multidisciplinary teams that include psychiatrists, psychologists, social workers, nurses and other health professionals. The CMHCs are distributed relatively evenly throughout BiH, in both rural and urban areas, as shown in Figure 3. PHC are allocated funding by the Health Insurance Fund (HIF) based on contracts agreed with the PHC directors, which take into account the number of departments within the PHC, and the number of people it covers. PHC then allocate funding to CMHCs, with the amount of funding allocated depending on the director's decision, rather than based on the performance and needs of the CMHC.

Finally, there are a number of support groups such as AA clubs, in addition to a number of service user associations that are present across the country.

In 2014, hospitals, clinics and wards in the RS and the FBiH had a greater number of psychiatrists, physicians and nurses compared to CMHCs. On the other hand, CMHCs have greater numbers of psychologists, social workers, special education therapists and occupational therapists compared to the hospital, clinics and wards (see Table 1). The number of education and occupational therapists is still relatively low in both entities, with no occupational therapists being present in the FBiH.

However, there are still more staff in hospitals, clinics and wards compared to CMHCs, and with the number of staff in hospitals being nearly double of that in CMHCs in RS. In addition, with the population of FiBH being nearly double of that in RS, RS has a greater number of staff available per person within mental health services, especially in hospital, clinics and wards. Given that there are 10 more CMHCs in FiBH than in RS, but the number of staff in the CMHCs within the two entities is

the same, it appears that CMHCs in RS are better staffed than those in FiBH, similarly to hospitals, clinical and wards within RS.

Mental Health services staff	**RS CMHC**	**FiBH CMHC**	**RS hospitals, clinics and wards**	**FiBH hospitals, clinics and wards**	**Total**
Psychiatrists/neuro-psychiatrists	33	47	52	37	**169**
Resident physicians	8	-	11	3	**22**
Psychologists	36	51	21	10	**118**
Social workers	10	28	11	5	**54**
Special education therapists	12	7	3	-	**22**
Occupational therapists	2	-	1	-	**3**
Nurses/technicians	83	51	277	143	**554**
Total	**184**	**184**	**376**	**198**	

Table 1: Structure and number of staff in mental health services in BiH (adapted from: Paranos, 2014)

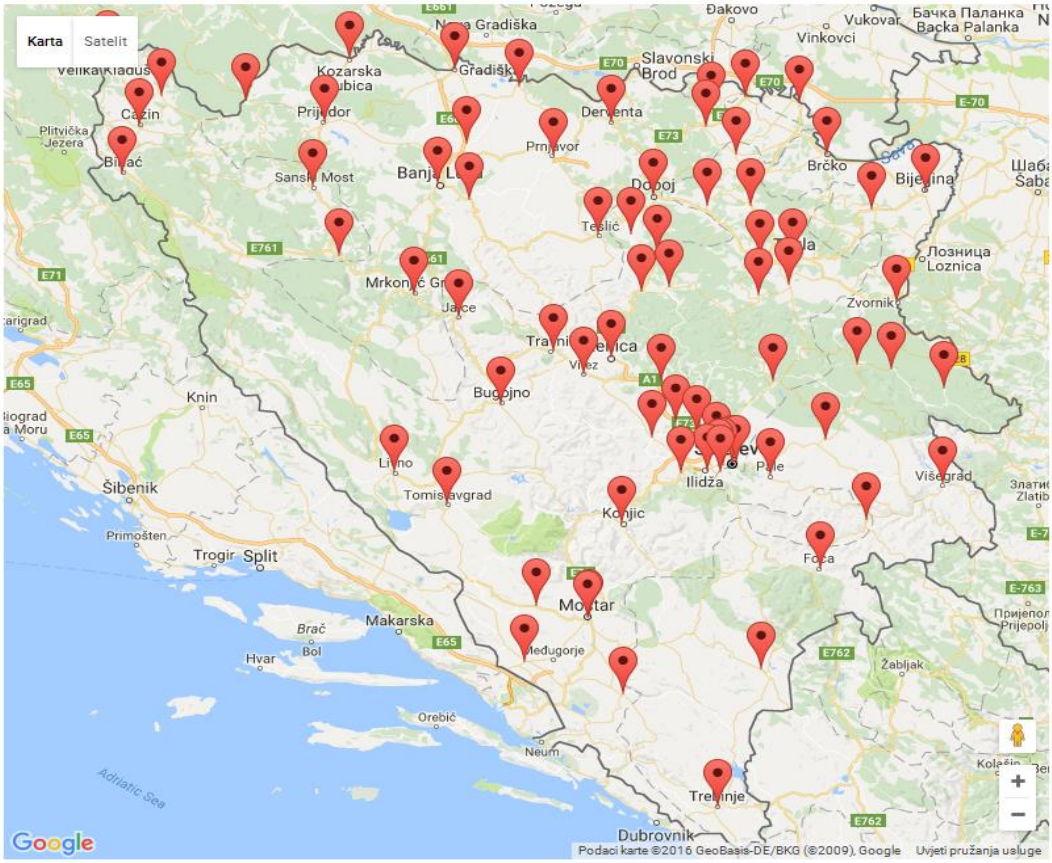

Figure 3: Overview of CMHC network in Bosnia and Herzegovina (adapted from Google©)

4.1.8 Stigma and discrimination

Research on the attitudes of the public, health workers and the media towards people with mental disorders in BiH was undertaken in 2012 by Entity PHIs with the support of the Mental Health Project.

It was found that the general population has overall positive attitudes towards the reintegration of people with mental disorders in the community and that deinstitutionalization, and the provision of services within communities, were overall seen positively. It was highlighted that lack of knowledge of both the general population and health workers was one of the leading causes of stigma and discrimination.

It was found that people who have had immediate experience of people with mental disorders have less social distance. In addition, women, people with higher levels of education and people form urban areas have more positive attitudes towards people with mental disorders. The most heavily stigmatized groups include people with schizophrenia and recovering drug addicts.

4.2 Project overview

Bosnia and Herzegovina (BiH) launched the mental health care reform in 1996, in order to develop community-based mental health services at the Primary Health Care (PHC) level. The “Mental Health Project in Bosnia and Herzegovina” (Project) has been supporting the continuation of the reform implementation and changes in mental health care within the Federation of BiH (FBiH) and Republika Srpska (RS) and Brcko District (BD), in alignment with their mental health strategies. The Project has provided technical support, quality control and technical assistance in the reform interventions, whilst local institutions and partners have implemented the reform activities. The Project enabled the continuation of the initial reform activities, further developing community-based mental health services at the PHC level.

The overall goal of the Project is to “contribute to higher quality of life for mental health service users and general well-being of people with mental disorders and those at risk of developing mental health problems”. The overall Project outcome is to have “reduced stigmatization, enhanced social inclusion and improved quality of life of people with mental disorders and those at risk of developing mental health problems/disorders” (Paranos, 2014).

The Project is funded by the Swiss Agency for Development and Cooperation (SDC); Phase 1 of the project took place from 05/06/2009 to 28/02.2014, with a budget of CHF 4,546,000. Phase 2 started on 01/03/2014, and is scheduled to end on 28/02/2018, with a budget of CHF 5,665,000. Phase 3 of the project, “the exit phase”, is planned to start in March 2018.

The Project implementation of Phase 1 and 2 has been undertaken by Association XY, a non-profit, non-political organisation based in Sarajevo dedicated to improve the health of citizens in BiH. Association XY is responsible for organizing and coordinating project activities and provides administrative support and facilitation for the Project implementation.

Given that the Project identified that there was an insufficiency of certain skills and knowledge of in-country experts to support the implementation of the Project, external support was provided from mental health experts and institutions within the Swiss Cantons of Bern, Friburg, Jura and Geneva. The Cantons have been responsible for the recruitment of experts and their management as required by the project action plan. The value of the Canton’s contribution to Phase 2 is of CHF 400,000 that includes the funding of the experts engaged in the project. Additional value is obtained

from the Swiss Canton's strategic and technical competencies, and the connections formed between the two countries, which will enable further capacity building within BiH.

4.2.1 Overview of Phase 1 achieved outcomes

The first phase (Phase 1) of the Project was launched in June 2010. Phase 1 of the Project aimed to "improve mental health of the overall population, as well as the ability of policy makers and relevant institutions in achieving European standards in mental health care in BiH". Phase 1 of the Project enabled significant results to be achieved in the above following four key areas (Paranos, 2014).

1. Developing a regulatory framework in the field of mental health

A regulatory framework has been developed following European standards and includes mental health indicators. The parliament of FBiH and the Federation Ministries of Health have adopted Mental health related legislations and regulatory frameworks. A Commission for protection of humans rights of persons with mental health disorders is operational in the FBiH, with allocated funding from the FMoH. The Entity Ministries of Health (MoH) have revised the nomenclature of their mental health services, resulting in more mental health services being adopted and provided. A digital mental health information system that enables the monitoring of the general population's mental health (based on pre-defined indicators) has been developed, established and tested.

2. Training of human resources to provide better quality of services in mental health

At the end of Phase 1, 66% of community-based mental health centers (CMHCs) used standardised methods to implement the Case Management approach. Education material on Case Management was developed, and 625 professionals from CMHCs and psychiatric hospitals/departments received training based in it. The capacity of health workers to work on prevention and promotional programmes has increased in 45% of all CMHC. The quality and safety of nursing in mental health has improved, via the provision of continuous education and training materials. The majority of nurses now work directly with patients and their families and have noted that the attitudes towards them by other health professionals have improved.

3. Improving the quality of management capacity in mental health institutions

57% of primary health care centers (PHC) have applied for their CMHCs to be accredited by the Accreditation Agencies, with 18 out of 68 CMHCs now being accredited. The rate of hospital referrals in voluntary hospitalisation for patients with severe mental disorders has decreased by 30%, and the care for the physical needs of patients with severe mental disorders has increased. Funding for mental health care in the primary health care system has progressed.

4. Fighting against stigma and discrimination of people with mental disorders

35 small grants were distributed in 29 communities, reaching 1154 people with mental disorders. Service users now have greater access to information about their own health status, treatment options, expected recovery outcomes, and their human rights. A research study on the "Public attitudes toward people with mental health difficulties" was undertaken in Phase 1, providing recommendations for anti-stigma programmes. 5000 mental health professionals in BiH have attended presentations focusing on good practice in mental health services. Service users are represented in the Commissions for the protection of the human rights of people with mental disorders, with 1/5 of all members being service users.

4.2.2 Phase 2 overview and objectives

Following the success of Phase 1, the second phase (Phase 2) of the project started in March 2014, and is planned to end in February 2018. The planned outcomes and outputs of Phase 2 are:

Outcome 1: Community-based services are managed more effectively and service quality is continuously improved based on evidence.

- *Output 1*: Established mental health standards of practice and a quality monitoring system
- *Output 2:* Established and functioning information system for mental health monitoring, data collection and analysis

Outcome 2: Persons with mental disorders and those at risk of developing such disorders have access to MH services of increased quality and scope in their communities.

- *Output 3:* Strengthened competencies and skills of multidisciplinary teams to provide quality outpatient mental health services (promotion, prevention, specialised services) via capacity building e.g. training, grants/funding opportunities]
- *Output 4:* Developed support system for effective application of Case Management in Mental Health
- *Output 5:* Strengthened outreach (promotional and preventative) services
- *Output 6:* Improved infrastructures of CMHCs

Outcome 3: Discrimination against persons with MH disorders in the communities has decreased

- *Output 7:* develop and implement community gender sensitive anti-stigma programmes targeting specific groups of population
- *Output 8:* Increased capacities of user associations for community partnerships and for the support to social inclusion of people with mental disorders

A detailed Logical Framework of Phase 2 of the Mental Health Project summarizing outputs, outcomes, key indicators and activities per output can be found in the **Appendix**.

4.2.3 Target groups

As detailed in the Project overall goal, the primary target groups are mental health service users, people with mental disorders and those at risk of developing mental health problems. Additional target groups include mental health and health professionals, in addition to family members of people with mental disorders.

4.2.4 Key stakeholders

There are a wide range of stakeholders in the Project. Primary stakeholders include: the Entity Ministries of Health (MoH) and the Brcko District of Health; the ministry of Civil Affairs of BiH, Cantonal MoHs in the Federation of BiH; entity/cantonal Health Insurance Funds (HIFs); entity/cantonal Public Health Institutes (PHIs), Primary Health Centres (PHC); Community-Based Mental Health Centres (CMHCs); Accreditation Agencies (AKAZ FBiH, ASKVA RS); psychiatric hospitals, departments and clinics; general population, patients and patient's associations; professionals associations. Secondary stakeholders include: Entity/Cantonal Ministries of Education; Centres for Social Welfare; Entity Gender Centres and the Media.

5 Introduction to review

Maudsley International (MI) was commissioned by the SDC to undertake a review of the Project (see **Appendix** for Terms of Reference), to produce evidence-based recommendations for the

Project phasing out (Phase 3). The review aims to provide information and make recommendations that will allow informed decisions to be made around the rest of Phase 2, and the exit strategy to be taken in Phase 3. MI was commissioned to:

- Systematically analyse and critically assess the project's strategy and progress made in achieving the expected outcomes, in addition to its sustainability
- Present the review recommendations in accordance to the DAC Criteria for Evaluating Development Assistance (see Section 6)

The review will also focus on equity issues around accessing healthcare that were tackled by the project, so that findings can be shared with the members of the SDC Learning Trajectory on Equity in Accessing Healthcare organized with the support of IDS. Finally, the review offered an opportunity for Peer Reviewers from the SDC (see **Appendix** for biographies) to gain and share knowledge for future relevant SDC funded projects. The preliminary findings and recommendations from the SDC Peer Reviewers Mrs. Erika Placella and Mr. Valeriu Sava can be found in the **Appendix.**

6 Applied methodology

The MI review team, led by Prof. Nick Bouras and assisted by Ms. Silvia Davey acted as external consultants in the undertaking and writing of the review report (see **Appendix** for biographies). The review methods were threefold:

1. Undertake a background desk review of relevant project documents shared by stakeholders and any other relevant academic literature of published reports.
2. Undertake field visits in Bosnia and Herzegovina in which qualitative interviews took place with relevant stakeholders (see the **Appendix** for a full list of stakeholders involved in the meetings). The MI review team was joined by the SDC Peer Reviewers for one week of the field visits, in addition to being assisted by a local resource person, who provided in-country operational and organisational support, and provided context-related information to the Review team.
3. Integrate the information obtained from the desk review and the stakeholder meetings in order to formulate Review findings and recommendations.

The Review findings and recommendations are focused around the DAC Criteria for Evaluating Development Assistance (OECD Development Assistance Committee, 1991). The Criteria include:

- Relevance: the extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor
- Effectiveness: a measure of the extent to which an aid attains its objectives
- Efficiency: a measure of the outputs – qualitative and quantitative – in relation to the inputs
- Impact: The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended
- Sustainability: measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn

The "know how transfer" from the Swiss Cantons, and the best practices that could be "capitalized on and replicated" were also reviewed.

Alongside the DAC criteria, the MI review team used other review tools including MI's project evaluation framework, in addition to the World Health Organisation Assessment Instrument for Mental Health Systems (WHO-AIMS) (WHO, 2005).

All relevant documentation and information was shared with the MI review team promptly and openly. The review had a combined format given that Peer Reviewers from the funding agency (SDC) were part of the review team, and were present in most meetings with stakeholders. This may have made the review process not fully independent. However, the Peer Reviewers had no decision-making role in the review, and the integration of their findings and recommendations lied with the MI Review Team. Their involvement in the review process offered significant benefit to the review, given their extensive knowledge and experience of the Project and local systems, and can be taken as complementary to the review process undertaken by the MI Review Team. The "Preliminary Findings and Recommendations" report generated by the Peer Reviewers can be found in the Appendix.

7 Review findings

7.1 Relevance

7.1.1 BiH's population mental health needs

There is little information regarding the mental health needs of BiH's population, in addition to those of their relatives. Preliminary results on the prevalence of mental health problems in the community are available, and indicate that the prevalence of common mental health problems is similar to those of other European countries, including ones who have not experienced a recent conflict (Wittchen et al., 2011). However, the needs of specific potentially at-risk groups such as children and young people, older people, people with disabilities and people with severe mental disorders remain unassessed.

Other sources of information available to understand BiH's mental health priorities include a "Situation Analysis and Assessment of Community Mental Health Services in Bosnia-Herzegovina" published by the Federal Ministry of Health and the Republika Srpska Ministry of Health and Social Welfare in 2009. The analysis focused on the resource needs in community-based mental health services, rather than on the general mental health needs of BiH's population and of the entire mental health system. The situational analysis provided recommendations focused on:

- the implementation of policy into practice
- the redesign of funding mechanisms based on monitoring and evaluation (M&E) data
- the development of human resources (in particular nurses) via relevant training curricula and continued education
- the development of evidence-based and needs-based community care that is inter-sectoral and has clear referral pathways
- the development of anti-stigma programmes.

