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PRIMARY HEALTH CARE REFORM HANDBOOK

Introducing family medicine in a transitional country with an NGO as facilitating agent: *fami* Foundation in Bosnia and Herzegovina

Sarajevo 2011

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THE REWIEV

The publication entitled " Introducing family medicine in a transitional country with an NGO as facilitating agent: fami Foundation in Bosnia and Herzegovina" is the sublimation of ten years of experience and specific knowledge gained through implementation of family medicine in Bosnia and Herzegovina by the foundation „Fondacija fami" .

The handbook, with its content and purpose, is a novelty in the literature on family medicine in Bosnia and Herzegovina. It is addressed to health authorities, managers of health institutions, physicians and family medicine nurses, and all other health workers.

This guide is tailored to the reader and in a simple way documents the experiences and approaches applied by the foundation within the FaMI project.

The articles in the handbook describe application of the most important phases of family medicine implementation as well as activities in each phase. The foundation, through this manual, generously shares its experiences and approaches as well as documents developed under the project.

The handbook contains five chapters that are clear and practical, and above all logical, covering almost the entire issue of the implementation model of family medicine as a form of organization of primary health care. The chapters describe the history of the reform process in Bosnia and Herzegovina and the reasons for family medicine introduction. The handbook, in a very concise way, explains the importance and role of facilitating NGOs in the overall reform process, describes family medicine in a broader context, lists key actors in the reform and explains the necessary steps and activities in primary health care reform. The text in the thematic units is a comprehensive, very structured and transparent.

In addition to the simplicity of text, the handbook's volume is adjusted to the primary purpose. Listed references direct the reader and facilitate its further study through internet and literature.

Annexes to this handbook, which will be published in an electronic form, include instruments made and used by FaMI for the implementation of all reform activities. Each instrument is accompanied by a brief description that explains its purpose, method of use, type of beneficiaries and the implementation phase in which it is used.

It is a robust and well documented guide. The authors have worked very hard to reconcile the different chapters to the basic concept of the handbook. Text and instruments of this handbook will be valuable for the family medicine teams in the implementation of various aspects of reform. In particular, the authors should be applauded for efforts to present the most significant barriers to the implementation of the reform process as well as in the implementation of changes on the ground.

Activities conducted within the FaMI project show high potential for use or inclusion in other, larger and more comprehensive programs that aim to reform the health care system to family medicine.

Based on a careful reading and insight into the text of the handbook, I recommend it for publication.

In Banja Luka, August 2011

Made by
Prof.dr Gordana Tešanović
Head of Family medicine cathedra
Medical faculty of Banja Luka

THE REWIEV

The handbook “Introducing family medicine in a transitional country with an NGO as a facilitating agent: fami Foundation in Bosnia and Herzegovina” by doc. dr. Esref Kenan Rašidagić systematically describes contemporary developments in the field of family medicine in Bosnia and Herzegovina through a facilitating agent foundation „Fondacija fami”.

After each chapter of this quality handbook there is a set of instruments, presented in the annex, which illustrate a number of activities that have been developed by the foundation and evolved over a decade of work in this area of health care, what represents an additional quality of this handbook. This allows interested readers to find the best information for each instrument, what will allow them to expand their knowledge.

The entire handbook has been written in a clear, concise, precise and very professional manner. The author has accepted a very difficult task for extensive and very complex matter of development and implementation of family medicine in our country has been explain in a detailed, friendly and completely understandable way. The author gradually introduces reader to the fundamental basis of the status quo in the health system in the post-war period all the way to a comprehensive process of implementation of family medicine in Bosnia and Herzegovina, which is extremely well done by the foundation „Fondacija fami” in the past decade.

I think that this handbook, with many practical tools / examples will be very useful for health workers in family medicine, residents in this area, managers of health institutions, staff of health insurance funds and institutes of public health, health policy makers, undergraduate and postgraduate students of medicine, but also for all other stakeholders who want to learn about family medicine.

By documenting of the main features of organization and implementation of family medicine in Bosnia and Herzegovina with the help of foundation „Fondacija fami”, this comprehensive handbook has an additional value, because it presents a plausible model for the reform of the primary health care and implementation of family medicine in other countries, adapted to the specificities of each country. This is certainly one of the first manuscripts in this area and is eagerly awaited by all the aforementioned categories of future users.

The handbook “Introducing family medicine in a transitional country with an NGO as facilitating agent: fami Foundation in Bosnia and Herzegovina” by doc. dr. Esref Kenan Rašidagić addressing the very current topic, is written in the accessible and simple style, but with a very large number of very useful and well-systematized data. This manual represents highly valuable and original contribution of the author and should be seen as a supplement to the general efforts to promote family medicine in Bosnia and Herzegovina.

I consider this manual a valuable and unique achievement, extremely well read easy reading and it fully meets the requirements of literature in this area. Therefore, I wholeheartedly recommend this guide to be published, and to the author, a respected expert in political science, I wish further success in his work.

Tuzla, September 2011 Doc. dr Olivera Batić-Mujanović

Introduction

Breaking with the former system's tradition of providing healthcare services mainly at the specialist level, primary healthcare was defined as the new foundation of the county's healthcare system by the health authorities of Bosnia and Herzegovina (BIH). The ensuing reform of BIH healthcare system aimed to provide the country's citizens with comprehensive and affordable healthcare coverage on a continuous base. In order to reverse the costly reliance on the secondary and tertiary levels of care, family medicine services were introduced and given central role in the overall healthcare system. Family medicine teams were tasked with resolving the majority of the population's healthcare problems and needs, as well as with taking an active role in health promotion and prevention activities, in order to improve health outcomes for the population while reducing costs of the system.