FBiH's and RS's mental health strategies also provide information regarding BiH's mental health priorities (Republic of Srpska Government Ministry of Health and Social Welfare, 2010; Federation of Bosnia and Herzegovina Federal Ministry of Health, 2012). The priorities include:

- further development of mental health services at the primary healthcare level
- adjustment of the legislation and development of sustainable financing systems

- human resource planning and development involving continuous training and education
- integration of the health and social sectors with inter-sectoral coordination and collaboration
- information and M&E system development and application
- awareness raising and destigmatisation of mental health problems
- improving and protecting mental health at work
- protecting specific at-risk groups
- promoting and preventing mental health across the life course at the community level
- improving the physical health of people with mental disorders
- strengthening user's and carers associations, and advocacy
- ensure conditions are met for the purchase, supply and distribution of effective psycho-pharmaceuticals
- implement and support continuous mental health research

7.1.2 Alignment of the Project with relevant policies/strategies/priorities

The Project has enabled the continuation of BiH's mental health system reform, by supporting the opening/development of CMHCs and the establishment of their therapeutic, preventative and promotional services. These activities have therefore successfully contributed to the deinstitutionalization process of mental health services and the development of a wide range community mental health services in BiH. These developments are aligned with international, donor and local mental health priorities, in addition to being aligned with BiH's Entities strategies and CMHC's needs assessment.

In particular, Phase 1 and 2 have enabled the successful development of the following priorities:

1. Implementing policy into practice by helping develop a regulatory framework in line with European standards
2. Widening the scope of mental health services provided to include promotional and preventative services
3. Developing a digital mental health information system
4. Training and continuous education of human resources in addition to the development of novel educational curricula
5. Contributing to the improvement of the management and funding of CMHCs
6. Supporting anti-stigma and discrimination activities within communities and institutions

The Project has supported service reorganization, developing human resources and by shifting mental health care provision from long-stay inpatient hospitals to community-based settings whilst focusing on assessment and treatment they also include prevention, promotion and rehabilitation services. It is therefore fully aligned with the "WHO Mental Health Action Plan 2013-2020" (WHO, 2013), in addition to the European Framework for Action on Mental Health and Wellbeing (EU Joint Action on Mental Health and Wellbeing, 2016). The Project is also in line with the SDC's priorities of cooperation with Eastern Europe, which include providing better access to primary health care (SDC & SECO, 2013).

Three additional priorities are highlighted by relevant strategies as being central for the development of an effective, efficient and sustainable mental health system

1. The provision of continuity of care via the full integration, collaboration and cooperation of CMHCs and primary level mental health care with mental health care providers at the

secondary and tertiary level (psychiatric hospitals and outpatients services), alongside clear, well-defined referral pathways, especially in back-referral/re-referrals.
2. Further strengthening of a multi-sectoral approach, and coordination and cooperation between mental health services, in particular of CMHCs, with other public sectors such as such as the health, education, employment, judicial, housing, social and other relevant sectors (WHO, 2013).
3. Taking a lifespan approach to the development of age-group specific/related services and programmes at the community level, particularly focusing on services for children and adolescents. Although some individual CMHCs have undertaken prevention and promotion programmes for children and adolescents, the Project has not provided the necessary emphasis to develop and deliver services appropriate for children and adolescents.

Although the Project has made efforts to address the first two priorities, more attention and systematic interventions in the future stages of the project is necessary (see below for further detail and recommendations). The third priority has been sparsely addressed, as it was not within the Project's purpose.

7.1.3 Alignment of the Project's activities with its intended impact and outcomes

Overall, the Project's activities and outputs are appropriate for the Project's stated outcomes and impact (see Logical Framework in the Appendix).

7.2 Effectiveness

7.2.1 Project set up, planning and delivery

The Project has significantly influenced the delivery of mental health services in a complex socio-political, structural and organisational context, whilst involving a significant number of stakeholders at the institutional and individual level. This has been made possible by the financial, coordination and planning support provided by the SDC and the Project Team, in addition to the expertise provided by the Swiss Cantons, to support mental health institutions to implement the Project's activities and improve BiH's mental health services.

The Project clearly defined its overall impact, outcomes and outputs, in addition to the activities needed to reach these outputs. It also clearly defined indicators for each output, which were realistic and achievable given the available resources. The Project has also clarified the different roles and responsibilities of the majority of the stakeholders involved in the Project, in addition to having enabled stakeholders to recognize the importance of – and supporting - the development of community mental health services in BiH. Lessons learned from Phase 1 of the project were clearly taken into account in the planning phase, and have been integrated in the planned outputs and outcomes of Phase 2.

The Project clearly identified all relevant stakeholders, and defined their involvement in the Project planning and delivery. The Project has taken a "bottom-up" approach in delivery, with project activities supporting the building of capabilities of individuals at the service delivery level (health workers) and those receiving services (service users). This approach was fundamental for the successful implementation of Phase 2; it is apparent that service users and health workers, the target population, have highly appreciated it.

However, by taking this approach, it appears that opportunities may have been missed to consider the impact of the Project at system level. Psychiatric hospitals as stakeholders "seem to have some

reservations of the mental health reform focused on community-based care" whose cooperation has "resulted in significant changes" (Paranos, 2014). Some stakeholders from psychiatric hospitals reported that they have felt uninvolved in the planning and delivery of Project activities, something that may have caused unintentional distancing of these stakeholders from the Project.

Not combining a "top-down" with a "bottom-up" approach may have resulted in decision-making organisations, such as the Entity PHIs and HIFs, having lower levels of policy dialogue with the Project with regards to addressing structural issues that may limit the continuous mental health system development and improvement, especially for Objective 1 (see section 7.2.2).

7.2.2 Service delivery and improvement (Objective 1)

Accreditation Process

The Project has successfully helped define and test a unified set of mental health indicators and standards that have been endorsed by all relevant stakeholders. The standards for accreditation are very similar in both the RS and FBiH, although they are presented differently. The Project has also provided strong financial (around 90% of the costs covered by the Project, 10% supported by PHC funding) and logistical support to CMHCs for the accreditation and re-accreditation process to be undertaken via the Entities Accreditation Agencies (AKAZ FBiH, ASKVA RS). Accreditation of CMHCs ensures that they are meeting the optimum standards of quality in service delivery. The Project's support has resulted in around half of all CMHCs in BiH being accredited. In addition, the Entity Accreditation Agencies have adopted a revised set of accreditation standards for CMHCs, and the Project has helped draft new Mental Health Strategies for both Entities (Output 1).

However, accreditation is not compulsory, given that CMHCs only require certification (ensuring that it is delivering optimum standards of safety in its services) to receive funding from the HIF. There are no funding incentives or disincentives currently put in place by the HIF for CMHCs to undertake the accreditation process, which is also a highly resource intensive process. The accreditation process has been reported to be challenging and time consuming; nevertheless, the Project has been successful in convincing CMHCs to invest in the accreditation process. Further, there is no clear evidence available for the HIF about whether the accreditation process and investment in primary/community mental health care increases satisfaction of service users and is cost-effective, giving little incentive for the HIF to financially support the accreditation process. The HIF also appears to have low awareness of the service improvement that would result from the accreditation process and the benefits it would bring to service users.

Mental Health Information System (HIS)

The Project has also supported the development of a mental health information system (HIS) in BiH, by having helped both Entities to draft the necessary data-collection statistical forms, in addition to helping develop relevant training workshops for staff (Output 2). However, there appears to be limited vision of integrating the mental health information system with the national health information system, although this is outside of the sphere of the Project. Psychiatric hospitals currently use a separate electronic database to store patient information, which was developed prior to the Project's inception. In addition, it has been reported that there was a lack of consultation with stakeholders in developing the software, resulting in staff (notably nurses), having to spend a considerable amount of time trying to identify and analyse relevant data. It has also been reported that parallel information systems (both electronic and paper systems) are being used when collecting patient data within CMHCs, resulting in significant duplication of work and administrative burden.

The HIF does not sufficiently use the monitoring and evaluation (M&E) data collected in the newly developed information health system in order to allocate funding to CMHCs based on their needs and performance. Similarly, PHIs do not use M&E data in order to generate evidence or for needs-based decision-making. Additionally, mental health services perform only occasional evaluations of individual treatments, rather than continuously evaluating the needs of the population and of the services provided as a whole. Business planning and healthcare management procedures of primary/community mental health care services based on concrete/robust data are still weak. Although a functional health information system has been developed and individuals have been trained to use them, their uptake from individual and institutional stakeholders is weak. Stakeholders are unclear about its tangible benefits, given that they have created duplication of work, and data collection and analysis does not influence decision-making, or service funding. CMHCs lack independence from a financial, administrative and decision-making point of view, and receive limited policy and technical support from the Entity PHIs, HFIs and Accreditation Agencies.

Integration of mental health services

It was also observed that the mental health system in BiH is not fully integrated, and that there is still some level of separation between the services delivered by CMHCs and those provided by psychiatric wards in hospitals. The system still appears to have unclear referral pathways and duplication of services may therefore occur at times. CMHCs receive referrals from family doctors within PHC, social welfare and other agencies e.g. the police; patients can also voluntarily refer themselves to a CMHC. Psychiatric hospitals also receive referrals from family doctors, CHMCs, emergency hospital department, and other agencies e.g. the police. Patients can refer themselves to the psychiatric hospitals regardless of symptom severity, and have the ability to decide what hospital to be admitted into, given that admission dates are different per psychiatric hospital. With psychiatric hospitals also providing outpatients services, upon discharge patients can decide whether to be referred to CMHCs or to continue being followed by the outpatient services. Some patients continue being followed by the hospitals rather than using CMHC services. It was also reported in one canton that service users who require disability benefits can only obtain them once they have obtained a “certificate” from a psychiatric hospital, and CMHCs cannot provide their patients with such “certificates”. Although hospitals are expected to send a discharge letter to CMHCs upon patient discharge, it has been reported that it does not happen systematically, creating problems in continuity of care. The issues mentioned above might vary between the two Entities.

Meetings between CMHCs and hospitals providing psychiatric services are infrequent and lack regularity. This situation prevents an active and ongoing involvement, collaboration and coordination between psychiatric hospitals and community mental health services. By not actively involving stakeholders from psychiatric hospitals, who are highly experienced mental health professionals, in the Project’s planning and activity delivery, the Project may not have fully achieved its intentions to support the integration of the two parallel mental health systems (community and hospital). This is a common issue experienced in systems transitioning from an institutionalized to a community based model of services.

Finally, collaboration and integration between mental health services and other public and tertiary sector services, such as social services and local NGOs, could be further strengthened and be more proactive. Increasing service quality and scope (Objective 2)

The Project has successfully strengthened the competencies and skills of multi-disciplinary professionals in mental health services, including CMHCs, PHC and psychiatric hospitals and wards. It did so by providing grants to professional associations for the development of educational programmes, monitoring the implementation of the programmes and supporting their delivery when appropriate. In addition, the Project provided funds for the development and delivery of mental health promotion and prevention programmes, and for the restructuring of a number of CMHCs. The Project has achieved most of the indicators planned for Outputs 3 & 4. The indicators for Output 5 have not been fully achieved, as outreach activities are undertaken sporadically, and therefore small numbers of BiH's population are involved in the Project's promotion and prevention activities. Activities for Output 6 were adjusted following the May 2014 floods, but its indicators are on track to being achieved (for more detail, see Appendix).

Training and educational activities

Capacity building activities for professional associations (Output 3) have been reported to be successful. Individuals and teams appear to be confident in applying their knowledge in order to improve the interventions and treatments provided to service users. More specifically, nurses have been effectively trained to strengthen their competencies, and it has been reported that the attitude towards the contribution made by nurses has improved. However, it is apparent that nurses are still burdened by doing administrative work, and therefore do not have maximum opportunity to use their patient-facing skills and to focus on their clinical roles. The project has also upskilled a number of psychologists and psychiatrists on how to use CBT techniques in treatment, and they have been found to be applying these skills when treating their service users. Social workers have been trained in family therapy methods, psychologists have been trained in self-help mental health therapies, and both groups of professionals have been applying their skills with service users. Given that a number of different types of professionals has attended the same training, the Project has also increased the inter-disciplinary collaboration between different types of team members. This training has successfully increased the confidence of mental health workers in delivering high quality services, which has been reported to positively impact on their wellbeing at work. However, it may not be possible for professional associations to retain or update the knowledge and skills acquired from the training once the project has ended. This would mainly be due to issues related to turnover and changes of staff within the associations, leading to loss of knowledge and skills, in addition to the training not being continuous and therefore the knowledge gained potentially becoming out of date.

An occupational therapy (OT) training programme and curriculum have also been developed, although these outputs had not been formally defined in the programme planning stages. A formal one-year mental health OT course has been designed and is being delivered in a training institution, and modules in OT are also being delivered as continuing training. A number of health professionals have been trained in OT for mental health, and have used OT related interventions with services users. A specialization programme in clinical psychology is also currently in development, that is considered necessary because of the limited number of available qualified clinical psychologists.

The Project has been particularly successful in introducing the use of case management (coordinated care) (Output 4). This has been achieved by developing a training curriculum consisting of three modules and a training module manual. Case management has been delivered to all staff of CMHCs and about 30% of staff in psychiatric hospitals. The Project also provided supervisory workshops and on-site supervision to help/assist CMHCs teams with the implementation of case management techniques. It is also apparent that this Project component has proactively improved the training programme following participant's feedback. The project was also

successful in embedding case management training in the education and accreditation system, by making it a requirement for accreditation standards, and by having the HIF including it into the nomenclature of services provided at the PHC level.

In addition to the benefits the introduction of case management has had on service users, it has also been highlighted that it has significantly increased collaboration within CMHC multi-disciplinary teams, with nurses' and psychologists' skills being more widely respected. The majority of times nurses are responsible for the delivery of case management (46% nurses, 20% psychologists, 17% psychiatrists, 13% social workers, 4% others). However, there are still ongoing discussions within CMHCs regarding the organisation of case-management and responsibilities that each team member holds. In addition, it was reported that nurses are still too over-burdened by administrative tasks to deliver case management effectively. This heavy administrative burden, in addition to a reluctance to task-shift, create conditions of overload and potentially predispose to burnout of staff and increased staff's frustration. The administrative burden could also result in reducing the time staff can offer to service users. It was also reported by some CMHCs that they did not have the full team composition and therefore lacking the capacity to meet in full the population's needs. Coordination and management of human resources within CMHCs should be further optimized.

Mental health prevention and promotion programmes

The Project enabled the successful development of a mental health prevention and promotion framework (Output 5), based on a needs analysis. This has resulted in the development of four mental health prevention and promotion programmes, designed to address the needs of the community, which are due to be implemented. However, a lack of strategic vision and coordination was observed within the promotion and prevention activities supported by the Entity Public Health Institutes (PHIs). Although CMHCs are required to spend 30% of their resources on outreach mental health promotion and prevention activities, in reality they are carried out by CMHCs in a fragmented and sporadic manner, due to financial and administrative obstacles and lack of incentives. In addition, some of the programmes, such as that focused on gambling problems amongst adolescents, are perceived to have been pushed forward based on political priorities, rather than based on the needs of the population.

Finally, due to the serious damage done by the floods that took place during May 2014, CMHC reconstruction and refurbishment activities (Output 6) were focused on PHC that had been affected and damaged by the floods, with up to seven CMHCs and a citizen association being reconstructed and refurbished. CMHCs highly appreciated the reconstruction and refurbishment activities, as it enabled them to offer services in safe and functional settings. In addition, crisis intervention programmes helping strengthen CMHC's mobile teams were also supported by the Project following the floods.

7.2.3 Decreasing stigma and discrimination (Objective 3)

Overall, the Project has successfully achieved the indicators planned for Output 7 (for more detail, see Appendix).

Service user associations and anti-stigma activities

The Project has successfully supported the establishment and strengthening of users associations, and has provided support for their activities in anti-stigma programmes. The service user associations' activities have been described as life-changing by service users who took part in them, and are viewed very positively by them. Over 500 people have been involved in anti-stigma

activities, and influential speakers such as Professor Norman Sartorius have delivered a significant number of public events covering topics related to reducing stigma and discrimination of people with mental health problems. Around 20 service users have also participated in activities that have provided paid work for them. In addition, over 150 staff have participated in a programme to decrease discrimination in the provision of physical care for people with mental health problems. However, a reluctance to investigate the somatic diseases of people with mental disorders has still reported to be prevalent amongst health professionals

There are very few partnerships and collaborations in place between associations and CMHCs (Output 8), although an example of the collaboration in Ključ shows that this greatly increases the service user association's capacity and improves the mental health services being delivered. However, it was also noted that such collaborations may be difficult, given that staff within CMHCs are already stretched, and do not have the capacity to participate in additional activities.

A number of training programmes, for example in public speaking, have been undertaken for user associations, which have increase service user's confidence to speak about their experience, in addition to increasing the association's capacity, especially for the implementation and evaluation of anti-discrimination programmes (Output 8). Although user associations have been supported and strengthened by the Project, it was observed that there is a variation in their capacity and strengths. Most of them have not expanded their membership and not been able to use their advocacy potential, especially within local authorities, fully. In addition, service user associations lack full time, paid employees, resulting in their activities being undertaken sporadically.

Media coverage

It has also been noted that although some efforts have been made to get media coverage on the Project as a whole, and in particular on the anti-stigma and discrimination activities, contact with the media has mostly been sporadic and in connection to specific events, rather than regular and consistent with specific briefings for journalists. In addition, although there has been a steady increase in positive coverage from the media about mental health, it was reported by some stakeholders that the media continues negatively portraying people with mental disorders, using stigmatizing imagery and language.

Other activities

Additionally, the Project has supported the design of studies that will help gather more information on the pathways to care and the burden experienced by family members when caring for people with mental disorders, which will be undertaken by the association of young psychiatrists in BiH.

Finally, a complaint mechanism inbuilt in the system for service users has been put in place at the PHC level, also covering services provided by CMHCs; it was however found that complaints were not recorded in at a least one CMHC in Banja Luka.

7.3 Efficiency

7.3.1 Efficiency of Project management

Project activities appear to have been delivered efficiently, with the appropriate use of resources, and inefficiencies in the management of the Project activities were not reported. Following Dr. Becker's review (2013) of the organisational structure of the Project, the new organizational structure has been found to be efficient, resulting in clearer decision-making and division of

responsibilities. The Project team has a clear structure and defined roles and responsibilities. Each component has an assigned leader and project team, which ensures that all Project components and outputs are focused on equality. It was not possible to assess the functioning and structure of the Steering Committee, which was set up to provide strategic guidance in the Project's decision-making processes.

The Project was costed and resourced appropriately, with the separate Project components having ring-fenced budgets for their activities; activities were budgeted for carefully, and issues with budgeting were not reported.

It was, however, reported that there were gaps in communication between the different Project components, and that a number of stakeholders reported that they were not aware about a number of the Project's activities. This lack of communication could have led to the duplication of activities and inefficiencies. For example, it appeared that there was limited communication between the mental health promotion and prevention component and the anti-stigma component, although they are strategically aligned. A stronger interaction between the different Project components, in addition to increased communication between stakeholders involved in the different components may further increase the Project's efficiencies.

All relevant stakeholders were directly involved in the Project's decision-making processes, and in the planning and delivery of the Project's activities. The Project took a facilitation role to enable the delivery of activities. It however appeared that stakeholders from all psychiatric hospitals have not been directly involved in the decision-making and delivery processes of the Project. Individuals within the psychiatric hospitals have felt that they should have been more consulted and involved when programme proposals within the Project were drafted. Inefficiencies and duplication between the Project's activities and activities already taking place in existing mental health services may therefore have occurred. In addition, there appeared to be limited communication and cooperation with stakeholders and representatives from social services.

Some issues with the management of the Swiss Canton's strategic inputs were also reported, which are further discussed in section 7.6.

7.3.2 Efficiency of BiH's mental health services

It has already been highlighted that community mental health services delivered at primary care level do not appear to be fully integrated with those delivered in specialised settings (secondary and tertiary care). This may result in some services being duplicated, especially between those provided by outpatients services in psychiatric hospitals and CMHCs. Further integration of the systems will ensure increased efficiency of the services provided. In addition, there are currently no established mechanisms in place to ensure collaboration between mental health services and other public sectors, such as social welfare and education. This lack of collaboration may result in inefficiencies in BiH's mental health system.

The HIS, whose introduction and uptake has been supported by the Project, was also reported to be causing duplication of work for staff, given that previous paper-based data inputting systems are still maintained, in addition to the new digital system. This has resulted in staff, specifically nurses, effectively having to input the same data twice. In addition, the data inputted in the HIS is not used efficiently, as it is not used for service planning, improvement and needs analyses or funding. The newly developed HIS is not integrated with the information system used in psychiatric hospitals and wards, resulting in inefficiencies in the down-referral pathway.

There has been little progress around undertaking cost-effectiveness analyses of the interventions introduced by the Project. It was reported that an informatics simulation model has been built in partnership with the Accreditation Agencies and with the support of Swiss Cantons, which focuses on whether newly introduced services improve the mental health system and service delivery. However, the model needs data to be inputted, and the relevant data is currently unavailable. It is therefore difficult to review whether the improvements put in place in BiH's mental health system are cost-effective.

7.4 Impact

The impact of the project has been wide reaching, and has contributed to increasing infrastructure in CMHCs, increasing the quality of the services being delivered, and further developing the capabilities of mental health staff, particularly in CMHCs. In addition, the project had an impact in decreasing the inequalities in health services access for people with mental disorders, and increasing their social inclusion and participation in decision-making processes. The Project has also had a significant political influence, with most decision-making bodies recognizing the importance of the mental health care reforms. It is clear that this level of progress in the mental healthcare reform in BiH would not have been possible without the Project's support.

The Project has enabled the significant improvement of services provided by CMHCs, and a significant decrease of hospital referral rates (30%) and hospital readmissions (50%) have been reported. With the Project mainly focusing on improving service quality in CMHCs, it was reported that the Project might have less of an impact on people with serious mental disorders (SMDs) compared to people with common mental disorders (CMDs). The former might tend to access services in psychiatric hospitals or wards more frequently than CMHCs.

The Project has had a positive impact on health professionals, by increasing their skills and knowledge in delivering high quality services and interventions. This has resulted in health professionals feeling more capable in treating service users, therefore decreasing their levels of stress. However, mental healthcare workers still face considerable burden of increased demands, due to some CMHCs not having the full team of health professionals necessary to deliver the service, an issue that lies outside of the Project's remit. It is important to note that the Project's introduction of a new HIS may have somewhat contributed to increasing the administrative burden on health professionals, especially nurses.

The Project also has a wide-reaching impact on decreasing discrimination in the provision of physical care for people with mental health problems, although health professionals have still been reported to be reluctant in investigating somatic issues in people with mental health disorders.

The Project's focus on strengthening the skills and capabilities of service user associations has empowered them to have an influence politically in decision-making processes and within their communities. In addition, the Project significantly involved service users in all of its stages, in addition to involving them in the decision-making processes. These approaches have been shown to change imbalanced power relations, and have a significant positive impact on the levels of social inclusion of people with health problems in their communities, in addition to decreasing health inequities they may experience (Belle-Isle et al., 2014). The Project has also helped create a small number of job opportunities within service user associations for people with mental health problems, a factor that can increase social inclusion and decrease health inequities. The positive impact the Project has had on service users was noticeable, and the Project was reported to be "life-changing" for a number of people.

It has been reported that the Project has helped increase awareness and decrease stigma of mental health problems within the community; however the full extent of the Project's impact on this is hard to determine, as there has not been a follow up study from the baseline study to measure any changes in stigma.

It was also observed that the Project's activities had less of an impact on high-risk groups such as children and adolescents, and the elderly. The Project had limited focus on increasing the capabilities of staff in their ability to provide specialist treatments and interventions that are appropriate for these age groups, which may therefore be particularly disadvantaged.

With the Project focusing on the whole network of CMHCs, which is evenly geographically spread throughout BiH, it has had an impact on people living in both rural and urban areas, and the Project's activities have been evenly spread across the two Entities. It was not possible for the reviewers to determine whether the Project had any effect on inequalities in access to services for ethnic minorities, and for immigrants. It is worth noting that nothing detrimental to that extent was reported or indicated throughout the extensive interviews and visits.

The Project had a strong focus on gender, and ensured that gender appropriate mental health services are provided in CMHCs, in addition for data collected in the HIS being segmented by gender. This has had a considerably positive effect on the quality of services accessed by both genders.

7.5 Sustainability

It is clear that there is strong commitment to the Project and mental health reforms from all stakeholders, ranging from the higher political authorities to the providers delivering services. In particular, the commitment drive and dedication of healthcare workers and staff within CMHCs has been crucial for the successful delivery of the Project, and will be instrumental for the future sustainability of the Project's achieved results.

However, issues related to health financing will significantly impact the sustainability of the Project's results. The Project has provided substantial financial support for the delivery of Project related activities, and questions remain open regarding the sustainability of such activities upon termination of the Project's financial support. This is due to the Entities not having specific ring-fenced budgets for mental health services and activities, which could result in many of the Project's activities not receiving continued funding upon Project termination. A commitment to the delivery of high quality and affordable mental health services from policy-makers and funders would help ensure the financial sustainability of the Project's activities.

Considerations around sustainability are to be made around the following Project activities and results:

1. CMHC service quality and delivery of programmes

It was observed that CMHCs are presently not fully sustainable, as some do not have the full necessary team composition to guarantee efficient service delivery, are under-resourced and do not receive enough funding in order to continue delivering high quality services. CMHCs also have very limited decision-making power, and depend on the decisions made by, and the resources provided by PHC. Although many of the directors within CMHCs are highly influential within the PHC, and ensure that the CMHC's needs are mostly covered, changes in leadership may significantly affect this. It was also observed that appointments are often politically motivated, and that there is high

turnover in leadership. It was also reported that PHC recognize the importance of CMHC's, as they would not be able to deliver the necessary mental health services otherwise; this increases confidence about the continued support of CMHCs by PHC.

In addition, it is unlikely that the CMHCs' community outreach activities, and prevention and promotion programmes will be sustained upon Project ending, given that the Project has contributed significant resources and funding for the development and delivery of these programmes.

2. Accreditation process

Although accreditation of CMHCs ensures that they deliver high quality services, accreditation is not compulsory and CMHCs are only required certification in order to operate and receive funding. The accreditation and re-accreditation processes have been reported to be complex, costly, time consuming and resource intensive. Although the Project has effectively managed to convince CMHCs to invest time into undertaking the accreditation process, the Project has offered substantial management and operational support, covering up to 90% of the costs of accreditation. In addition, there are at present no incentives in place for CMHCs to undertake the accreditation process. The sustainability of the re-accreditation process for CMHCs upon Project termination is therefore questionable, given that the current financial support given by PHC and HIFs is insufficient. Questions also remain open about whether HIF would provide funding for the re-accreditation process, given the low levels of awareness HIFs have of the improvement in service quality accreditation brings, and the lack of evidence regarding the economic benefits and the cost-savings it would bring.

3. Health information system

The sustainability of the mental health information system (HIS) introduced by the Project appears to be limited. The HIS was developed in consultation with stakeholders, and staff within CMHCs have been trained thoroughly in its use. However, the system appears to be causing particular administrative burden to staff (especially nurses), in addition to duplication of work, given that staff continue imputing patient data in previously used systems. This may cause staff to discontinue using, or underusing the new HIS put in place by the Project.

The Entities' PHIs do not appear to use the evidence available from the collected and analysed M&E data when making policy recommendations and decisions related to service delivery and development. In addition, the collected data does not appear to influence the funding given to CMHCs by the Entities' HIFs, with the money being allocated based on number of people covered by the CMHC rather than by its performance or needs. There is therefore little incentive for staff within CMHCs to use a HIS that is underused by policy-makers and funders when making decisions around service delivery, quality and funding, especially if it is perceived administratively burdensome. This lack of incentive may also impact the accuracy and reliability of the collected data.

4. Service user associations

User associations have been established and developed, resulting in service users having a stronger voice and considerably more influence in relation to service improvement and anti-discrimination activities within the community. The Project has considerably strengthened their skills and capabilities, by providing service users targeted training opportunities in public speaking, project planning, management and evaluation. However, many of the service users association's

mental health promotion and prevention programmes and activities depend on small grants awarded by the Project. It is likely that this funding will not be sustained upon termination of the Project.

Very dedicated and passionate individuals lead the majority of the associations, and very few have permanent paid staff to manage the association's activities. The associations' leaders are often service users, and may therefore not be able to dedicate a consistent amount of time to the management of the association due to personal and health constraints. This may result in a lack of leadership within the associations, which could significantly affect their sustainability.

5. Maintenance of refurbished CMHCs

Questions remain about the sustainability of the refurbishments of CMHCs funded by the Project, especially related to the maintenance of new electronic equipment. Sustainability will depend on future funding granted by PHC.

6. Teaching and training activities

The teaching and training activities provided from the Project have the potential to have a long-lasting effect for individuals and the quality of services delivered, given that there is evidence that what has been taught is routinely applied in practice. This is especially true for the use of case management methods, which appear to be embedded in services provided by CMHCs. These activities have and will continue to make a long lasting improvement to service delivery, positively influencing both service users and health workers.

Efforts have been made to embed the teaching and training activities within the national curricula (e.g. for case-management and occupational therapy), which increases the sustainability of these training activities. However, it is unclear who will take on the leadership role of managing, updating and delivering these training curricula, raising doubts about the long-term sustainability of the new educational programmes. The fact that there is no single institution in charge of medical education in mental health and that curricula are not coordinated at a national level may pose an additional significant barrier.

In addition, professional associations may not have the resources to continue delivering the training that has so far been supported by the Project, which would result in future professionals joining the associations not being trained.

7.6 Know-how transfer

This contribution of the Swiss Cantons of Bern, Geneva, Jura and Fribourg to the Project has been highly appreciated by all stakeholders involved, as they have provided invaluable expertise and knowledge that was unavailable in-country, in addition to providing strategic and legislative expertise. In particular, they have enabled the:

1. Development of a standardized and accredited OT curricula
2. Delivery of anti-stigma talks and activities; the contribution of Professor. Norman Sartorius to the anti-stigma component was mentioned by numerous stakeholders as being particularly valuable
3. Development of promotion and prevention programmes
4. Capacity building and training of nurses

The contribution of the Swiss Cantons to the Project has been strategically and operationally managed by the Cantons themselves, rather than by the Project Team. It was noted that this separation might have created lack of clarity and administrative and bureaucratic burden, especially for the Project Team. It was also apparent that stakeholders in BiH do not make a distinction between the contribution made by the Swiss Cantons and the SDC. Given the value of the technical advice and support provided by the Swiss Canton's contribution, it is recommended that their cooperation be continued. However, it is suggested that a mechanism is identified to make their contribution more incorporated with the Project on a strategic and operational level.

7.7 Capitalization and replicability

The project has introduced innovative approaches to mental health service delivery that could be replicated in contexts that are at similar stages of mental health service development.

For example, the approach taken to develop and deliver training in case management could be replicated in other contexts. Additionally, the developed case management curriculum could be adapted to the new context (adapted according to the mental health system set-up, and levels of knowledge), thus avoiding the need to develop a similar curriculum from scratch. The follow-up supervision offered by the Project on case management for CMHC teams is also particularly good practice, as ongoing support reinforces the use of case management in routine care.

The training curriculum and manuals developed for OT, and the approach taken to embed the training programme into the existing education system, are also elements that could be replicated in other contexts similar to BiH. In addition, the training materials developed for the training of members of professional associations, could be replicated in similar contexts that require capacity building in areas such as the use of CBT techniques in treatment, family therapy and self-help techniques.

The use of external specialists to provide knowledge that is unavailable in-country has also been particularly valuable, and should be used as an approach in future Projects requiring specialist knowledge. Not only does this approach develop the capabilities of the receivers of the project, but it also forms strong partnerships and knowledge sharing that can be sustained even upon project termination in a wide range of activities, including academic research.

The Project's focus on increasing the social inclusion of service users in their communities and its approach to including them in the Project's decision-making processes were particularly valuable. It is recommended that similar approaches be taken in future Projects focused on mental health services.

8 Conclusions

The Project has had an important role in facilitating the continuing mental health reform in Bosnia and Herzegovina, and has significantly influenced the country's shift towards community focused mental health services. This is in line with international mental health and human rights policies. Overall, the Project has met its objectives in a timely, effective and efficient way, and has had a significant impact on its target population.

The Project has helped increase the capabilities of mental health and other health professionals to provide appropriate interventions to service users. It has increased the capacity and influence of service user associations that now have a clearer voice in decision-making processes. It has also

helped increase mental health awareness within BiH's population and decreased levels of stigma and discrimination against people with mental disorders. It has contributed to increasing and helping maintain the quality of services delivered in CMHCs, in addition to developing an HIS for mental health within CMHCs, which was missing. The Project has therefore contributed to the development of a more equitable and inclusive mental health system in BiH, increasing the levels of social cohesion within the country.

However, there are a number of issues still present within the mental health system, which could be addressed during the Project's exit phase (Phase 3). It was observed that even though the Project has put efforts into the integration of the mental health system in BiH, there is still some level of separation between the services delivered by CMHCs and those provided by the psychiatric hospitals. The system still appears to have unclear referral pathways and duplication of services may therefore occur at times by having two parallel systems, rather than in an integrated model. In addition, CMHCs do not appear to be fully integrated with social and other relevant services. There also appears to have been low uptake of the HIS developed by the Project and it is considered administratively burdensome. Additionally, the M&E data provided by the HIS is not used for decision-making and funding processes. Addressing these issues would ensure that the outcomes of the Project are sustainable in the long-term, especially once external financial support has ended.

9 Recommendations

Following the above review of the Project' activities, outcomes and impact, the MI Review Team proposes that the following Recommendations be taken into consideration when planning the Project's exit phase (Phase 3).

A. General Project Recommendations

- **Recommendation A.1** In addition to continuing its bottom-up approach focused on improving services and on collaborating with service users, the Project includes **top-down involvement** in the activities of Phase 3. We recommend that policy dialogue to be more systematic within the Project, as well as between the Project and the decision-making implementation partners (such as **policy and funding institutions**). "The Peers suggested that the Project could explore using a newly developed SDC Policy influencing tool that is being piloted in Moldova". This would ensure that these institutions at national, cantonal and local level have higher levels of accountability in steering the reform and delivering continuously improving mental health services.

- **Recommendation A.2** The **communication and collaboration between the Project's components is further strengthened in the future**, to ensure alignment of the all the Project's activities and reduce any potential inefficiencies. In particular, it is recommended that CMHCs' outreach mental health promotion and prevention activities (Output 5) and anti-stigma activities (Output 7) be further aligned. In addition to the already existing Project meeting schedules where project leads present their current activities, a specific communication strategy should be developed about Project activities and outcomes, targeting difference audiences, including policy-makers, health institutions and their staff, service users, the general public and journalists.

- **Recommendation A.4** The capabilities of the **Project Team within Association XY** are further strengthened, to enhance their skills in negotiation, policy dialogue and advocacy, in addition to strengthening their competencies to provide relevant technical assistance to CMHCs.