The Swiss Government, through the Swiss Agency for Development and Cooperation (SDC), has supported BIH healthcare reform process from 2001 onwards, facilitating the introduction of the family medicine concept in the country. Over a ten years period, through the so-called Family Medicine Implementation Project (FaMI), more than 9 million Euros were invested in BiH's primary healthcare sector. The FaMI project was implemented in 35 municipalities - in the Cantons of Zenica-Doboj, Posavina, Sarajevo, and Bosansko-Podrinjski in the Federation of BIH, and the regions of Doboj, Bijeljina, Foca, and a part of Banja Luka region in the Republika Srpska. Particularly in its initial phases, the project benefited substantially from the professional assistance of the Geneva University Hospitals. In 2007, the local project team established the foundation „Fondacija fami" and took over the full responsibility for the project implementation from the Swiss implementers.

The FaMI project has helped to establish an access to family medicine services for more than 20% of the population of BIH. In particular, it contributed to strengthen the accessibility, quality and scope of curative and preventive services provided by the family medicine teams. This was achieved by supporting the relevant BIH institutions in ensuring favourable conditions for the practical implementation of the family medicine concept and in establishing a system of additional education in family medicine for doctors and nurses. Within the project, 161 family medicine healthcare facilities (ambulantas/ departments) were reconstructed and equipped, Centres for Additional and Continued Education of health care providers were established in Sarajevo, Zenica, Doboj, and Foca, and 611 doctors and nurses successfully completed the additional education in family medicine. Furthermore, the project supported the establishment of a system of continuous professional development for doctors and nurses in 23 community healthcare centres and facilitated the introduction of community nursing services in Sarajevo Canton and Doboj region, which cumulatively reached over 38'000 direct beneficiaries belonging to the most vulnerable population groups.

Based on the learnt lessons and good practices from the FaMI project, the given handbook provides a collection of practical and ready-to-use tools and instruments which can be used for scaling-up and replicating the project's successfully tested approaches in family medicine implementation.

We hope that this handbook will be used and consulted by primary healthcare decision-makers and practitioners throughout BIH, thereby making a contribution to an increased efficiency and higher quality in the provision of healthcare services to the citizens of BIH.

Simone Giger
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Swiss Agency for Development and Cooperation
Swiss Cooperation Office in Bosnia and Herzegovina

1. FaMI and Reform of Primary Health Care through Family Medicine Implementation in Bosnia and Herzegovina

Health sector was one of the principal losers of the war-induced developments in Bosnia and Herzegovina. Damage induced included destruction of physical infrastructure on all levels, whereby many primary healthcare centers and hospital were reduced to rubble. Brain drain, or flight of skilled medical practitioners, was another most damaging consequence of the conflict and post-conflict instability and insecurity. This flight took two forms: one was emigration of the most skilled practitioners (specialist doctors and senior nurses and technicians) who left the country and restarted their careers elsewhere, perhaps never to return. The other form was internal migrations where the remaining medical practitioners left the areas most scarred by conflict, which also typically turned to be the poorest and most unstable parts of the country after the war.

Having reestablished themselves in richer and larger urban areas of the country, they left majority of health institutions in poorer and more rural areas short-staffed and unable to provide appropriate level of healthcare to population. Great majority of medical practitioners who remained in the country suffered from a decade of isolation from developments in mainstream medicine. Medical practice accordingly failed to keep up with latest trends in medicine, with new advances not finding its way into provision of medical services in BiH.

On top of it all, healthcare system itself suffered disproportionally from fragmentation of country's political framework. In such a small country suffering from dearth of material, financial, human and knowledge resources, provisioning of healthcare services was compartmentalized among myriad newly formed authorities, including 10 cantonal and 2 entity Ministries of Health, comparable number of Public Healthcare Institutes, Health Insurance Funds, and educational institutions. Resources were not pooled, activities not coordinated, education followed different curriculums. As a result, for example, richer areas could afford levels of healthcare comparable to prewar situation, while other areas were struggling to fund and organize provision of even basic services. While large swathes of territory were not covered by a single medical doctor, in other areas politics triumphed over reason, mandating duplication of primary, secondary, and even tertiary healthcare facilities within shouting distance from one another. By and large, healthcare system and medical practitioners were consumed by everyday struggle to continue functioning in such adverse circumstances, which left no time for their professional improvement and development of services.

Recognizing these problems, a variety of donors have extended financial and expert support to different parts of the healthcare sector in Bosnia and Herzegovina

in the postwar period. While generally credited with providing for some of the more urgent needs of the health sector, including physical reconstruction of numerous facilities and provision of necessary equipment, it has been largely acknowledged that donors' attempts at structural reforms enjoyed mixed success.

Reasons for such mixed picture are many and are related both to complex realities of Bosnia and Herzegovina's unique political arrangements, as well as to donors' own shortcomings. Regarding the donor side, observers of the scene have identified a range of problems, which the intervention in this field shares with other sectors such as welfare, education, civil society and the like (Maglajlic and Rasidagic, 2008, 2011). In short, these problems mainly revolve around the failure of the donor community to coordinate their disparate interventions and align them with strategic blueprint for action (which is in itself missing). In addition, donor-driven projects suffer from limitations related to project-based interventions: frequently short lived (maximum 3-4 years) and with serious image problem (often viewed as condescending and imposing its own agenda and interests).

1.1. Family Medicine Implementation Project in Bosnia and Herzegovina

Contributing to assuring the access to affordable, equitable and efficient health services for the population of Bosnia and Herzegovina

The project started in 2001, originally with the goal to support the primary healthcare reforms through provision of additional education in family medicine of medical practitioners. Responding to the established needs of the healthcare system, the project over the years extended its activities to direct family medicine implementation. The project was implemented with professional assistance of the Geneva University Hospitals and through two project offices in the country, in Sarajevo and in Doboj.