- **Recommendation A.5:** The Project should continue its activities in **strengthening institutional capacity building** regarding management, steering, organisational development and human resource allocation and management.

- **Recommendation A.6** (related to: Swiss Cantons). It is recommended that the Swiss Cantons' funding bodies continue their contribution to the Project **in Phase 3**, to provide valuable technical and specialised expertise as and when needed by the Project. It is recommended that a mechanism is found to make the Cantons' contribution more incorporated on a strategic and operational level. For example, the Project team could lead the coordination of the financial and operational side of the Canton's technical contribution directly.

- **Recommendation A.7** (related to: SDC). The **good practices identified in this review (see section 7.7) are systematized, capitalized** and used in other similar Projects/contexts.

B. **Service delivery and improvement: Funding systems and Accreditation** (also related to: MoHs, PHIs, Accreditation Agencies, PHC)

- **Recommendation B.1** (related to: Project & HIFs). The Project can strengthen the collaboration with **Entity HIFs** in order to explore ways in which **performance and quality of CMHCs can be related to the funding awarded**. Ideally, this would involve M&E data collected on mental health by the HIFs being used to develop reward, incentive and disincentive mechanisms. This would also help increase CMHC's accountability, by incentivizing them to continuously collect mental health data, and improve their service's performance.

- **Recommendation B.2** (related to: PHCs). Although not fully within the Project's remit, the **Project support discussions with PHC to ensure that CMHCs are fully integrated within PHC**, and that CMHCs are allocated sufficient resources to sustain a full multi-disciplinary team of health professionals, that has the capacity to deliver mental health services without being over-stretched and burnt-out.

- **Recommendation B.3** (related to: Project & PHCs). The Project supports **CMHCs** in identifying manners in which they can **further financially support the re-accreditation process**. Other sustainable funding options could be explored, for example with **PHC giving extra funding** to CMHCs undergoing the re-accreditation process, or the **HIFs awarding funds** based on performance. The Project should continue the excellent work it has so far undertaken within CMHCs in **highlighting the importance of the accreditation process** to maintain service quality.

- **Recommendation B.4** (related to: Accreditation Agencies). The Project supports **Accreditation Agencies** and **CMHCs** in order to identify **resources and capabilities necessary for continuous training** of staff in CMHCs around re-accreditation process and standards.

- **Recommendation B.5** (related to: MoHs, Accreditation Agencies, PHIs and HIFs). The Project should support **Accreditation Agencies** strengthen their voice and influence, so that they can **highlight the importance of the accreditation process for service quality improvement** to policy and financing institutions. Only if a suitable and sustainable funding option for the accreditation process is identified, it is recommended that the project work alongside **Accreditation Agencies, the PHIs, and the HIFs** to ensure that accreditation is made compulsory for CMHCs.

C. Service delivery and improvement: Health Information System (also related to: MoHs, PHIs and HIFs)

- **Recommendation C.1** (related to: Project). The Project focuses on **further training staff in CMHCs on the importance of using the newly established HIS**, and increases awareness of any potential incentives the HIF may put in place around data collection. Training should also continue to increase the technical capabilities of staff in using the HIS.

- **Recommendation C.2** (related to: Project). It could be advantageous for **the Project to undertake a thorough analysis on whether the newly introduced HIS is causing duplication of work** and administrative burden to specific staff, and solutions to these problems should be found in collaboration with relevant stakeholders.

- **Recommendation C.3** (related to: Project). Focus should be given by **CMHCs on releasing nurses from their administratively burdensome tasks**, so that they can focus on their clinical roles.

- **Recommendation C.4** (related to: MoHs, PHIs and HIFs). the Project works alongside the **Entity MoHs, PHIs and HIFs** to ensure that **M&E data obtained from the HIS is used in policy and decision-making processes**, in particular to make recommendations around mental health service development and improvement. Recommendations on how this could be done can be found within the WHO “Mental Health Information Systems Policy and Service Guidance Package” (2005), although this must be adapted the local resources and expertise.

D. Service delivery and improvement: Integrated, effective and efficient services (also related to: Psychiatric Hospitals, Social Services, MoHs, PHIs)

- **Recommendation D.1** (related to: Project). The Project promotes additional **inter-sectoral collaboration** between mental health services and other public/third sector services. Relationships with social services are particularly important, given the increased social needs of people with mental health problems. Efficient inter-sectoral collaborations would ensure effective continuity of care, and that a **biopsychosocial model of service delivery** is adopted within BiH, which would include services that enable effective prescribing of medication, psychological treatments and meaningful social support.

- **Recommendation D.2** (related to: Project). The development of **management skills, leadership skills and capacities of staff within CMHCs** should continue to be supported by the Project, and it is recommended that this support be also given to PHC, as CMHCs are funded and managed by PHC.

- **Recommendation D.3** (related to: Project, Psychiatric Hospitals). The Project focuses on improving and strengthening **communication, coordination and collaboration between CMHCs and Psychiatric Hospitals and further supports the integration of these two mental health services**. It is therefore recommended that stakeholders from psychiatric hospitals are more directly involved in planning and delivering the Project's activities in Phase 3, especially in collaboration with staff from CMHCs.

- **Recommendation D.4** (related to: MoHs, PHIs, Project, Psychiatric Hospitals, Social Services)**.** The Project should support **CMHCs and Psychiatric Hospitals fully define and strengthen their referral pathways**, especially back-referral pathways. This should be done with the support of the Entity MoHs, social welfare services, and service users so that referral pathways are not duplicated and do not disadvantage service users. The newly defined pathways should be agreed by all relevant stakeholders and clearly outlined in all relevant policies. It is recommended that staff in mental health services receive training on how to effectively communicate the newly set referral pathways to service users.

- **Recommendation D.5** (related to: Project, HIFs). It is also recommended that the Project supports the **CMHCs and service users in increasing their understanding and awareness of the funding and budgeting mechanisms that are in place within the country**, so that they can improve their skills in holding policy makers accountable for the delivery of quality and affordable mental health services. The Project could also support **MoHs and HIFs to produce clear documentation and guidelines** with regards to **the funding mechanisms** in place.

E. Service delivery and improvement: outreach promotion and prevention activities (also related to: MoHs, HIFs and CMHCs)

- **Recommendation E.1** (related to: Project). Future promotion programmes should include **programmes on promoting mental health in schools, and activities on promoting healthy life styles and the physical health and well-being** of people with mental health problems.

- **Recommendation E.2** (related to: Project, CMHCs, HIFs, MoHs). The **importance of CMHCs continuing their outreach promotion and prevention activities in their communities should also be highlighted** by the Project, particularly to MoHs, HIFs and PHC who could provide incentives to CMHCs who undertake such activities. The importance and value of investing in promotional and prevention activities should be fully explained to the funding bodies. An umbrella organization/structure coordinating CMHC's promotion and prevention activities could be set up to enable better management activities, in addition to ensuring their sustainability.

F. **Increasing service quality and scope: training and capacity building** (also related to: Professional Associations, Education Institutions, clinical specialists, Swiss Cantons)

- **Recommendation F.1** (related to: Project). In order for CMHCs to have the skills and capabilities to deliver appropriate services for high-risk groups, **including children and adolescents and older adults**, **the Project should support the development of training workshops for mental health staff** in the provision of such services. It is recommended that the Project seeks support from specialists within BiH in the development and delivery of such training, and if such expertise is not identified, then seek the support of external specialists.

- **Recommendation F.2** (related to: Project). The Project should continue its excellent work in directly **supporting CMHCs in applying case management methods when delivering services**, so that they become part of routine care.

- **Recommendation F.3** (related to: Project & Professional Associations). The Project puts in **place mechanisms ensuring the sustainability of the educational/training programmes undertaken within professional associations**. One proposed mechanism of doing this is to take a train-the trainer approach, in which a number of individuals from the professional associations are trained in the knowledge and skills necessary to organise and deliver trainings for their peers/other members of the association. Individuals chosen as trainers would ideally have previous experience in being trainers and/or facilitators.

- **Recommendation F.2** (related to: Project, Education Institutions, clinical specialists). Based on best practice evidence to support strong educational outcomes, the Project should facilitate the formation of **strong links between the training and education programmes and clinical specialists who could provide continuing clinical supervision** for mental health professionals. A mechanism of routine clinical supervisions could be set up to enable this.

- **Recommendation F.4** (related to: Education Institutions). The Project collaborates with Universities, Academic and **Education institutions in both Entities to ensure that they take a leadership role in managing, updating and delivering the developed training curricula** (such as those developed in case management and occupational therapy). Particular efforts should be made to ensure they become fully embedded within the national medical training curricula.

- **Recommendation F.6** (related to: Project, Education institutions in FBiH). In addition to the already existing clinical psychology specialization provided in the RS, it is **recommended that the Project continue supporting the development of a training curriculum in clinical psychology in FBiH.** Higher numbers of certified clinical psychologists would therefore be trained and skilled in the delivery of psychological and talking therapies for service users with both common and severe mental disorders.

- **Recommendation F.7** (related to: Swiss Cantons & Education Institutions). A number of the courses and curricula have been developed in partnership with both with national and international specialist support, in particular in occupational therapy, case management, clinical psychology and anti-stigma. It is recommended that **the Project strengthen the link between education and research leadership in BiH and with external experts**. This will enable the formation of a strong partnership, which will enable development of future research and training collaborations.

G. **Decreasing stigma and discrimination** (also related to: Swiss Cantons, MoHs, HIFs)

- **Recommendation G.1** (related to: Project). The Project should undertake **further work with the national and local media outlets,** which could include briefings of acceptable language to be used when reporting about mental health, and televising issues around mental health problems. This could ensure increased awareness around mental health in the general population, and sustainable change in the manner in which mental health is reported about in the media.

- **Recommendation G.2** (related to: Project). The Project **continues supporting the research studies** being planned around pathways of mental health care and the burden experienced by family member of people with mental health problems, which will be **undertaken by the Association of Young Psychiatrists in BiH.**

- **Recommendation G.3** (related to: Project, Swiss Cantons). The Project continues its **work strengthening the capabilities and voices of service users and their family members,** in topics such as patient rights, quality standards of services, decrease of stigma and discrimination, **via additional organizational strengthening support**. This would ensure they continue significantly influencing decision-making process on mental health service delivery.

  Recommendation G.5 (related to: MoHs, HIFs). In order to sustain the projects and activities undertaken by service user associations, **it is recommended that the Project ensure that there is ring-fenced funding available for such activities**. Funding could be secured from the Entity MoHs, HIFs or charitable/third sector organisations. The Project should also focus on **fostering partnerships between service user associations and other relevant NGOs, in addition to CMHCs**, in addition to maintaining the social entrepreneurship activities undertaken by the service user associations.

- **Recommendation G.6** (related to: Project & Swiss Cantons). The Project **should ensure that anti-stigma activities and public talks continue being delivered throughout Phase 3.** The Project could further empower service user associations in planning, organizing and delivering such activities, if supported by adequate resources and funding.

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11 Annexes

11.1 List of key documents

Below is a list of documents shared with the MI Review Team by key stakeholders. The documents were analysed as part of the review process.

1. MHP Phase 1 (2010 - 2013), End of Phase Report
2. Phase 1 Review findings of David Becker
3. Credit Proposal for the MHP with annexes
4. MHP Project Document, Phase 2 (March 2014 – February 2018)
5. Project progress implementation reports Phase 2 – half-yearly and yearly:
    a. 1st report – March – August 2014
    b. 2nd report – March 2014 – February 2015
    c. 3rd report – March 2015 – August 2015
    d. 4th report – March 2015 – February 2016
    e. 5th report – March 2016 – August 2016
6. Project's components related documents, products, reports:
    a. Annex to the 5th MHP progress report – a detailed overview of the project results, outputs and activities in the period March 2016 – August 2016
    b. Reports by the mental health professional associations implementing the educational projects with the professionals in community mental health centres: "Self-help in mental health", "Cognitive-behavioural techniques – needs and application", "Strengthening nursing competences in community mental health centres"
    c. Report by the Health Faculties implementing the mental health occupational therapy training (English summary)
    d. Curriculum for care coordination (case management) in mental health training (the content in English)
    e. Curricula for mental health occupational therapy training – one year study programme (the content in English)
    f. Curriculum for the clinical psychology specialisation programme in the Federation of BiH (the content in English)
    g. Analysis of the situation and needs for implementation of promotional and preventative programmes in mental health in BiH – report on the findings
    h. Reports by the partners – mental health service user associations – implementing projects fighting stigma and improving social inclusions (English summary)
    i. Narrative reports on meeting objectives
7. Documents related to the cooperation with Swiss Cantons:
    a. Report on the contribution by the Swiss Cantons to the Mental Health Project in BiH, Phase 2, in the period from January 2016 – December 2016)
    b. Swiss experts reports:
        i. Reports on the expert support to the development of the Mental Health Occupational Therapy curriculum and training delivery by Prof. Sylvie Meyer, EESP - School of Social Work and Health, Lausanne

   ii. Reports on the expert support in the Mental Health Nursing Documentation Development by Prof. Nicole Zangrando, Haute école de santé Arc (Bern, Jura. Neuchatel
   iii. Reports on the expert support in the development of a long-term strategy for reducing discrimination and stigma against persons with mental health issues by Prof. Norman Sartorius
c. Other:
   i. ToR for the Swiss expert support to the implementation and evaluation of the promotional and preventative programmes in BiH (planned for 2017)

8. Documents around equity and inclusion:
   a. Draft concept note for a learning trajectory “Ensuring equity and inclusion in health”
   b. Terms of Reference for IDS-SDC QA Collaboration (2014-2017) Project 7 (P7) LT Ensuring Equity and Inclusion in Health
   c. Minutes of “Learning Trajectory: Ensuring Equity and Inclusion in Health” meeting
9. Other documents requested for by MI Review Team
   a. The Policy and Strategy for the Protection and Promotion of Mental Health (2012 – 2020), Federation of Bosnia and Herzegovina
   b. The Republic of Srpska Mental Health Development Strategy (2009 – 2015)
   c. Situation Analysis and Assessment of Community Mental Health Services in Bosnia-Herzegovina
   d. Public Attitudes towards Persons with Mental Disorders in Bosnia and Herzegovina: Research Findings Report

11.2 Project Logframe

Hierarchy of objectives Strategy of Intervention	Key Indicators	Data Sources Means of Verification	
Impact (Overall Goal)	**Impact Indicators**		
To contribute to improved general well-being of people with mental disorders and those at risk of developing mental health problems/disorders	- Disability-adjusted life expectancy (of people suffering from mental health disorders), B 67, T increase - % of mental health disorders contribution to the country level burden of disease, B 21.9%, T decrease (by 2020)	WHO reports WHO reports	
Overall project outcome (milestone to long-term impact)	**Outcome Indicators**		**External Factors (Assumptions & Risks)**
Reduced stigmatization, enhanced social inclusion and improved quality of life of people with mental disorders and those at risk of developing mental health problems/disorders.	- % of Mental Health service users experiencing discrimination, B (TBD in baseline study), T decreased - % Hospital readmission rates for persons suffering from mental health disorders, B (TBD in baseline study), T decrease - % of suicide and self-harm rates in the country, B (TBD in baseline study), T decrease	Baseline and end-of-phase survey, Project reports AKAZ/ASKVA reports Entity PHIs	Increased sensitivity and responsiveness of the community services and citizens with respect to the needs of people suffering with mental health disorders and those at risk of developing mental health disorders. People with mental health conditions are able to carry their responsibilities, manage their own affairs, make decisions about their lives and participate fully in their societies by taking part in public affairs such as policy decision making processes.
Outcomes	**Outcome Indicators**		
Outcome 1: Community-based mental health services are managed more effectively and service quality is continuously improved, based on evidence.	- % of facilities that apply established standards and procedures for quality assurance B 20%, T> 60% - % of facilities that use data for planning and management in accordance with a unique set of indicators for monitoring the mental health in BiH, B 0%, T> 60% - % of facilities that, based on the quality indicators for monitoring, improved treatment outcomes, B 0%, T> 60% - % of facilities that improved practices based on feedback from service users, B 10%, T 60%	AKAZ/ASKVA reports AKAZ/ASKVA and PHIs reports AKAZ/ASKVA reports AKAZ/ASKVA reports	The implementation of other health care policies supporting positive processes within the mental health system.
Outcome 2: Persons with mental disorders and those at risk of developing such	- # of hospitalizations, sex disaggregated, B (TBD in in baseline study), T decrease - # forced hospitalizations, sex disaggregated, B (TBD	AKAZ/ASKVA reports AKAZ/ASKVA/PHIs reports	People with mental health problems are supported by the community/municipality to use the services of CMHCs (travel

Hierarchy of objectives Strategy of Intervention		Key Indicators	Data Sources Means of Verification	
disorders have access to mental health services of increased quality and scope in their communities.		in baseline study), T 10% reduction - # arrivals accompanied by police, sex disaggregated, B (TBD in baseline study), T 20% reduction - # repeated hospitalization, sex disaggregated, B (TBD in baseline study), T 30% reduction - # of referrals of patients from the local community to the hospital, sex disaggregated, by local community, B (TBD in baseline study), T reduced - User's satisfaction with the quality of mental health community services based on their needs, including gender-differentiated needs, sex disaggregated, B (will be available end of Phase I), T increased - The level of burn-out amongst professionals in CMHCs, sex disaggregated, B 70%, T 40% - % of users involved in the Case Management and occupational therapy that are recovering well, at the level of social, health and psychological functioning, sex disaggregated, B 0%, T 65% - # of supported persons who started using new coping strategies, sex disaggregated, B n/a, T > 300	Hospitals reports Hospitals reports AKAZ/ASKVA reports Project Reports and PHIs Survey, Project Reports Survey, standardized measuring instruments, Project Reports Survey among users on quality of life (test-retest)	expenses, health insurance). The local communities/municipalities provide space and time for carrying out promotional and preventive services.
Outcome 3: Discrimination against persons with mental health disorders at community level has decreased.		- # of supported persons who started accessing mainstream work, sports, exercise, arts, cultural or other leisure activity groups or facilities, sex disaggregated, B n/a, T 600 (300 M, 300 F); - Statistical indicators of change in attitudes towards people with mental disorders compared to baseline, sex disaggregated, B from study on public attitudes, Phase 1; T reduction - Self-assessment of MH service users about exposure to discrimination in health care institutions and other facilities and organizations (discrimination type, by gender), B (TBD in baseline study), T reduction	Project reports - reports on the users' trainings (test-retest) PHIs' reports- Research on public attitudes Project reports- survey among users (test-retest)	Willingness of decision-makers at all levels to invest resources in the social inclusion of people with mental disorders and fight against discrimination
Outputs (per outcome) and costs		**Output Indicators**		
Outcome 1: Community-based mental health services are managed more effectively and service quality is continuously improved based on evidence.				
Output 1	Established mental health standards of practice and a quality monitoring system	- # of defined quality indicators whose relevance and feasibility of collection is proven in practice, B 0, T6 - # of CMHC that applied for the process of accreditation / reaccreditation, B 15, T 40 - Republika Srpska Mental Health Strategy revised and officially adopted, integrating GIA's recommendations	AKAZ/ASKVA reports AKAZ/ASKVA reports Documents: minutes from sessions, reports of MoHs	AKAZ / ASKVA have the capacity to lead the process for establishing a system of monitoring the quality of MH. Facilities are willing to apply the standards of practice in continuity.