Funded by the Swiss Government to the tune of CHF 1.45 million annually, the project sought to address most of the above-identified issues plaguing donor-driven interventions. First of all, the donor committed itself to long-term intervention, coupling financial and expert assistance with the existing local resources and plans. Selection of an NGO (*fami* Foundation) as a local implementing partner was made in order to bridge the ethnical/political divide, which could not be accomplished in the absence of public coordinating authority on any level.

Based on baseline research and consultations with all relevant stakeholders, the project outline varied from phase to phase, as implementers and the donor sought to respond to the health sector needs. In early stages, the project focused on creating preconditions for successful introduction of family medicine through assistance in reconstruction and equipping of physical infrastructure. Later, the project moved towards capacity building, initially with the assistance of Swiss experts. The overall goal of the third phase of the project, which served as a kind

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

The project was implemented in eight main 'areas of influence', including additional education of family practitioners, and, to a smaller extent, continuous medical education, evaluation and monitoring, capacity building measures, rehabilitation of primary care structures and health promotion campaigns. Technical assistance was mainly used for the outline and implementation of the retraining programme to family practitioners.

FaMI established **close cooperation with all relevant stakeholders** on all levels of government and practice, involving them as genuine partners in decision making and implementation of the project, which is precisely what sets this project apart from other comparable projects. Project partners included:

- Primary healthcare centers and ambulantas in cantons (Federation of BiH) and municipalities (Republika Srpska) covered by the project
- Entity Ministries of Health
- Cantonal Ministries of Health
- Entity and cantonal Public Health Institutes

1.2. *fami Foundation*

The foundation grew out of the Family Medicine Implementation Project in BiH (FaMI Project). After the project team registered as the *fami* Foundation with the Ministry of Justice of BiH in 2007, the Foundation took over the implementation of the FaMI Project from the Swiss implementing agencies. This transition marked the maturing of the project after capacities of the implementing agent and partners were judged as sufficiently developed to take over management of the project.

The overall goal of the foundation is the improvement of the quality and quantity of health and social care provided to the population in BiH, including the support to all segments of the health and social care system, as well as their linking for achievement of better accessibility, comprehensiveness and continuity of health and social care.

2. This Handbook

The Family Medicine Reform Handbook has been conceived on the basis of observation and study of a decade of implementation of the family medicine concept in Bosnia and Herzegovina. This SDC-funded project has been judged by all involved stakeholders and several external experts as unique in terms of its design, organization, and approach to implementation. Therefore, it has been decided to try to document its main features and experiences of the implementing agent –*fami* Foundation – into concise, yet comprehensive, handbook that could provide a sort of blueprint for similar endeavors elsewhere.

Bearing in mind the potential for its wider use, the handbook does not delve more than necessary into project-specific details regarding the experiences from implementation of family medicine in Bosnia and Herzegovina. Instead, it strives to compile these experiences in a manner that could help the reader adapt the lessons learned from the project implementation to country-specific setting.

For the same reason, structure of this handbook does not closely follow the project objectives and activities as they were formulated and outlined in project documents for various phases of FaMI project. Rather, the handbook identifies **the key stages of family medicine implementation** and **the activities to be undertaken** in order to achieve the intermediary and overall objectives.

The handbook is organized into **five main chapters** and numerous subsections. As reader moves from the **first chapter** he/she is introduced to the history of the family medicine implementation in Bosnia and Herzegovina, and with the main stakeholders involved: SDC as the main sponsor, FaMI as facilitating agent, other partners/implementing agents involved in the effort. **Second chapter** introduces the logic and structure of the handbook. **Third chapter** explains the importance of family medicine in wider context of universal healthcare and reforms of primary healthcare. It also provides an introduction into what this handbook calls “the FaMI approach to primary health care reform”. **Chapter four** introduces key stakeholders necessary to implement the reform. Special emphasis here is put on a rationale behind choosing an NGO as facilitator of primary health care reform in a transitional country with complex political set up. **Chapter five** outlines the segments of the reform that need to be accomplished and explains in detail the activities undertaken to achieve the reform objectives in each of these segments. Finally, **appendices** to this handbook include instruments developed and used by FaMI as tools to implement individual reform activities. Each instrument is preceded by a short ‘manual’, explaining its purpose, how it is going to be used, by whom, and at what stages of project implementation.

3. Why the reform?

3.1. Placing family medicine and prevention in general at forefront of public health

Public health system strives to achieve better health of general population, looking at both individual members of society, vulnerable groups, as well as society as a whole. The rationale behind making public health system more effective and efficient is multifold. On the long run improvements in the public health system lessen the burden on the clinical health care, which is far more expensive and its effects limited to individual patients treated for manifested health problems. Also, by placing emphasis on prevention, public health system improves general welfare of population through reduction in health problems and preventable illnesses. To fulfill its intended purpose, public health system works either directly (e.g. by implementing preventive health checks of vulnerable groups) or indirectly (e.g. by improving the health standards and living environment through education or awareness campaigns). Indirect action is often carried out in close cooperation with other stakeholders in society, e.g. education system, public and nongovernmental welfare organizations, etc.

It is obvious that functional public health improves health of individual and society as a whole, while reducing the direct and indirect costs associated with treating the health problems. As such, even if not immediately manifest, an efficient and effective public health system contributes to general advancement and wellbeing of society that was invested in this sector.