Hierarchy of objectives Strategy of Intervention		Key Indicators	Data Sources Means of Verification	
Output 2	Established information system for mental health monitoring, data collection and analysis	- # of CMHCs team members who have undergone training in data collection and analysis, B 65, T 368 - % institutions that collect key data on daily basis, B 0%, T 60% - % institutions that are technically equipped (have access to internet and at least one computer unit per team) to collect data through web application, B 70%, T 100%	Project reports PHIs reports PHIs reports	MoHs, PHIs and health institutions take their share of responsibility in data collecting, monitoring and analyzing in MH
Costs of outputs for outcome 1: BAM 838.200,00				
Outcome 2: Persons with mental disorders and those at risk of developing such disorders have access to better quality and a bigger scope of mental health services in their communities				
Output 3	Strengthened competencies and skills of multidisciplinary teams to provide quality MH services	- # of staff from MH services who have undergone training in OWA directed towards recovery, T 200 - # CMHCs/facilities received basic set of materials for OWA, T> 68 - % CHMC/facilities who apply OWA in their facility, T> 80% - # of beneficiaries covered by OWA, sex disaggregated, T> 1000 - # of CMHC staff who successfully passed continuous professional development training organised by professional associations, data gender disaggregated and per professional group; B 0, T 120 - # of CMHCs who apply newly gained skills/methods; B 0, T 40	Project reports Project and facilities reports Project/consultants/CHMCs reports Project reports Professional associations' reports Professional associations' reports, project reports	Professional associations and sections within the associations have the capacity to initiate, plan and organize training and mutual cooperation. Directors of health institutions are supporting education and providing participation of professionals in education.
Output 4	Developed support system for effective application of Case Management in Mental Health	- % of CMHCs who apply Case Management approach, B 66%, T 100% - # of users who are involved in Case Management, B 1282, T 2720 (min. 40 per CMHC) - # Case Management supervisory education, B 0, T 4 (all CMHCs, 1 cycle per year)	Project and supervisors reports Project and supervisors reports Project and supervisors reports	Hospitals and CSWs cooperate with CMHCs in the preparation and implementation of care plans. CMHCs have the capacity to achieve cooperation with institutions and organizations in the local communities in which programs will be implemented.
Output 5	Strengthened outreach services	- # of implemented gender sensitive promotional and preventive programs in the community, with a special focus on children and adolescents, B 0, T > 30 - # of persons who are directly involved in the promotional and preventive programs in the community; B 2200, T 4500 - # of local communities in which integrated	PHIs reports PHIs reports PHIs reports	PHIs have the capacity to implement prevention programs in cooperation with CMHCs.

Hierarchy of objectives Strategy of Intervention		Key Indicators	Data Sources Means of Verification	
		promotional and preventive programs under leadership of PHIs are carried out, B 0, T 30		
Output 6	Improved infrastructure of CMHCs	- # of reconstructed and equipped CMHCs, B 25, T 41	Project reports	Institutions have defined their needs and proposals for reconstruction projects.
Costs of outputs for outcome 2: BAM 2.548.000,00				
Outcome 3: Discrimination against persons with mental health disorders at community level has decreased.				
Output 7	Implemented community gender sensitive anti-stigma programs targeting specific groups of population	- # local communities that participated in anti-stigma programs in cooperation with PHIs, CMHCs and users associations, T 5 - # of persons from the local community who participated in anti-stigma programs: T more than > 500 - # of users associations that have participated in the creation and implementation of anti-stigma programs T>5 - # of public events as a part of an anti-stigma programs T>5 - Gender Impact Assessment document entitled: Assessing the burden of caring for persons with severe mental disorders and multiple needs in the community developed, and its findings used in designing community actions and in formulating policies and strategies by health authorities - Gender Equality Assessment in mental health conducted, ensuring equality in benefits gained by women through the project	Reports by program implementers (grant recipients) Reports by program implementers (grant recipients) Reports by program implementers grant recipients) Reports by program implementers Project Report / GIA document Project reports	The existence of capacities in the country for creating and implementing anti-stigma programs in the field of mental health.
Output 8	Increased capacities of user associations for community partnerships and for the support to social inclusion of people with mental disorders	- # of associations and users who have undergone training (empowering the individual, capacities of the organization, capacities for partnerships), B 0, T 30 associations / > 450 users - # of associations that have implemented partnership projects (2 or more associations together) for the working-occupational engagement and improving the quality of life of users / number of users involved, T 30 associations / > 450	Project reports User associations' reports	Willingness of public institutions / services in the local community to cooperate with users associations. Users associations are actively working towards their sustainability. .
Costs of outputs for outcome 3: BAM 910.100,00				

Activities (per output)	Inputs
Output 1: Established mental health standards of practice and a quality monitoring system	
Quality indicators 1.1 Development of quality indicators 1.2 Subcontracting AKAZ / ASKVA for testing indicators' feasibility and relevance 1.3 Integration of quality indicators in the MH information system 1.4 Subcontracting AKAZ / ASKVA for on-site trainings and expert support to CMHCs in applying MH quality indicators in work *Accreditation of CMHCs* 1.5 CMHCs Accreditation standards revision 1.6 Subcontracting AKAZ / ASKVA: providing support to CMHCs accreditation *Revised Strategy for MH in RS* 1.7 Revising Republika Srpska Mental Health Strategy 1.8 Design, printing and distribution of the revised strategy	- A pool of experts tasked with the development of draft set of MH quality indicators - Subcontracting AKAZ/ASKVA to test the MH quality indicators feasibility and relevance in 4 communities - An IT company for the integration of the quality indicators in the information system - Subcontracting AKAZ/ASKVA to provide on-site support to (68) CMHCs in applying MH Quality indicators in work - AKAZ / ASKVA subcontracted for the CMHCs accreditation - Local expert workgroup - Graphic design, printing, distribution and promotion of the Strategy document
Output 2: The information system for mental health monitoring, data collection and analysis established	
The mental health information system 2.1 Identification of the needs for modification of the software application for data collection in mental health 2.2 Contracting an IT company for modification of the application 2.3 Organizing on-site training and support to the CMHCs and psychiatric hospitals in data collection and analysis 2.4 Purchase of computer equipment for institutions 2.5 Distribution of computer equipment to institutions	- An IT company subcontracted to identify and deliver the necessary modifications of the software application for data collection - An IT company tasked to provide for the on-site training on technical issues - Local expert work group/ experts' pool for the on-site training on data analysis - The costs of the procurement and distribution of the IT equipment
Output 3: Competencies and skills of multidisciplinary teams to provide quality mental health services strengthened	
Trainings by professional groups 3.1 Implementers of educational programs for MH service providers selected 3.2 Projects for continuous professional development of MH service providers developed by professional associations, based on the set criteria and with the project's quality control 3.3 Funding the implementation of the trainings by the professional associations and monitoring by the p[project *Occupational and Work Activities (OWA)* 3.4 Preparation of an OWA training manual and program 3.5 Development of a plan for regional trainings and recruitment of trainees 3.6 Delivery of regional trainings 3.7 Organization of on-site support to CMHCs for OWA implementation 3.8 Procurement of materials to be used in the application of OWA	- Professional associations (associations of psychologists, MH nurses and social workers) subcontracted to conduct organizational needs analysis, carry out the selection of educational topics and implement the educational program selected - A local pool of experts composed of representatives of professionals from primary and secondary (hospital) health care and the educational sector tasked with the preparation of the OWA manual and training program - Materials for the OWA implementation in 68 CMHCs - Regional trainings and in-service trainers/ supervisors team - The costs of the training (participants accommodation, travel, training material) - Graphic design and printing of the manual

Activities (per output)	Inputs
Output 4: The effective application of Case Management in Mental Health settings developed and implemented	
Monitoring of and supervision in the application of the Case Management approach organized 4.1 Development of an on-site support plan for the Case Management implementation in CMHCs 4.2 Organization of on-site support to CMHCs teams in applying Case Management 4.3 Preparation and implementation of CMHCs teams Case Management regional meetings (on annual basis)	- Local consultants / team for the development and implementation of the Case Management on-site support plan - An IT company subcontracted for the preparation and inclusion of electronic records in the information system - The costs of the regional meeting for CMHCs Case Managers (68 CMHCs) - Local consultants tasked with designing and conducting a survey on users' satisfaction with the quality of mental health community services - The costs of the regional meetings for CMHCs Case Managers /68 CMHCs/ (participants accommodation, travel, training material)
Output 5: Outreach services strengthened	
Promotion and preventive activities 5.1. Preparation of Entity-level promotion and preventive programs in cooperation with PHIs 5.2. Grant awarding to CMHCs for the implementation of promotion and preventive programs	- Work group/experts for the development of Entity level promotion-preventive programs - Financial support to CMHCs in implementing the preventive and promotional programs in 30 communities
Output 6: Infrastructure / equipment renovation of CMHCs supported	
CMHCs reconstruction and equipment 6.1 Reconstruction / renovation of mental health institution premises 6.2 Administrative supervision of the reconstruction works	- Construction materials and equipment for the reconstruction of 16 mental health facilities - An architectural/construction company subcontracted for the reconstruction of MH facilities in 16 communities - Costs of the administrative supervision of the reconstruction works
Output 7: Anti-stigma community programs aimed at specific target groups of population supported and implemented	
Anti-stigma community programs 7.1 Setting up a strategic framework for anti-stigma collaborative programs 7.2 Developing local communities anti-stigma collaborative programs in accordance with the strategic framework 7.3 Organizing trainings for local community stakeholders on the implementation of the collaborative anti-stigma programs and activities 7.4 Awarding grants for community anti-stigma programs 7.5 Organizing expert support to local community stakeholders in the implementation of the collaborative anti-stigma programs 7.6 Transversal end-of-phase research conducted by PHIs on public attitudes towards people with mental disorders and users' self-perception about their exposure to discrimination 7.7 Organizing Gender equality assessment 7.8 Organizing promotion of the results of the anti-stigma activities	- Local experts tasked with the preparation of a strategic framework and collaborative anti-stigma programs, trainings and on-site support delivery in 5 communities - Costs of the trainings (meals, refreshment, training material) - Costs of grants for the collaborative anti-stigma programs to be implemented in 5 communities - PHIs subcontracted to conduct a research of public attitudes towards people with mental disorders - Local team of consultants - Costs of the preparation, printing and promotion of the results of the implemented anti-stigma activities

Activities (per output)	Inputs
Output 8: Increased capacities of user associations for community partnerships and for the support of social inclusion of people with mental disorders	
User associations capacity development 8.1 Preparation, implementation and evaluation of trainings for users associations 8.2 Support to user associations in their establishment of a basic administrative secretariat 8.3 Awarding grants to user associations aiming at improving the quality of users' life, generating working activities and providing legal advisory 8.4 Designing, development, writing, printing and distribution of "Gender Impact Assessment: Assessing the burden of caring for persons with severe mental disorders and multiple needs in a community" in order to prepare a policy proposal based on the findings of the study	- Local consultants for the preparation, implementation and evaluation of effects of the education of users - Costs of the trainings (participants accommodation, travel, meals, training material) - Costs of user associations grants (30 associations) - Costs of graphic design, printing and distribution of ''GIA'' document
Cross-cutting activities	
9.1 Initial presentation of the Project, mini conference/s 9.2 Promotion of MH through specialized magazines 9.3 Project Conference 9.4 Maintenance of the MHP web page	- Costs of the Initial Conference - Costs of publishing articles on mental health in professional medical journals - Costs of the Project Conference Costs of the web master and maintenance of the web site
Steering & Coordination	
10.1 Steering Committee meetings 10.2 Stakeholders meetings 10.3 Cost effectiveness analysis	- Meeting costs (accommodation, meals, meeting materials) - Meeting costs (accommodation, meals, meeting materials) - A local pool of experts tasked with the preparation of the Cost-effectiveness analysis - Costs of graphic design, printing, distribution and promotion of the results of the analysis

11.3 Terms of reference

TERMS OF REFERENCE

Review of the Mental Health Project in Bosnia and Herzegovina
(7F-06515.02 / Phase 2, phase duration: 01.03.2014 – 28.02.2018)
Mandate duration: 9 January 2017 – 15 May 2017

1. Background Information about the Project

The Mental Health Project (MHP) in Bosnia & Herzegovina (BiH), which is financed by the Swiss Agency for Development and Cooperation (SDC), was launched in June 2010. The project's second phase started in March 2014 and will last until end of February 2018. The phase budget is 5.46 million CHF.

The overall goal of the MHP is to contribute to an improved general well-being of people with mental disorders and of those at risk of developing mental health problems in BiH. The project facilitates the implementation of existing mental health strategies in the two entities of BiH - the Federation of BiH (FBiH) and the Republika Srpska (RS)[1], focused at development of the mental health care services at the primary health care level. In its second phase the project comprehensively covers BiH's mental healthcare reform with the following intermediary outcomes to be pursued:

1. Community-based mental health services are managed more effectively and service quality is continuously improved, based on evidence;
2. Persons with mental disorders and those at risk of developing such disorders have access to mental health services of increased quality and scope in their communities;
3. Discrimination against persons with mental health disorders in the communities has decreased.

In alignment with the mental health strategies of the two entities[2], and in order to strengthen local ownership and domestic institutional capacities as well as to enhance the intervention's sustainability prospects, the project is to primarily play a facilitation role, providing technical advice, ensuring coordination and organizational support as well as quality control to local stakeholders, i.e. the relevant entity-level institutions, in implementing project activities. The project is closely steered by the two entity Ministries of Health. The MHP covers both entities with joint overall and specific project objectives, while allowing a fine-tuning of proposed project interventions to the specificities of the health systems in the two entities. The project works with numerous partners within the health sector, providing leadership in enhancing the quality, scope and efficiency of mental health care provision and in strengthening the voice of service users.

The project is implemented by the Association XY, a local non-governmental organisation. It is financed by the Swiss Agency for Development and Cooperation (SDC). In addition to the funding by SDC, Swiss Cantons of Jura, Geneva, Bern and Fribourg, organized in the so-called "Inter-cantonal Cooperation Project", provide expert and advisory support in the project implementation through the so-called Expert Pool, comprised of the Swiss mental health and management experts. Swiss experiences and expertise are used in areas where local know-how is missing, such as nursing in mental health, quality monitoring, occupational therapy, reduction of discrimination of persons with mental disorders, and organisation of preventive actions in communities.

Given a complex project setting, an external review of the organizational structure of the MHP was organized in the project phase 1 (Dr David Becker, 2013) in order to establish what were the

[1] The health system administration in FBiH is decentralized, with ten cantonal administrations having responsibility for the provision of health care through its own ministry, while the Federal Ministry of Health is responsible for health policy and strategy development; planning of medical facilities and human resources; development and regulation of compulsory insurance. The health care system in RS is centralized with the overall power concentrated within the Ministry of Health and Social Welfare of RS.
[2] Mental Health Strategy of Republika Srpska 2009-2015; Mental Health Policy and Strategy of Federation of BiH 2012-2020

needed changes in the project set-up that would allow a more effective and efficient decision-making process, improve team morale and support project performance. Following the recommendations of the review, the new organizational structure was introduced with the project phase 2 and has so far proven to contribute to clearer lines of accountability and a more effective and efficient decision-making within the project.

2. Purpose and Objective of the Review

The second project phase will come to an end in February 2018. It has been planned to continue the project with a third and final three- or four-year phase, at which end BiH's health authorities are expected to be able to maintain a sustainable system of community-based mental health care which provides responsive and quality services, being continuously improved according to best available evidence.

The objective of the project's review is to **obtain evidence-based recommendations for the project phasing out**. The review will present elements for informed decision making, on the project objective system and exit strategy in its last phase and, related to it, in the rest of the ongoing project phase. The review recommendations should focus on the Relevance[3], the Impact[4], the Effectiveness[5], the Sustainability[6], and the Efficiency[7] of the project interventions, in accordance with DAC Criteria for Evaluating Development Assistance.

As the program and the approach are considered as innovative and its results and best practices useful and relevant for other contexts in Eastern Europe and Central Asia (EECA) where SDC is supporting community-based mental health programs (i.e. Moldova), it is suggested to involve peers in the review. This format is also meant to foster synergies and further engage SDC-funded projects in the EECA region in a mutual experience and knowledge sharing. Peers will not have a decision-making role in the review process.

Due to the importance of equity issues in relation to the access to healthcare for mentally challenged people, a specific focus will be put on related aspects during the review. The results and findings in this regard will be shared with the members of the SDC Learning Trajectory on Equity in Accessing Healthcare which has been launched with the support of Institute of Development Studies (IDS) from UK.

3. Scope of the Review

The review is expected to:

[3] The Relevance of a project exemplifies to what extent its objectives and themes respond to essential needs of the defined beneficiary groups (individuals, targeted population groups, organizations that work in solving essential problems of groups in need); a project can also systematically influence a sector system through important reforms or through focused policy work. The basic question is: Are we doing the right things?

[4] The Impact refers to the positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended. The basic question is: What has happened as a result?

[5] The Effectiveness appraises to what extent planning and implementation of the project corresponds to achievable results (outcomes) within the working context. The basic question is: Are we doing the things right? And, are we working in the frame of a realistic objectives' system?

[6] The Sustainability refers to the continuation of benefits from a development intervention after major development assistance has been completed, the probability of continued long-term benefits, and the resilience to risk of the net benefit flows

over time. The basic question is: Are the positive effects sustainable?

[7] The Efficiency appraises to what extent provided means are economically and timely implemented (converted into adequate results / outputs). The basic question is: Are we allocating the available means (financial, professional, institutional) in a reasonable (economic) way? And, can we show this in comparison to similar actions?

1) Systematically analyze and critically assess the project's strategy and progress made in the achievement of expected outcomes and related sustainability prospects, and
2) Provide recommendations on the key issues and elements of the project's phasing out / exit strategy aiming to secure full sustainability of the project results.

Some of the key questions to be addressed by the review are as follows:

- *Relevance and Impact*: To what extent are the project interventions suited to the priorities of and shaped the reform? To what extent do the project interventions contribute to relevant capacity development, strengthening of the targeted institutions and improvement of their performance? To what extent have staff knowledge and attitudes towards mentally challenged patients changed with the integration of mental health care at primary health care level? Could access to health care be improved for a range of people with mental disorders? Were the interventions suited for reducing stigma in facilities and in the community? What real differences have the project interventions made to the beneficiaries? How many people have benefited from the project interventions and how? Do women and men equally benefit from the project? Do people with different kinds of mental disorders benefit equally? Do the impact hypothesis and its assumptions hold? What would the development have been like without the project interventions?
- *Effectiveness and Sustainability*: To what extent were the objectives achieved, i.e. are likely to be achieved? What are the major factors influencing the achievement or non-achievement of the objectives? What are the major factors hindering or helping the achievement of the inclusion oriented objectives (barriers at individual, facility, community, system and policy level)? To what extent did the project help to improve the upward and downward referral system for people with mental health issues (continuity of care)? What other effects and unexpected results – also negative ones – have been established? How far and in which aspects has the support of the Swiss experts, provided by the Swiss Cantons of Bern, Geneva, Jura and Fribourg, contributed to the project's results? To what extent has the project strengthened and promoted local ownership and leadership? To what extent is the participation of the health authorities and institutions, and of service users and communities in the project related decision making and implementation contributing to the result achievement? What are the sustainability prospects of the achieved results and factors influencing the sustainability? Have the methods and approaches introduced with the project's support been integrated in the (mental) health care system? What are the alternative interventions that could be taken to raise the sustainability prospects of the project results?
- *Efficiency*: Are the interventions planned and implemented with genuine participation of key stakeholders? How is the project being steered? How has the projected changed the cost-efficiency of mental health care delivery? How is the coordination and communication between the project team in B&H and the Swiss Cantons of Bern, Geneva, Jura and Fribourg been organized, is it result-oriented, timely and transparent? Is the relationship between input of the project's resources and results achieved appropriate and justifiable?
- *Know-how transfer*: What is the added value of the engagement by the Swiss Cantons of Bern, Geneva, Jura and Fribourg compared to other possible sources for know-how transfer? Is there a need to revise the established cooperation modalities in order to strengthen result orientation? Is there a need for the Cantons' support in the next project phase?
- *Capitalization and replicability:* Have best practices been identified (at technical, policy and management level), collected and systematized, which could be transferred and adapted to other contexts in the EECA region? If not, what kind of capitalization or learning process would be the most suitable? For access and inclusion, what best practices have been identified and what policy changes have been made? How did their implementation go? What were the challenges? Any innovations on the ground?

4. Review Approach and Methods

The review will comprise the following:

- Desk study of relevant project documents (Project Document, project reports, communication, etc.)
- Briefing with the Embassy of Switzerland in Sarajevo
- Briefing with representatives of the Swiss Cantons of Bern, Geneva, Jura and Fribourg
- Field visits and interviews with the Project Team, local health authorities (Ministry of Health and Social Welfare of Republika Srpska, Ministry of Health of Federation of BiH, Ministry of Civil Affairs of Bosnia and Herzegovina, Department of Health of Brcko District) and other project partners (two Public Health Institutes, two Agencies for Accreditation and Quality in Health, primary health care workers and facility managers), project beneficiaries (mental health service users and their families, users' associations).
- Debriefing with the Embassy of Switzerland in Sarajevo and with members of the Project Team - discussion on the main findings / it is expected that the reviewers present a brief *Summary Report* with key conclusions and recommendations
- Preparation of the Review Report

The above list of activities is not exhaustive and the reviewers may engage in other activities deemed important for accomplishing this mandate.

The review is ending with a Management Response provided by the Embassy of Switzerland in BiH. It shall contain a general assessment of the conducted review and its process as well as a statement of the Embassy's position regarding the conclusions and recommendations given in the final review report.

The final Review Report and the Management Response will be presented and discussed with the project's Steering Committee.

5. Composition of the Review Team

An external consultant will be engaged as the leader of the review team, responsible for preparation and organization of the review process, collection of the contributions to the review report by other review team members and preparation of the draft and final review report.

In order to select the external consultant, several consultants will be invited by SDC to express their interest in this mandate. The consultant will be chosen by the Swiss Embassy in BiH based on his/her professional experience relevant to the mandate.

A local resource person will be engaged to provide relevant context-related information to the international Review Team's members, particularly related to the administrative structure of B&H and its health systems, and to support organisation and logistics of the field visits during the review.

Other review team members (peer reviewers from SDC) will include:

1. Mrs. Erika Placella, Health Advisor Eastern Europe and Central Asia, SDC
2. Mr. Valeriu Sava, National Program Officer - Health, Swiss Cooperation Office in Molodova

6. Review Timetable

		Workdays

Activity	Tentative Dates	External Consultant	Peer Reviewers (SDC) - each	Local Resource Person
Preparation				
• Desk review and preparation for the interviews and field work; • Communication with Swiss Embassy in Sarajevo on organizational matters of the review; preparation of the field mission	January – February 2017	4 ½	2	2
Field Mission (in BiH)				
• Briefing and debriefing with the Swiss Embassy in Sarajevo • Travel, interviews with the project team, project partners and stakeholders (Ministries of Health, partner institutions, beneficiaries)	5-16 March 2017	12	12	10
• Interview/briefing with the representatives of the Swiss Cantons (skype)	week of 18-25 March 2017	½		
Reporting				
• Inputs for a draft report • Consolidation/writing of the draft report	10 April 2017	5	1	1
• Finalization of the report	30 April 2017	1		
TOTAL		**23**	**15**	**13**

7. Requirements of the Review Report

The report shall be written in English and not be longer than 30 pages (excluding annexes); it shall comprise the following sections:

1) Table of content
2) Acronyms and abbreviations
3) Executive summary
4) Background of the mission and applied methodology
5) Review findings
6) Conclusions and recommendations, with elements for decision making on the orientation of the project in the future
7) Annexes

The Embassy of Switzerland in BiH reserves the right to request changes in the report structure or the inclusion of additional information. Nevertheless, the external consultant – team leader - has the full ownership of the report; s/he is absolutely free to express her/his independent assessment of the project and its performance.

A first draft report shall be delivered to the Embassy of Switzerland in BiH not later than the 10th of April 2017. The final report revised based on comments and remarks of the Embassy shall be submitted on the 30th of April 2017, the latest.

8. Required profile of the External Consultant - Team Leader

The required qualifications for the external consultant – Team Leader are:

- MA degree in management, social sciences or related field
- Substantial experience in the field of mental healthcare reform, decentralisation of services and community based service provision
- Proven experience in the field of reviewing development projects, if possible involving peers for institutional learning
- Experience in engaging with health care service users
- Experience in working in complex settings
- Excellent analytical skills
- Excellent spoken and written English skills
- Strong communication, negotiation, and writing skills
- Previous work experience in BiH or in the region is considered an advantage

9. Contract and logistics

The external consultant and local resource person will sign a contract with the Swiss Embassy in BiH. Logistics, interpretation, and transportation in BiH for the contracted services will be organized by the Embassy for the field mission in the country.

Flight costs, accommodation and travel cost in BiH for the peer reviewers from SDC will be paid by the Swiss Embassy in BiH.

11.4 Schedule of evaluation

Activity	Dates
Preparation	
• Desk review and preparation for interviews and field work • Communication with Swiss Embassy in Sarajevo on organisational matters of the review; preparation of the field mission	13th January – 3rd March 2017
Field Mission (in BiH)	
- Briefing and debriefing with the Swiss Embassy in Sarajevo - Travel, interviews with the project team, project partners and stakeholders	5th March -15th March 2017
- Interview with the representatives of the Swiss Cantons	23rd March 2017
Reporting	
- Development and writing of draft report	15th March – 13th April 2017
- Review of draft report by SDC representatives	18th April – 24th April 2017
- Development of final report based on comments	24th April – 28th April 2017
- Final report developed and sent to SDC	28th April 2017

11.5 List of key informants

Swiss Embassy

- Barbara Dätwyler Scheuer, Director of Cooperation
- Maja Zarić, Programme Officer for Health

Mental Health Project Team Sarajevo

- Dženita Hrelja Hasečić, Project Directress
- Emina Osmanagić, Executive Director of Association XY

MHP team in Banja Luka – Component 1

- Tatjana Popović
- Tanja Čeko

MHP team in Sarajevo - Component 2 (occupational therapy, MH Professional Associations, reconstruction)

- Irina Puvača
- Lejla Sahačić
- Selma Džonlić

MHP team in Banja Luka – Component 2 (care coordination, programmes of prevention and promotion)

- Biljana Lakić
- Selma Mehmedić-Džonlić
- Zvjezdana Stjepanović
- Mirko Zrnić

MHP Team Sarajevo - Component 3

- Enisa Mešić
- Selma Kukić

Ministry of Health of Federation BiH

- Dr Goran Čerkez, Assistant Minister / project contact person in the Ministry
- Adisa Mehić, Head of Office for Legal Affairs in the Ministry

Ministry of Health and Social Welfare of Republika Srpska

- Dr Milan Latinović, Chief of Dptm for Hospital Care / member of the Project Steering Committee
- Dr Andreja Subotić-Popović, project contact person in the Ministry

Public Health Institute of Federation BiH

- Dr Davor Pehar, Director
- Iskra Vučina, MH Coordinator

Health Insurance Fund of Republika Srpska

- Dr Zlatko Maksimović, Deputy Director
- Dr Milenko Pađen, Manager of the Health Sector in the Fund

Agency for Accreditation and Quality in Health of Federation BiH

- Mr Ahmed Novo, Director
- Mr Alhijad Hajro, MH coordinator

Agency for Accreditation and Quality in Health of Republika Srpska

- Mr Sinisa Stević, Director

Professional associations

- Ms. Belma Žiga, on-site supervisor for professional associations
- Mustafa Šuvalija, representative of associations of psychologists (project „Self-help in Mental Health“)
- Inela Šehić, representative of associations of social workers (project „Work with families of users of CMHCs„)
- Dejan Milanović, representative of associations of nurses (project „Strenghtening nurses' competences in CMHCs“)

Members of Association of Service Users “Dodir”

- Haris Džananović
- Zvonko Ivačić
- Ismar Olovčić
- Dženo Krndžija
- Saša Milutinović
- Elvira Podrug

Association of Service Users “Zajedno” - members of the association and volunteers:

- Ružica Atanacković
- Mirjana Perišić
- Tanja Valentić
- Sejad Merdžić
- Đorđe Basta
- Darko Višić

Primary Healthcare Centre Vogošća

- Dr Enisa Ahmić, Director of PHC

Team of the Mental Health Center Vogošća:

- Dr Maja Dobranić Posavec, Psychiatrist
- Irma Džambo, Psychologist
- Alma Šahmanija, Social Worker
- Ediba Kustura, Nurse

- Kandić Besima, Nurse
- Service users and members of their families

Primary Health Center Vogošća – a Family Medicine team:

- Dr Amra Huseinović Čolić, Family Doctor
- Semia Omić, Chief Nurse
- Kelemiš Senka, Nurse

Mental Health Center Banja Luka - multidisciplinary team (work with children, adolescents, elderly):

- Prim. dr Tamara Balaban, Chief of the Centre
- Dr Ranka Kalinić, Chield Psychiatrist
- Dr Dragan Tešanović, Psychiatrist
- Anita Đuričić, Specialist of Medical Psychology
- Sanja Gidumović, Chief Nurse

Mental Health Centre Prnjavor

- Dubravka Malić, Defectologist-Logopeditian
- Sanja Durtka, Psychologist

Primary Health Center Prnjavor

- Dr Nina Nikolić Blagojević or dr Nataša Sandić (Family Doctor)

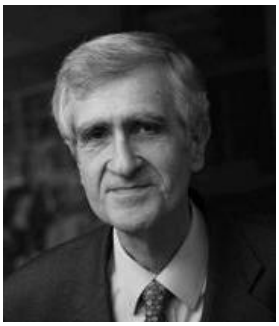
Psychiatric Hospital "Jagomir"

- Dr Muhamed Ahmić, Director

11.6 Evaluator biographies

Maudsley International Review Team

Professor Nick Bouras



Professor Emeritus of Psychiatry
King's College London, Institute of Psychiatry, Psychology & Neuroscience

Joint Programme Director
Maudsley International

Nick Bouras (MD, PhD, FRCPsych) is Professor Emeritus of Psychiatry at the Institute of Psychiatry, King's College London and Honorary Consultant Psychiatrist at South London and the Maudsley NHS Foundation Trust (SLaM). He is currently Programme Director of Maudsley International.

Nick led the research programme of the first Community Mental Health Centre in UK (Lewisham – Open Door) in 1979 and carried out extensive studies of service monitoring evaluation.

Nick was Consultant Psychiatrist, at SLaM from 1982 to 2008. He was instrumental in the re-provision of services from three large institutions, Darenth Park, Grove Park and Bexley Hospital. This included the development of community based multi-professional mental health services that have been supporting numerous residential facilities in local communities for people with chronic schizophrenia, complex needs and forensic problems and neurodevelopmental disorders.

Nick initiated the development of the Estia, (Evaluation, Services, Training, Intervention, Assessment) Centre, in 1999 (www.estiacentre.org). He was Director from 1999 to 2008. This was and remains an innovative concept combining clinical services, training and research & development, jointly funded by the NHS and university.

Nick has been an active member of national and international organisations with roles including: Chairman, World Psychiatric Association, Section of the Psychiatry of Intellectual Disability, Vice President of the European Association of Mental Health in Developmental Disability, and Vice President of the International Association for the Scientific Study of Intellectual Disability.

Nick's research is focused on health service related topics including, assessment and clinical effectiveness of specialist mental health services, evaluation of multi-professional training methods, social and biological determinants of behaviour in psychiatric patients. He has been involved in several mental health service developments internationally, including evaluation, review and monitoring of large scale programmes.

Nick has been editor and member of the editorial board of several journals. He has published extensively in community psychiatry and mental health aspects of people with intellectual disabilities. Several of his books have translated in to different languages.

Silvia Davey

Business Support
Maudsley International

Silvia joined Maudsley International after completing her Masters in Global Mental Health at King's College London (KCL) and the London School of Hygiene and Tropical Medicine (LSHTM). She previously completed her undergraduate studies in Biochemistry at Imperial College London.