Nature of the public health system changed in the recent years. Classic approach to public health was born out of need to provide societies with healthy and fit workers and soldiers in population suffering from range of preventable health problems related to pollution, work-related stress, as well as poor living standards typical of early industrial societies. Continuing emphasis on resolving these health-aggravating issues remains necessary in all but a few most developed societies. However, changing nature of relatively developed societies, combined with improvements in general health condition of population during the last century, necessitated formulation of new approach to protection and continuing improvement of public health.

The New Public Health is a concept which evolved from the World Health Organization's concept of Health for All, formulated in the 1978 Declaration of Alma Ata (http://www.who.int/publications/almaata_declaration_en.pdf). It consists of a range of programs and activities that link individual and societal health. In addition to continuing emphasis on 'classic' public health issues, the New Public

Health concept addresses a whole new range of health-related problems, such as the need to provide appropriate care to an increasingly ageing population, tackle the outbreaks of communicable and chronic diseases, as well as to provide measure of equal health protection in situation of growing disparities in wealth and living standards across the population.

The book 'New Public Health', defines this concept as 'a comprehensive approach to protecting and promoting the health status of the individual and the society, based on a balance of sanitary, environmental, health promotion, personal, and community oriented preventive services, coordinated with a wide range of curative, rehabilitative, and long-term care services' (Tulchinsky and Varavikova, 2009). The public health system structured along these lines clearly represents very complex structure, necessitating involvement and linking of all relevant stakeholders in society. According to the cited concept, these stakeholders include 'all levels of government and parallel ministries; groups promoting advocacy, academic, professional, and consumer interests; private and public enterprises; insurance, pharmaceutical, and medical products industries; the farming and food industries; media, entertainment, and sports industries; legislative and law enforcement agencies, and others.' It also requires 'continuous monitoring of epidemiologic, economic, and social aspects of health status as an integral part of the process of management, evaluation, and planning for improved health.'

Modern public health system therefore incorporate all **relevant contributing stakeholders** and factors to ensure better health care tailored to the need of an individual and a society. Due to its all-inclusive approach, the system is adaptable to different societal and political contexts. In response to different organizational and environmental inputs, the system evolves to satisfy the needs of wealthy and relatively poor societies, as well as societies with long-established health systems and those which recently started to address public health issues. It can also be managed either as centralized, hierarchically integrated structure, or as diffused structure, with only limited possibility for horizontal integration of relevant stakeholders. It is clear therefore that the modern approach to public health embodied in the New Public Health concept is suitable to implementation in most societies, including transitional ones such as Bosnia and Herzegovina.

What is therefore the **mainstay of modern public health care**? Ever since the introduction of the Health for All Concept, health practitioners and theoreticians alike gradually came to realize that modern public health must be grounded in social, community and preventive medicine approach. In other words, health of both individuals and population at large is based on combination of personal care and community action, with emphasis on preventive aspects of healthcare. Preventive medicine naturally involves whole range of activities and specializations within the general medical practice. It is also practiced in all segments of healthcare system, on primary, secondary, and tertiary level. In addition, it calls for involvement

of large number of organizations and institutions which are formally not part of healthcare system as such, along the lines of new public health concept.

However, even if preventive medicine is practiced across the public health system, it is chiefly based and carried out on the level of primary healthcare. Medical practitioners on the primary healthcare level are ideally positioned to realize most activities from the area of preventive healthcare. They are the ones directly facing the entire population, unlike specialists on the higher levels who are exposed to narrow sections of society, or only the ones with already manifested health problems. Primary healthcare is also the only one with hands-on universal coverage of population, being organized territorially to cater to society as whole through individual communities (neighborhoods, villages, towns, etc.). It is ideally placed to involve and realize cooperation with other relevant stakeholders in a community (schools, authorities, police, center for social work, NGOs).

Finally, **primary health care**, if properly organized and staffed with motivated, well educated, and continually trained medical practitioners, **acts to resolve majority of health problems faced by population**, thus relieving some of the burden from healthcare institutions on the secondary and tertiary levels. This frees up relatively small number of specialists working in these institutions, enabling them to organize their time more rationally. Resolving health problems of population on primary level, either through prevention or treatment by competent medical practitioners, is also on average tremendously cheaper when compared with treatment by specialists doctors on higher levels of healthcare system.

Primary healthcare system in countries with universal healthcare coverage (chiefly developed European societies and former socialist countries) has traditionally been organized along similar lines. Health institutions on the primary level attended to the range of most common health problems experienced by the general population. Additional emphasis was placed on some of the most vulnerable groups, such as women (maternity and specific health issues related) and children. As already mentioned, ageing population added new vulnerable group to the range of issues tackled by the primary healthcare. As product of stressful work environment and work-related pressures and resulting health problems, working-age men and women increasingly demanded range of healthcare services that could easily be provided on the primary care level.

All of these factors contributed to **conceptual shift in philosophy of primary healthcare towards new public health concept of *family health* or *family medicine***. What are the basic tenets of this form of primary healthcare? Family medicine recognizes that individual patients belong to principal social cell – a family. They have their individual health problems, but also experience range of health-related issues as members of certain population groups. As already mentioned above, traditional public health focused particularly on some of these groups, judged to be more vulnerable than others, such as women (particularly maternity-

related issues) and children. Changes in society added new vulnerable groups, such as elderly and working age men and women. Instead of targeting individual groups in isolation, the new public health concept of family medicine applies holistic approach seeking to establish links between members of vulnerable groups and their health conditions. It has been established that a family unit is the perfect starting point for all-inclusive holistic approach to primary healthcare, since individual patients for most of their lives live in some form of family union.