Silvia's passion for improving global mental health has been developed throughout her MSc, in which she has gained expertise in international mental health, disability, public health and policy, and social psychiatry, in addition to developing the qualitative, quantitative and critical analysis skills. Silvia has applied these skills during her time at Maudsley International, by helping write a Mental Health Research Priority Agenda for Qatar, assisting with the review of mental health of children and young people in schools in Qatar, and coordinating Maudsley International's training programmes in Qatar

Silvia has a particular interest in the mental health of immigrants, on which she has undertaken a systematic review. She also has an interest in mental health and stigma, and has co-authored two papers on the stigma experienced by family members of people living with schizophrenia in Belarus:

1. Krupchanka, D., Kruk, N., Sartorius, N., Davey, S., Winkler, P., & Murray, J. (2017). Experience of stigma in the public life of relatives of people diagnosed with schizophrenia in the Republic of Belarus. Social Psychiatry and Psychiatric Epidemiology, 1–9.
2. Krupchanka, D., Kruk, N., Murray, J., Davey, S., Bezborodovs, N., Winkler, P., Bukelskis, L., & Sartorius, N. (2016). Experience of stigma in private life of relatives of people diagnosed with schizophrenia in the Republic of Belarus. Social Psychiatry and Psychiatric Epidemiology, 51(5), 757–765.

Peer Review Team

Erika Placella

Health advisor for Eastern Europe and Central Asia
Swiss Development Cooperation Agency

Erika Placella has over 17 years of experience in public health. She is currently the SDC health advisor for Eastern Europe and Central Asia and the focal point for Non Communicable Diseases (NCDs) within the SDC Global Program Health. Before joining SDC, Mrs Placella worked for various medical and public health organizations in Africa, Asia and the Middle East in the field of zoonoses, sexual, reproductive and child health, Food security and NCDs

Mrs Placella has a thorough understanding and knowledge of health trends, health reforms, health systems and related challenges in Eastern Europe and Central Asia, with a focus on Primary Health Care and control and management of major NCDs.

Mrs Placella provides strategic, thematic and technical support and backstopping on SDC health strategies and programs in Eastern Europe and Central Asia (Bosnia y Herzegovina, Kosovo, Albania, Ukraine, Moldova, Tajikistan, Kyrgyzstan), including in new EU member states (Lithuania,

Poland, Bulgaria, Czech Republic). She also provides health policy and policy influencing guidance and contributes to positioning SDC/Switzerland in international and global health debates.

She is a member of the WHO Global Coordination Mechanism of Non Communicable Diseases working groups and collaborates closely with WHO office for Europe on supporting member states in developing, monitoring, steering and evaluating NCDs strategies and action plans. countries and regions.

Her responsibilities also include ensuring continuous thematic coaching and backstopping of SDC national program officers and expats involved in health programs. Finally, she facilitates the exchange of experiences and capitalization on health programs between countries and regions

Valeriu Sava

National Program Officer in Health

Swiss Cooperation Office Moldova

Valeriu Sava is a National Program Officer in Health and has been working at SCO Moldova since April 2011. He is physician by training and after graduating from Medical University, was lectured for 15 years at the Department of Pathology of the Moldova Medical University. He accomplished the PhD in Pathology at the Moldova State Medical University and Master in Public Health at the School of Public Health of the same University. He also hold certificates from the World Bank Institute and Harvard School of Public Health in Health Systems Strengthening and Sustainable Financing, Japanese National Institute of Public Health in Health Policy Development, Swedish Health Care AB / Lund University in Health Strategy Management, as well as from many others training courses in Health Management, which attended. In the period of 1994 to 2011 he was working in several governmental and international organisations at different positions: Deputy Director at the Centre for Public Health and Management, Head of Ministry of Health Department on Health Financing Policy, Training and Health Policy Coordinator within World Bank Project and Project Coordinator within Health Program of the Open Society Institute in Chisinau. During all this period he was involved in developing concepts, policies, strategies and action plan with respect to public health financing, health system management, health services quality, as well as patient rights and medical ethi

11.7 Input SDC Peers – Preliminary Findings and recommendations

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
General Approach	• Switzerland is the **major donor** supporting the health reform in BiH (with minor contributions from UN organizations and WB) and no other donor is supporting mental health services in both Entities. • The project is **well on track** and **major results** have been achieved, despite a **challenging environment and major structural constraints:** (i.e. fragmented policy environment, CMHCs financing mechanism, accreditation system for CMHCs, CMHCs submission to PHC, heavy administrative workload for CMHCs staff and big staff fluctuation, fragmented medical education system, high turnover of PHC management due to political changes/reasons) which go beyond the sphere of influence of the project. • The project is very well **aligned on the strategic orientation of the Mental Health Reform in both Entities**[9] and is recognized as a key catalyst of change in BiH mental health reform, thus highly contributing to the process of **deinstitutionalization of mental health** in the country. The project has compiled best practices which have the potential to be transferred and replicated in similar contexts in the region. • The project has a **unique partnership network**, with a broad high level experts roster, Swiss institutions, central, federal and local authorities, health care centres, health care professionals, professional associations, accreditation agencies, and users' associations. The strong **commitment, motivation** and involvement of **key stakeholders** (MoH, PHC-CMHCs, health professionals,	• Maintain a high level of **policy dialogue** to address structural issues such as standards, and norms regulating CMHCs and PHC, accreditation system, medical education, coherence in decision-making at central, cantonal and local level, etc. See also section below on policy dialogue. • A closer cooperation between the different stakeholders at local level, including **intersectoral collaboration** between health and social welfare, education institutions or involvement and collaboration with municipalities (i.e. setting up health councils) should be fostered. • Fostering **good governance** and **shared responsibility** in community issues related to mentally affected groups could contribute to sustain and leverage the project's achievements. • Further adopt a **bottom-up approach** (focus on service delivery and users) **combining it with a top-down support** aiming at empowering health institutions at national, cantonal and local level and holding them accountable to steer the reform and to deliver quality MH services (i.e. Health Insurance Funds as regards the performance and quality of services). • As regards the project organizational structure, please see related section below.

[8] Some recommendations can appear in more than 1 section.
[9] The *Republic of Srpska Mental health Development Strategy* and the Federation of Bosnia and Herzegovina and the Federation of Bosnia and Herzegovina *Policy and Strategy for the Protection and Promotion of Mental Health (2012-2020).*

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
	accreditation bodies and end-users), at national, federal and local level, is one of the strong factors of the project's success. • The project applied a **systemic approach** by tackling regulatory, legal, policy, service provision (at promotional, preventive, curative and rehabilitative level), and human resources issues, with a nationwide coverage. Both demand and offer related issues have been addressed. Whenever possible, local resources (i.e. ToT/cascaded training) have been used. Due to difficulties to work at central and national level (complex political and administrative structure resulting in fragmented management and governing structures with a problematic dilution of responsibilities), the project rightly chose a **bottom up approach** based on the **empowerment** of health workers, users' and the community, with the aim to build their capacities to **hold governmental structures responsible** for delivering quality and affordable mental health services. • The project is highly contributing to build and maintain **social cohesion** in the country, by reducing inequities in accessing mental health services, bringing together communities and local authorities, fostering good governance and transparency, empowering health professionals and end-users to participate in decision-making processes, increasing solidarity and promoting common values (i.e. anti-stigma related activities), creating job opportunities, and establishing connectivity between CMHCs. • However, some open questions on the **adequacy of the project organizational structure and the balance between individual and institutional capacity building/empowerment** still remain (see sections on project set up and capacity building below)**.** • A closer cooperation between the different stakeholders at local level, including **intersectoral collaboration** between health and social welfare, education institutions or involvement and collaboration with municipalities (i.e. setting up health councils) should be encouraged.	

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
	• Fostering **good governance and shared responsibility** in community issues related to mentally affected groups could contribute to sustain and leverage the project's achievements.	
Service Delivery and Quality Management System	• The **quality of MH services** is reported to have considerably **improved**: policy and regulatory framework for MH brought in line with European standards, patient- and family-centered approach applied, case management/care coordination as well as new forms of occupational therapy successfully introduced, quality mechanisms and tools introduced, education modules updated, trainings to all members of CMHCs multidisciplinary staff provided, learning techniques related to self-care activities introduced, scope of available MH services covered by the health insurance increased, mechanism for users' participation introduced. This results notably in a significant decrease of hospital referral rates by 30% and hospital readmissions by 50%. However, the better quality and increased performance of MH services providers are not yet connected to any financial incentives, results-based payment, etc.) • Via both Entities Accreditation Agencies, strong **support** has been provided to CMHCs to enter in the process of **accreditation** (financial and methodological support based on a peer support approach) and to apply the developed standards. At the same time, both Entities Accreditation Agencies have been supported (financial contribution to working groups, organizational strengthening) by the project in developing or updating these standards and indicators. The collaboration between both Entity Accreditation Agencies and the project coordination unit is reported to be good. • The **accreditation system** is not compulsory (only certification/license is obligatory) and **no specific related incentive/disincentive scheme** is currently in place to promote accreditation (for example granted by the Health Insurance Fund). Additionally, clear evidence that accreditation can save money is currently not available to	• Possibilities to increase the financial participation of CMHCs (10% currently) to get **accredited/re-accredited** should be explored for the exit phase. Other sources of funding could also be identified (i.e. participation of Health Insurance Fund with earmarked funds/pay for performance, payment by PHC for CMHCs they are legally, administrative and financially responsible for, getting a loan from the bank, etc.). • In the same vein, explore the opportunity to conduct a pilot study to quantify the **financial burden of psychiatric hospitals/clinics** (both at inpatient and outpatient level) as regards patients which could be taken care by CMHCs and to identify which incentives/disincentives mechanisms could be put in place, in collaboration with the Health Insurance Fund, not only at health institution level but also at population-based intervention level, in order to increase the general responsiveness of the system. Political reluctance of hospital/clinic management staff might be an obstacle as such studies imply downsizing hospital beds and thus possible budget cuts. This might be particularly the case in FBiH where to date, no DRG system has been introduced (WB will support a costing study on DRG on hospitals), while this is the case in RS, resulting in less interest in getting more patients and extending the length of stay. • This is to be combined with further fostering the **quality culture** so that facilities will be reaccredited. • Providing training to CMHCs for a **better adherence to reaccreditation standards** has also been mentioned by both Accreditation Agencies. • Further **clarifying roles and responsibilities** within CMHCs, thus avoiding overlapping and **strengthening team spirit and cohesion,** is necessary. • **Further strengthening counter/back referral system,** by engaging a more fluid communication and proactive

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
	convince the Health Insurance Fund to invest in accreditation (low awareness on performance issues related to the quality of services). The mechanisms on permanent systemic analysis of all collected data/indicators by accreditation institutions in cooperation with Health Insurance Funds and Public Health institutions are not yet in place. The project has been however successful in convincing CMHCs to investing in the process to get accredited. This effort should be pursued in the exit phase. It is to date not clear whether the CMHCs **reaccreditation process** (every 3 years) will be **sustainable,** as financial and methodological resources are currently provided by the project which covers 90% of the costs of accreditation, with a participation of 10% by CMHCs. • The peers found that further **clarification of roles and responsibilities** within CMHCs, thus avoiding overlapping and **strengthening team spirit and cohesion,** is necessary. Additionally, some services provided by the team according to the protocols in place (i.e. established number of home visits to be performed) should still be seen from a **cost-effectiveness** point of view, also taking into account budgetary constraints (evidence-based driven services versus standardization). • While the **referral system** is reported to be good (the number of referrals to psychiatric hospitals from CMHCs has considerably dropped), the counter/back referral system is not optimal. The collaboration and coordination with psychiatric hospitals/clinics is reported to be poor. There is currently no functional integrated information system, in particular in FiBH, and patients' pathway via network of health services providers (hospitals/CMHC/PHC) seems to be fragmented. CMHCs are often perceived as a competition and no **back referral** case from the psychiatric clinic has been reported for example by the CMHC in Banja Luka. This lack of coordination in the continuity of care contributes to make the **patient navigation** in the system rather **complex**.	collaboration with psychiatric hospitals/clinics, building mutual trust and avoiding duplicating services. • **Data collection** is still a challenge which should be given special attention in the next phase, eventually through a closer collaboration with both Health Insurance Funds in this regard. • A closer **intersectoral collaboration** between health and social welfare institutions and services, at local, cantonal and local level, in order to ensure integrated/continuity of care, should be actively promoted in the next phase. • The **causes and factors causing heavy workload**, **burnout** and **frustration** at CMHCs level should be thoroughly analyzed and appropriate solutions identified. Should the heavy administrative burden be identified as the main cause, ways to rationalize this kind of tasks in coordination and concertation with PHC' management should be explored.

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
	• Concerns about the **workload of CMHCs** related to the demand for services like medical examination when enlisting for service, or for driver license, and for other services which could be partially provided by PHC, have been raised. However, the pressure on the staff is not only due to the number of patients (daily caseload difficult to assess during the mission), but also to heavy administrative burden, rigid salary schemes, insufficient task-shifting, and non-recognition of some professions. This leads to overload, burnout (or condition described as burnout by the staff), frustration and insufficient time spent with patients. • **Data collection** is still a challenge which should be given special attention in the next phase. There is no clear vision of integration of data from CMHCs into the national HIS (sustainability issue). Low involvement of PH institutions in data analysis and evidence generation for better decision-making aligned to needs. • **Health and social care** are not sufficiently integrated at users' level, thus creating a disruption in the continuity of care.	
Mental Diseases Prevention and Mental Health Promotion	• The **capacities of both Entities Institutes of Public Health** remain rather **limited**, although the project invested important resources in strengthening their capacities to draft and implement national promotion and prevention programs. As a result, their role and contribution is not clearly perceptible and tangible. Additionally, there is a lack of strategic vision, no proper coordination mechanism and established action plan within central and federal representations of both Public Health Institutes and the collaboration with CMHCs is rather fragmented and sporadic. • According to the reform, the CMHCs teams should dedicate 30% of their time to prevention and **promotion activities in community settings**. However, the review found that **outreach activities** carried out by the CMHCs teams are rather fragmented and carried out very	• As many persons with mental health disorders tend to have a **poorer physical health** and to engage in high risk behavior (smoking, drinking, insufficient physical activity, unhealthy diet), we highly recommend to sensitize users and to develop activities promoting healthy lifestyles (best practice in Prnjavor CMHC with the development of an Alcoholic Anonymous group). • We recommend to **increasing promotional and preventive activities in school** settings in the next phase. • We recommend to **supporting both Health Insurance** Funds in becoming more aware about the added value of investing in promotional and preventive activities from a cost-benefit point of view (to date, according to legislation, insurance only reimburses curative services and prevention is financed at cantonal and municipal level).

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
	sporadically, without a proper structured framework, planning, monitoring and follow-up mechanism. The major **obstacles** reported are heavy administrative workload, limited resources, lack of incentives, and lack of national programs on prevention and promotion, and weak coordination with local representations of Public Health Institutes.	• See previous section as regards heavy administrative workload.
Governance **Participation**	• In a very difficult and fragmented context with highly dilution of responsibilities at central, cantonal and local level, the project played a major role in **clarifying roles between the different stakeholders** and their respective **responsibilities**. However, this remains a major challenge which is somehow beyond the sphere of influence of the project. • Improved **governance** indicators observed by the peers are: users'/community participation, introduction of accreditation processes, increasing performance and accountability at health care facilities level by the introduction of business planning and health care management procedures. However, this last component should be strengthened in the exit phase. The main obstacles are the limited autonomy of CMHCs from an administrative, financial and decision-making point of view and the lack of technical and institutional supervision at canton (FBiH) and Entity level (RS). • **Key stakeholders have been involved** in the project's assessment, design and implementation. In FBiH, protocols have been signed between CMHCs and **psychiatric hospitals/clinics** and joint meetings are organized twice a year. However, the staff and management of the psychiatric hospital "Jagomir" have expressed their disappointment as regards their involvement in the project. The impression of the peers is that there is still room for further **rationalization of hospital-based mental health services**, including at outpatient level (i.e. Jagomir hospital bed occupancy and length of stay figures) and an optimal coordination mechanism with PHC and CMHCs has still to be found.	• Address **governance** aspects more strategically, notably by identifying key governance indicators which can be easily monitored for the next phase (see SDC Key health indicators currently being developed). • We strongly support the intention of the project to further **strengthening the management skills and capacities of CMHCs** (business planning, human resources management, activities planning, data reporting) in the exit phase and to explore possibilities to extend this support to PHC' management, as CMHCs are directly subordinated to PHC'. To a possible extent, this training should be provided by an institution embedded in the national education system (management school or institute). This training should also focus on strengthening negotiation and advocacy skills. • **Regular monitoring and analysis** of the context in the country specifically linked to gender issues related to the project could be developed, based on the findings of the 2 studies/assessmetnt conducted within the project. • The participation of **women in users' association** activities should be further encouraged. • Synergies with the Swiss supported Young Men Initiative – Promoting Healthier lifestyles among youth in BiH by **challenging gender stereotypes** should be further promoted. The same applies as regards the project on Strenghtening **the skills of nurses**. • **Further strengthening counter/back referral system,** by engaging a more fluid communication and proactive collaboration and coordination with psychiatric hospitals/clinics, building mutual trust and avoiding duplication of services.

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
Gender	More generally, the impression is that there are no clear admission criteria/standards/regulations at hospital level (or they are not applied), especially for hospitals which are not accredited. Consequently, the decision lies with the user (self-referral) who is free to visit CMHCs or the outpatient psychiatric services at hospital level, regardless of the severity of the mental disorder he might have. Less competition between CMHCs and psychiatric hospitals/clinics is reported in the RS, as a DRG system has already been introduced in the hospitals. • **Gender considerations are properly addressed:** gender sensitive service provision (majority of users are women), gender disaggregated data is available (gender equality indicators are integrated in the CMHCs monitoring system), gender impact assessment and gender equality assessment carried out. However, the review didn't have the opportunity to assess whether these analyses contributed to better gender mainstreaming in health policies and in the project and whether gender as a cross-cutting issue is addressed in a systematic way. The majority of users' associations' members are men.	

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
Project set up **Intervention Strategy** **Steering and Monitoring**	• The new project's **organizational structure** is effective: clearer lines of accountability, more effective and efficient decision-making, and more clear division of labor and related responsibilities. • The project has set up a Steering Committee for the strategic decision-making related to the project's interventions. For time constraints reasons, it has not been possible to further investigate about the functioning and the structure of this Committee. • The project plays a **facilitation role** and is thus totally aligned with the current SDC Bill to the Parliament on the Cooperation with Eastern Europe and Central Asia. However, possibilities to **further strengthening the competencies of XY Association** in identifying national institutions which could provide technical assistance to CMHCs (clinical and in terms of management) should be explored for the next phase or a different international backstopping scheme with a stronger and more structured coaching component should be found. We are aware that this is somehow in contradiction with the need to design an exit phase, but it is crucial to sustain the results at individual and organizational level. • Some gaps in the **communication** on the project's activities, and more generally on the reform of mental health in the FBiH have been reported (i.e. some CMHCs staff were not aware of all components of the project).	• Due to the complexity and context, we recommend a **4-year duration** for the exit phase. As regards the priorities, **3 components could be developed:** at **policy dialogue/policy influencing level (**pushing the MH reform agenda forward, identifying institutions which could take over specific aspects, fostering intersectoral cooperation between MoH, Ministry of Social Welfare and Ministry of Education at central, federal and local level in both Entities, collaborating with the Health Insurance Funds on performance and financing of CMHCs including for outreach activities, as well as with PH institutions in health promotion and prevention activities); at **service delivery level** (strengthening CMHCs management capacities, optimizing power relations with PHC, improving data management); and at **population level** (strengthening users' associations, sustaining national campaigns, improving communication on the project and the reform in general). • Further adopt a **bottom-up approach** (focus on service delivery and users) **combining it with a top-down support** aiming at empowering health institutions at national, cantonal and local level and holding them accountable to steer the reform and to deliver quality MH services (i.e. Health Insurance Funds as regards the performance and quality of services). • It is recommended to select **fewer indicators** for the next phase and to consult the newly developed SDC key health indicator list and related working aid. • Possibilities to **further strengthening the competencies of XY Association** in identifying national institutions which could provide technical assistance to CMHCs (clinical and in terms of management) should be explored for the next phase or a different international or national backstopping scheme on a more continuous basis.

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
Sustainability	• Overall, the project has **strengthened and promoted national, cantonal and local ownership and leadership** in both Entities. • Overall, peers found that **CMHCs are not fully sustainable** and that there is currently no vision, including at implementation unit level, on how to ensure their functioning (including quality-related issues) beyond the project timeframe. CMHCs are legally, administratively and financially embedded in PHC facilities. Consequently, they have very limited decision-making power and face some reluctance from PHC to refer MH patients to CMHCs (no incentive mechanism in place). At the same time, PHC estimate that there is a need to have CMHCs and that they could not deal with mental health patients (especially as regards transgenerational trauma). • In both Entities, the extent to which the **training**s provided by the project (i.e. case management for all CMHCs staff profiles or occupational therapy) are **embedded** in the **national education system** in terms of responsibilities, leadership and coordination after the project completion, remains an open question (systemic approach to medical/nursing education; i.e. who will be in charge in periodically updating the curricula and guidelines developed by the project?). Major structural obstacles have to be mentioned here: clinical psychologists not recognized (no law on psychology practice), no single institution in charge of medical education in MH, mushrooming of private medical universities and colleges. • **Users' associations** have been newly established and the voice of users has been considerably strengthened, due to project support, notably via small grants. However, these associations are currently not sustainable for obvious reasons pertaining to the length and complexity of such processes which are somehow beyond the sphere of influence of the project. However, ways to link these associations to umbrella organizations (i.e. revitalizing the Union of the Associations of User's associations in FBiH) should already be explored in the current phase. •	An **exit strategy** should already be developed in the current phase. The **strategy** should be built taking into consideration the following possibilities to be still explored: • **Identify national institutions/counterparts** to be empowered and prepared to take over specific project components (training, quality management, supervision of staff, etc.), including cantonal public health institutes. • **Further strengthen institutional and management capacities at CMHCs level** (i.e. expanding and strengthening business planning and general management skills and competencies). • At demand level, s**trengthen users' associations'/community organizational and individual capacities** and involvement in decision-making and in collaborating with CMHCs in joint advocacy actions. Possibilities to link these associations to umbrella organizations (i.e. revitalizing the Union of the Associations of User's associations in FBiH) should already be explored in the current phase. In order to further support the deinstitutionalization of MH services, foster increased **intersectoral cooperation** at Entity, cantonal and local level with other ministries/ministries representations (Education, Social Welfare, and Justice) and with civil society organizations. In RS, the advantage is that the MoH and the Ministry of social welfare are merged. • **Strengthen the counter/back referral system,** by engaging a more fluid communication and proactive collaboration with psychiatric hospitals or clinics, building mutual trust and avoiding duplicating services.

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
Sustainability	• **Health financing issues** are a key element to sustain the project's results and at the same time constitute a major structural obstacle. In both Entities, the Health Insurance Fund is contracting the services provided by CMHCs. However, the budget, a "lump sum"/"global budget", is provided via PHC (contract signed with the insurance on a yearly basis) and is not based on "real" CMHCs' needs and/or performance. Consequently, there is little flexibility in the budget and no incentive is provided for better performance, increased responsiveness, efficiency and quality of services, especially for promotional and preventive outreach services. The peers found that at PHC and CMHCs level, there is a confusion and lack of knowledge on the sources and mechanisms of financing of both services, including as regards the possible contribution of municipalities to CMHCs. In RS, a "global budget" is received by the PHC director and distributed among the different services. • **Health Insurance Fund in RS** conducts limited analysis and actions in order to increase the performance of the contracted service providers and no incentive/rewarding or disincentive mechanism is in place in this regard. Additionally, both Insurance Funds conduct limited activities aiming at informing providers and users about the functioning of the mechanism at population, healthcare providers (practitioners) and service delivery level. The potential of database created by both Health Insurance Funds for evidence-based decision-making and strategic planning is underused. • As regards the **sustainability of the accreditation system**, see section on quality assurance system above.	• Further strengthen the **role of accreditation agencies** and **promote** the advantages of **accreditation/reaccreditation** in terms of quality and visibility/prestige, including as regards the financing of the process. • Optimize the information and awareness activities in order to **better explain the funding system** to CMHCs' staff, users, and general public, in order to improve their skills and self-confidence in holding service providers and policy-makers accountable for quality and affordable MH services, i.e. eventually organize a workshop to bring different stakeholders at the same level of knowledge, fostering transparency and accountability. • Strengthen the **collaboration with the Health Insurance Fund** in both Entities, to explore ways of increasing the performance and quality of CMHCs. In this regard, better use the data on mental health services produced by the insurance to feed the policy and advocacy dialogue. Eventually support the Health Insurance Fund in better using the data for performance purposes, in developing rewarding/incentives/disincentives mechanisms, especially as regards promotional and preventive services ("cost-effectiveness" issue) and to better understand cost-benefit issues related to quality of care and performance/costs of ill health.

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
Sustainability		• Possibilities to **link users' associations with umbrella organizations** (i.e. revitalization of the Union of the Associations of User's associations) should be explored already in the current phase. Another measure could be to strengthen the collaboration between users' associations and professional associations (mentoring and motivating users' associations, i.e. Association of Young Psychiatrists) or with users' associations at hospital level. The collaboration between CMHCs in a more structured and formal way could also foster p**eer-support and peer pressure** beyond the timeframe of the project. • In order to **advocate for the better performance** and for (in the case the exercise would demonstrate it) increased financial resources for CMHCs, we suggest to conduct a **costing-study i**n order to calculate the costs of production of the services provided by CMHCs, including for promotional and preventive services. The analysis could be benchmarked with MH services provided at hospital level, in private practices or with similar services provided in neighboring countries having introduced community-based mental health services. This should be done in the current phase if possible. • As regards the **sustainability of the accreditation system**, see section on quality assurance system above.

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
Anti-stigma Discrimination Inclusion	• See also above comments on **users' associations.** • Although a social distance towards people with mental health disorders is still predominant, the **attitude of the society and health care staff** towards mentally affected people has reported to have **changed**, thanks to the awareness and anti-stigma campaigns supported by the project: journalist report differently about mental health, mental health issues are discussed in TV shows, public is more interested in better understanding mental health disorders, some mentally ill people have reintegrated the job market and/or the society (i.e. "being a grand-mother again" and taking care of grandchildren, better self-perception-"feeling not a parasite anymore"), closer collaboration between mental health professionals and between professionals and users. • Lack of competencies and/or high **reluctance** of medical staff to investigate about **somatic disease**s of people suffering from mental health problems have still been reported, although clear mindset changes are taking place thanks to the project activities at facility and community level. At CMHCs, a change in the perception and attitude of nurses and other mental health professionals towards mentally ill patients has been reported (more respect and more empathy towards patients). • There is a lack of clarity as regards the availability and efficiency of **legal protection mechanisms** for mentally ill users experiencing discrimination and abuses (including information confidentiality related issues, exposure to the media). Patients tend to be reluctant to record cases of discrimination and legal advisors at federal and municipal level don't fully play their role. The role of the newly established entity-level Commissions on Human Rights of Persons with Mental Health Problems is not clearly perceptible. • **Users' feedback/complaint mechanisms** are in place at PHC level and also cover the services provided by CMHCs. In Banja Luka CMHC, the staff reported no complaint to date.	• As many persons with mental health disorders tend to have a **poorer physical health** and to engage in high risk behavior (smoking, drinking, unhealthy diets, lack of physical activity, unhealthy diet), we highly recommend to sensitize users and to develop activities **promoting healthy lifestyles** via user's associations. • We recommend to strengthening the participation of **family members** (including parents of mentally challenged children) of mentally affected persons in anti-stigma activities and advocacy and as members of users' associations. • We fully support the intention of the project to work more closely with the **media** in anti-stigma campaigning (i.e. involving well known and influencing personalities as champions of change) in order to increase public pressure. We also recommend to increasing the involvement of families of persons affected by mental diseases in the campaigning activities. • We encourage the project to develop activities aiming at increasing the **collaboration between users' associations** and **CMHCs** beyond the participation of its members to trainings to share their personal trajectory (some reluctance of CMHCs in engaging with users associations in a "peer learning format" has been reported). • The peers fully support the intention of the project to provide additional **training on child, adolescent** (transgenerational trauma related to the war) **and geriatric psychiatry** (increasing dementia cases) in the next phase of the project. Additionally, we highly recommend to increasing **intersectoral collaboration with educational and social welfare institutions** and with the police. Constraints such as the fact that there is no PHD for adolescent MH in the country to date have been mentioned.

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
Anti-stigma Discrimination Inclusion	• Unfortunately, **users suffering from heavy psychotic disorders** can for obvious reasons be unintentionally excluded from the activities conducted by the users' associations. In such cases, the strong involvement of family members should be promoted. • **Adolescents/juvenile patients, victims of family violence and the elderly** have been described as groups at high risk of mental health disorders and a lack of specialized skills and competencies in this regards among CMHCs' staff has been pointed out. • Users associations are reported to have efficiently used the **small grants** provided for small scale projects implemented at community level, aiming at reducing stigma and discrimination and increasing social inclusion of people living with mental disorders. • Thanks to the "speakers training" provided by the project, users have gained **confidence** and **self-esteem**, and strengthened their capacities to share their personal experience. • The review team has been informed that a new program supported by the MoH of FBiH on **social inclusion** is being currently drafted. It is primarily addressed to social welfare institutions and to the Ministry of Social Welfare. MoH of FBiH is also providing training on MH to social welfare and educational institutions staff. • MHP has already established cooperation with SDC's project on youth employment on establishing **social enterpreneurship** models with users' associations. Fenix and other two associations have been assessed as ready to engage in this model and will receive support in establishing social enterpreneurship already in current project phase. This is considered as a pliot activity based on which results roll out in the next phase will be planned.	• As poor education is the main cause of stigmatization of mentally ill people in BiH, we suggest to strenghten the awareness raising and anti-discrimination interventions in **educational settings**. • Establishing links and collaboration with civil organizations engaged in the defense of **human rights** as regards the discrimination of mentally ill people, should be considered for the exit phase. The work done by Mens Sana Association would be a good entry point. • Seize opportunities to **increase cooperation between Ministry of Health and Social Welfare in FBiH**. Working on child violence has been defined as a good entry point in this regard. • Increase **exchanges between users' associations in a spirit of horizontal learning and peer support**. Fenix Tuzla Association (experienced, structured, experience in exchanges with similar regional associations) could be used as a "champion" in this regard. • **Collaboration between users' associations and municipalities, community, and NGOs has started and** should be further promoted (municipality can provide premises for example). **Social entrepreneurship** opportunities are also being explored and should be further promoted (i.e. Slovenian model). Fenix Tuzla Association (vision-oriented, good organizational capacity, structured, experience in exchanges with similar regional associations, advocacy capacities, memorandum of understanding with different institutions at local level concluded) could be used as a "champion"/driver of change in this regard, mentoring and strengthening the organizational capacities of younger associations (how to develop partnership, how to enter in coalitions, increased role and obligations of members). Possibilities to bring more volunteers on board should also be explored.
Capacity Building	• See also comment on trainings in the previous section and in the section on project set up.	• We highly recommend to develop a mechanism to **foster peer support/pressure between different CMHCs**, building on the dynamism of champions of change (i.e. organizing

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
	• The project has highly contributed to **strengthen** the **capacities of XY Association** in project management, financial procedures, standard operating procedures, etc. These tools are now used for other projects implemented by the organization and financed by other donors. • For sustainability purposes, a better balance should be found between activities aiming at improving i**ndividual competencies** and skills and measures to strengthen the **organizational competencies** of the health institutions involved in the project (management capacities, communication and negotiations skills, collaboration with other stakeholders, fundraising, human resources management and mentoring, governance issues, etc.). • The introduction of **case management/care coordination** has considerably contributed to empower CBHMCs staff, including psychologists and nurses, and to increase the collaboration among them. • The **support of the Swiss Cantons and the Swiss backstopping** in general is very much valuated. However, the need for a more permanent clinical supervision at the level of health system has been expressed by CMHCs staff (some psychiatrist's part of the CMHCs get supervision on a private basis). • The project provided capacity building for **professional associations**. However, the peers found that currently, professional associations are not strong enough to sustain the training and quality management system put in place by the project, to advocate for this and to hold authorities accountable for delivering good services.	exposure visits). SDC has compiled interesting and successful experiences in accredited peer-reviews in the Balkans (Kosovo, Albania) and Central Asia (Tajikistan, Kyrgyzstan) which could be maybe replicated in the BiH context. This mechanism is low cost and has a good potential to be sustainable beyond the project timeframe. • We fully support the intention of the project to put more focus on the **protection of MH health care staff** and on the prevention of burnout by improving the working conditions. • The same applies for the a**lleviation of burden of families** of people affected by meantal illnesses. • We fully support the intention of the project to strenghten the **management capacities of CMHCs** (business planning, staff management, reporting, quality management, accreditation/reaccrediation process, etc.). In this regard, best practices which can be shared have been compiled by other projects supported by Switzerland in Albania, Kosovo and Central Asia. • Possibilities to **further strengthening the competencies of XY Association** in identifying national institutions which could provide technical assistance to CMHCs (clinical and in terms of management) should be explored for the next phase or a different international backstopping scheme with a stronger and more structured coaching component should be found.
Policy Dialogue	• **Swiss Embassy** influence in terms of policy dialogue and policy influencing is reported to be used optimally. Joint Swiss Embassy and XY Association policy and advocacy initiatives have and are being conducted on a regular basis and lead for example to major systemic changes in both Entities: CMHCs services contracted by Health Insurance Funds, curricula for case management training	• Maintain a high level of **policy dialogue** to address structural issues such as standards, and norms regulating CMHCs and PHC, accreditation system, medical education, and coherence in decision-making at central, cantonal and local level. • Explore the possibility of using and adapting the newly developed SDC **policy influencing concept** (piloted in

Observation Areas	Preliminary Findings/Open Questions	Recommendations[8]
	embedded in the medical education system, strengthening of both Entities Accreditation Agencies and promoting accreditation at MoH level. • **Policy dialogue activities** should however be better systematized (with a clear strategy and action plan), p**olicy messages** should be conveyed in a more structured way and clear policy issues and objectives should be defined and agreed between the Swiss Embassy and the implementing partner.	Moldova) which is defining the main policy priorities related to the project and the respective role of SCO and implementing partner in conducting this dialogue. • Ways to further **strengthening XY management staff skills in negotiation, policy dialogue and advocacy** should be explored. • Develop a **communication strategy** on the project's activities and about the reform in mental health, in order to improve users' skills and self-confidence in holding service providers and policy-makers accountable for quality and affordable MH services.
Capitalization	• The project has introduced **innovative approaches and compiled very good practices** (i.e. case management or modern forms of occupational therapies) which could be further documented, systematized, and replicated in similar contexts.	• Further document and systematize the **good practices** introduced by the project. • Further intensify the **cooperation and exchanges** with other SDC funded mental health projects in Moldova and Ukraine. Additional resources for this kind of exchanges should be made available within the project budget ("regional exchanges and capitalization").