Society with well developed family medicine programs stand to benefit both through increasing living standards due to improvement in general health of population, and by decreasing costs of healthcare treatments due to effective prevention measures and primary care services. Prevention and effective primary healthcare in other words replace much more costly and incomparably less efficient treatments for advanced health problems. Many medical, economic, and ethical issues are at play, and when properly considered demonstrate clear advantages of strengthening the role of preventive and primary healthcare sector.

3.2. Healthcare system reform in Bosnia and Herzegovina

Several key reports concluded that situation in public health system in Bosnia and Herzegovina has been conducive for introduction of family medicine. 2005 World Bank report thus suggested that in BiH there was an enabling environment through appropriate regulatory changes and laws for the reforms to be further extended and scaled up. Taking into consideration economic arguments for introduction of family medicine in BiH, official policy documents emphasized the introduction and strengthening of family medicine as a means for sustainable, equitable and cost-effective delivery of services in public health sector. Furthermore, the Mid-Term Development Strategy of BiH 2004-2007 created sectoral policies designed to alleviate poverty. In health sector, such poverty-alleviating measures are best served by introduction of family medicine services with universal population coverage. Growing wealth disparities between individuals and groups in society, as well as between different geographic regions (city-village, etc.), also speak in favor of introduction and strengthening of family medicine as defining feature of primary healthcare. Family medicine has potential to best address inequities in access to healthcare by working in community and in collaboration with other key stakeholders, enabling it to best satisfy the healthcare needs of different vulnerable groups.

BOX 1.1(a): Excerpts from the Declaration of Alma Ata

(International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978)

(I) The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

(III) The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

(IV) The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

(V) Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

(VI) Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. (…) It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

(VII) Primary health care: (…) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly; (…) relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

(VIII) All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors.

BOX 1.1(b): Differences between family medicine and clinical medicine

Family medicine:	Clinical medicine:
- Group minded	- Patient minded
- Assessment	- Diagnosis
- Comprehensive care	- No
- Anticipatory care	- No
- Promotive, preventive, and curative	- Curative
- Simple	- Complicated
- Economic	- Expensive
- Biopsychosocial approach	- Biomedical approach
- Patient centered	- Doctor centered

3.3. FaMI approach to primary health care reform

In order to utilize favorable climate for introduction and further strengthening of family medicine in Bosnia and Herzegovina, FaMI pursued **two-pronged strategy**: strengthening and improving the existing key resources in primary healthcare in the country, as well as by devising strong public-relations exercise to 'sell' the family medicine concept. Key resources that FaMI sought to strengthen form crucial building blocks in health sector reform in a complex institutional complex of a transitional country. They include human resource development (training of trainers and supervisors; retraining of family practitioners and the subsequent supervision of family medicine practices, facilitating commencement of FM; introduction on a pilot basis of continuing medical education programs for health practitioners – doctors and nurses), development of material resources, including reconstruction and equipping of healthcare facilities; as well as activities related to community health promotion and prevention.

The efforts on development of material resources formed the basis for successful introduction and subsequent strengthening of family medicine concept in selected communities. FaMI reconstructed and equipped more than 160 ambulantas over five-year period, which is a significant number for a country the size of Bosnia and Herzegovina. It is important as the intervention in this area was substantial in order to make the impact stronger, facilitating the introduction of family medicine in targeted areas. In many instances, FaMI sought to couple the money dedicated to physical reconstruction with participation by local community and/or public funds, thus multiplying the effects and strengthening the commitment of local partners for cooperation in the reform effort.

One of the important features of FaMI-facilitated primary health care reform was that intended beneficiaries were continuously sponsored and supported in all stages of intervention. From physical reconstruction and equipping, which created preconditions for successful introduction of family medicine, to efforts on development of human resources, FaMI established itself as genuine partner that local partners could always count on. Having completed physical reconstruction, FaMI proceeded to develop human resources through retraining of health practitioners that were to form family medicine teams in targeted communities. The intervention did not stop here, however, as FaMI provided follow up guidance and supervised performance of retrained personnel. Introduction of continuing education into family medicine practice was seen as a way of ensuring sustainability of intervention and guaranteeing its future development. To this end, FaMI established area training centers in selected Primary Healthcare Centers that were associated and supported by the relevant departments of Medical Faculties and Institutes of Public Health.

In final phases of intervention, FaMI facilitated intervention in the area of palliative care, patronage and health promotion, for the purpose of strengthening the prevention alternative to mainly curative oriented family medicine services. These efforts demonstrated readiness of health practitioners who were successfully sensitized to continuing development to adopt the new approach. However, functional holistic approach to preventive care requires cooperation of many stakeholders, whose participation is crucial to ensure that all aspects of community-based care are satisfied. FaMI invested maximum effort into creating the preconditions for involving community into organization of family medicine care through employment of holistic approach to health protection. However, in this regard, the organization suffered from limited resources that could be spared from an otherwise extremely complex reform intervention. Another limitation is the nature of an NGO, which seriously affects the ability of a facilitating agent to bring together disparate stakeholders in community. NGO lacks authority and necessary clout to coalesce so many key stakeholders with deeply entrenched interests into investing extra efforts and giving concessions.

3.3.1. 'Marketing' of the family medicine concept

Cognizant of the importance of reform of primary healthcare along the lines of modern public healthcare concept, FaMI strives to promote introduction of family medicine into the public health system in Bosnia and Herzegovina. To this end, FaMI placed an emphasis on the marketing ('selling') of the family medicine concept, by highlighting its importance for health of general population, as well as by trying to raise awareness of health practitioners and relevant authorities and achieve behavioral change on the level of both providers and beneficiaries of the healthcare services. To this end, different instruments were prepared and

disseminated: leaflets and information brochures, articles in local newspapers and a television spot. The information material focused on advantages of family medicine services such access to treatment and prevention services which are geographically close to the people who need them.

One of the highlights of the marketing campaign was strengthening the message that **family medicine allows more personalized relations between the patient and the care provider**, including a regular follow-up of patients without reference to the secondary and tertiary level services (with all pertinent complications). FaMI reviewed the cost and efficacy of these instruments and established that brochures are the most cost-effective way of conveying the message to the target population and health practitioners, with electronic media reports used as complimentary method.

In addition to information campaign aimed at intended direct beneficiaries of introduction of family medicine, FaMI supported activities aimed at documenting and disseminating the lessons learned from family medicine implementation among relevant decision makers. Support of e.g. Ministries of Health, Public Health Institutes, and the like is essential for winning official endorsement and thus ensuring the sustainability of reform intervention and continuation of practices introduced through FaMI-facilitated primary health care reform. To this purpose, FaMI documented a number of initiatives successfully undertaken and tested in previous phases of project implementation, e.g. experiences in formation of FM teams, retraining and supervision of health practitioners, etc.

FaMI also supported organization of a conference on primary healthcare to improve exchange of evidence gathered through experiences at the level of the FaMI project to contribute to efforts to systematically feed such information into the decision-making process. It is important to facilitate the process of evaluation and addressing the crucial questions related to policy choices and modes of implementation among development options, on the basis of understanding of their potentials and limits.

FaMI-introduced activities in the course of primary health care reform demonstrated **high potential for replication and integration** into other large-scale programs aiming at reform of healthcare system, such as those supported by the World Bank or the European Union in the course of European integrations. FaMI did not retain copyright over intellectual property related to reform blueprint, instead transferring the ownership of the concept to the Ministries of Health and other competent authorities, ensuring the concept's sustainability. Such selfless approach further strengthens the possibilities for further development and replication of the family medicine implementation as conceptualized by FaMI.

Accompanying instruments:

Methodology checklist

BOX 1.2: BRIEF SUMMARY OF STEPS FOR INTRODUCTION OF FAMILY MEDICINE IN PUBLIC HEALTH SYSTEM

Step 1: Physical intervention in primary healthcare to create preconditions for adoption of family medicine by health practitioners and general population alike

Step 2: Bringing together all relevant stakeholders in one functional and coordinated network

Step 3: Dissemination/marketing strategy

Step 4: Implementation of family medicine
- Introduction of lifelong learning among FM practitioners
- Introduction of :
  - Appointment system
  - Team meetings/case presentations
  - Task division (Dr/nurse)
  - Phone advice
  - Patient groups/education
  - Health promotion
  - Patient files/nursing care plan
  - Palliative care

4. Who are the reform stakeholders?

There could be no structural reform in any sector of society without involvement of authorities and other 'official' stakeholders. Creating lasting impact on the way certain public sectors operate requires pro-reform actions of relevant stakeholders, which in this case include ministries, healthcare institutions, public health institutes, medical chambers, schools of medicine, etc. Problem with conceptualization and implementation of reform in complex setting of transitional societies, such as Bosnia and Herzegovina is directly related to a sheer number, competencies, and willingness for change of individual stakeholders. Political, territorial and interest divisions of a country in need of reform mean that in place of single competent authority, there could exist myriad different ministries, institutions, agencies, institutes, and the like, responsible for fragmented healthcare sector. Due to the nature of society in a flux of transition, multitude of competencies also usually translates into intense turf war between stakeholders, competing for their share of limited resources and dwindling funds. Competencies of stakeholders also suffer from brain drain (the most competent professionals leaving for private sector or abroad due to financial reasons and environment not conducive for professional development), and inability to achieve critical mass of expertise and resources due to their dispersion throughout a fragmented healthcare sector (imaging staffing of more than a dozen health ministries, public health institutes, different agencies, etc. in a small country with limited pool of competent professionals).

4.1. NGO as facilitator of primary health care reform

So, **why use nongovernmental organization to champion the reform of primary health care** and in which capacity? Nature of reform requires possession of critical mass of expertise, long-term commitment to action, and, above everything, willingness to invest additional time, effort, and resources over a protracted period. With directly responsible stakeholders consumed by infighting, lacking necessary competencies, and with limited funding available, it is natural that little can be expected from them beyond formal exercising of day-to-day duties. It is because of this that most transitional societies require an additional 'push' in order to commence much-needed reforms. Due to complex political setup and impossibility of higher levels of government to order top-down reform processes, an external agent is necessary to bring together different stakeholders and provide the necessary reform impetus.

What **qualities does this external agent need to possess,** in order to fulfill its intended role? An external agent needs to be in possession of professional expertise, commitment to long-term action, has to be able to invest some seed money to demonstrate the effectiveness of reform measures, and has to be

professionally and politically acceptable to all stakeholders involved. In Bosnia and Herzegovina, NGOs have for much of the country's post-conflict history fulfilled the role of external agents pushing for reforms in different sectors of society. In many ways, due to the weaknesses of public organizations and undefined roles of individual stakeholders, their involvement constituted precedence in the sense that NGOs here transgressed the traditional role of civil society, themselves taking over the responsibility for operation of certain segments of society.

In the area of sectoral reforms **NGOs they have been successful to a different extent**. Findings of in-depth analysis of causes of relative success of sectoral reforms ran by nongovernmental organizations reflect the outcomes of wider discourse related to the roles of NGOs as *agents of change* vs. their positioning as *facilitators.* In order to be successful and have lasting impact, the reform has to come about through reforms *of*, and *by* official structures. No amount of changes *advocated*, *promoted*, or even *piloted* by NGOs cannot supplant behavioral change by key stakeholder, which, if it is to have lasting effect, has to be based on changes in legal framework within which these stakeholders operate.

Many NGO, especially the large international ones, sensed golden opportunity in working in weak post-conflict societies. Confronted with weak, almost powerless, official structure, these well-funded INGO, were actually able to *take over* some of the responsibilities of the government, running institutions and forcing through the reforms. In other words, instead of pushing for reform, they chose the role of *agents of change*, accomplishing the change themselves. In the eyes of these *agents*, in such way the change came much quicker, was more in tune with latest advances in the field, and was more effective in satisfying the needs of beneficiaries (Maglajlic and Rasidagic, 2008).

However, the accomplishments of NGOs espousing this strategy proved to be short-lived. One great weakness was lack of necessary long-term commitment to sustain the reform. Review of relevant literature suggests that in order to achieve the change of mindset of decision makers, professionals and other stakeholders, sustained effort over a period of a decade, or even more, is necessary. Most INGOs behind such reform attempts work within project-based framework, dependent in turn on donors' funding cycles. This limits their ability to sustain an effort to between one and three, very rarely four to five years. More importantly, no matter how strong the NGOs, and how weak the government, it is the latter that writes laws and not the other way round. NGOs draft policy papers, strategies, proposals, and the like, which ideally do get acted upon by the government in charge. However, bureaucrats and decision makers dislike being pushed around by NGOs, which they regard (at best) as junior partners or (at worst) as nuisance.

NGOs, acting as agents as change, tried to accomplish the reforms by **co-opting the key stakeholders in individual capacity**. Ministers, their deputies, heads of institutions, and other individuals occupying the key posts in government

hierarchy and relevant public institutions, would thus be engaged as 'advisors', 'consultants', etc. In exchange for (sometimes much needed) additional income and other perks, they were expected to provide the NGO effort with some measure of legitimacy through their involvement in projects and translation of policy papers into official documents. However, such arrangements survive only until the project is finished, and with it the financial incentive for the involved officials to support the NGO line.

4.1.1. How to involve NGOs in a sectoral reform?

First of all, it has to be borne in mind that **effective reforms come about only through reforms of relevant stakeholders' mindset and legal framework**, not through multiplication of NGO-run projects. A single, properly positioned NGO, with well thought-through project design can accomplish more than a host of flashy, lavishly funded, but ill-conceived projects, run by a number of NGOs trying to act as agents of change. Instead of forcing its way through, properly positioned NGO makes the best use of its *nongovernmental* character, i.e. positions itself as competent, non-affiliated, non-political, well-meaning stakeholder, striving to *facilitate* the reform process. Its character actually makes it an ideal facilitating agent, able to bring together elements of the fragmented sector it is trying to reform, while providing the missing ingredients for the reform: expertise, willpower, and seed funding.

The NGO acting as **facilitating agent** then a) identifies the way of inserting itself in the relevant professional and political debates, and b) finding the ways to influence those debates. Eventually, with NGO successfully co-opted into reform process, it will use its expertise and lessons learned from implementation of previous projects (either in the country by the NGO in question, or its parent/partner NGOs in comparable settings elsewhere) to influence the design of blueprints for reform. Genuine reform of particular segment of society is implemented in close cooperation with relevant government stakeholders with the ultimate purpose being *assisting* those stakeholders to improve the services they provide. NGO in the role of facilitating agent therefore does not take responsibility for actual delivery of services. Instead, it strengthens those with responsibility for delivery of services in question, and, indirectly, the services itself.

This is exactly the strategy FaMI used to introduce and strengthen family medicine within the broader framework of primary healthcare reform in Bosnia and Herzegovina. Family Medicine Implementation Project in Bosnia and Herzegovina started in 2001 by providing support to the primary healthcare reform through provision of additional training in family medicine to healthcare practitioners. In addition, FaMI assisted in physical reconstruction and furnishing/equipping of family medicine departments in primary healthcare institutions serving over 20% of the total population of BiH. Purpose of these

measures was to create favorable environment for actual introduction of family medicine in healthcare system in BiH.

In keeping with its role as facilitating agent in the reform of primary health care, FaMI formulated the following **General Principles of Cooperation** to serve as guiding principles for intervention in primary healthcare sector in BiH:

- Alignment to government policies, strategies and action plans
- Responsiveness to local context and needs
- Knowledge management and capacity building of individuals and institutions
- Intersectoral collaboration and holistic system approach
- Sustainability and co-financing (20% of financial and other contribution)

FaMI worked hard to bring together all relevant stakeholders in a functional network that would ensure success of primary health care reform in BiH. In keeping with the holistic approach governing the General Principles of Cooperation, key stakeholders were identified among in the public sector, and included Entity Ministries of Health (as primary decision makers), Primary Healthcare Centers (as principal beneficiaries), Organizations of importance to public health (Public Health Institutes, etc.), but also Centers for Social Welfare (for community-wide intervention), Civil Society Organizations, etc. FaMI's principal international partner was Geneva University Hospital (HUG), which served as principal source of expertise to be transferred to the country and incorporated in primary health care reform process. It is important to note that FaMI stressed importance of building up competencies of local stakeholders (see continuing education section), so that with each stage of the project the role of HUG decreased and increasing number of tasks and roles were fulfilled by local partners who benefited from the project in earlier stages.

External evaluations of the FaMI project concluded that the project was fully aligned with the national priorities for health reform. Also, very important achievement of the FaMI project has been recognition of the principles of reform facilitated by FaMI, which were accepted and scaled-up by other relevant stakeholders in the healthcare sector (WHO, World Bank, CIDA), and were officially adopted as the national standard by the authorities, such as:

- Curriculum for additional training in family medicine (FM);
- Supervision tools for FM implementation;
- A guideline for smoking cessation counseling;
- Guideline for Public Health Care Workers on Early Detection and Brief Intervention for Hazardous and Harmful Drinking;
- Patient-friendly approach toward reconstruction and organization of FM practices;
- A list of basic medical equipment and furniture for the FM teams; etc.

Accompanying instruments:

- Curriculum for additional training in family medicine (FM)
- Supervision tools for FM implementation
- A guideline for smoking cessation counseling
- A Guideline for Public Health Care Workers on Early Detection and Brief Intervention for Hazardous and Harmful Drinking
- Patient-friendly approach toward reconstruction and organization of FM practices
- A list of basic medical equipment and furniture for the FM teams

5. What constitutes the reform?

5.1. Intervention based on assessment of needs

Availability of relevant data is essential for intervention into healthcare sector in order to identify capacity gaps in the system. Such data is computed with data on available resources and key stakeholders in order to decide on the best possible ways to address system deficiencies, taking into consideration available resources and limitations posed by e.g. legislative framework, political considerations, etc.

Healthcare system in which an NGO intervenes to facilitate implementation of major sectoral reform is likely to be deficient in aspects related to availability of data that would allow proper designing, targeting and implementation of reform. Therefore, in order to enable the intervention to succeed, agent facilitating reform has to perform crucially important assessment of targeted healthcare services. This assessment starts with system mapping exercise, the purpose of which is to define basic characteristics and available resources in targeted healthcare system. Data pooled through this exercise are most likely to be possessed by competent authorities, and include relevant legislation, bylaws and guidelines; geographic coverage of medical services; number and kind of health institutions; vertical organization of healthcare system; as well as some (usually very basic) data on number, education profiles, specialization, and mobility of health practitioners.

While such information are essential for designing the outlines of healthcare reform, they are by no means sufficient to ensure success of intervention. Reform of such complex sector has to be based on wealth of useful data, directly related to intended targets of intervention, which may include institutions and services they provide, as well as beneficiaries. Assessments are performed in three stages: pre-intervention, at certain stage during intervention, and post-intervention. Pre-intervention assessment is used to provide relevant data for designing the reform, but also to provide baseline from which eventual success of intervention will be measured by post-intervention, or final, assessment.

Assessment(s) performed in the course of intervention are usually performed to ensure that intervention is on course, or whether adjustments are needed to ensure that intervention achieves its objectives. Such mid-term assessments are also usually requested by donors to ensure that money invested is being spent in accordance with project objectives.

Depending on the format of intervention and requirements of donors or key local stakeholders (namely health sector authorities), an additional assessment can be performed after passage of certain period of time following completion of project/intervention. This type of assessment (usually performed one year after final assessment) is ideal for measuring ultimate success of intervention – whether

lasting impact on targeted areas was achieved, and whether intervention was sustainable, creating local ownership of the introduced concept.

5.1.1. Assessment of healthcare structures

Assessment of healthcare structures represents an essential precondition for implementation of family medicine. If working alone, an NGO can only undertake assessment of those institutions where family medicine project will be directly implemented. Wider-ranging assessments of entire healthcare sector can only be implemented by actively including healthcare authorities in the exercise. While this represents an ideal scenario, in real-life setting competent authorities are usually reluctant to be dragged into this form of cooperation. Reasons quoted include shortage of funds, lack of personnel that could be dedicated to this, operational reasons, and the like.

FaMI performed pre-intervention, mid-term, and final assessments of selected healthcare institutions using evaluation checklists. These instruments, developed jointly with respective Public Health Institutes, represent preliminary assessments of situation in primary healthcare centers (PHC). They are completed by the PHC directors, under FaMI guidance. The checklist includes data on size and characteristics of PHC's coverage area, wards, medical staff (number of specialist doctors, general practice doctors, nurses), information on district ambulantas (their coverage area, distance from PHC, medical staff – doctors and nurses). The checklist also sources data on current state of premises in the general medicine ward, average number of consultation per ordination and most frequently encountered medical problems. Component part of the checklist is a list evaluating the existing equipment and allocation of tasks.

Separate checklist can be used for assessment of district ambulantas, which similarly requires information on population in coverage area, medical staff employed working in ambulanta (general practice and specialist doctors, nurses – number and qualifications), the most frequently encountered health problems, vaccination data, and state of premises. Identical forms as used in PHCs are used for evaluation of equipment and allocation of tasks.

These checklists are collected by the project manager leading the family medicine implementation. He/she performs preliminary analysis of data contained in checklists and informs the steering body in charge of primary health care reform on most likely obstacles to introduction of family medicine in primary healthcare.

5.1.2. Assessment of activities and allocation of tasks

Prior to introducing any changes, FaMI, as facilitating agent, performs assessment of targeted health institution's activities. This assessment forms baseline for monitoring and later evaluation of the reform process. The assessment

is conducted during field visits by FaMI's supervisors and implementers supporting the intervention. The same assessment is then repeated at certain stage(s) during intervention, as well as post-intervention to evaluate the achievements. Assessed data refer to patients' epidemiological record, organization of work, context for implementation of family medicine, health prevention and promotion, team work and skills of health practitioners.

When newly formed family medicine teams begin to work in new environment, clear division of tasks has to be established, defining exact responsibilities by individual members of the team (doctor, nurse, community nurse), as well as among nurses. Situation in this regard is assessed at the beginning of intervention, with changes and problems in this regard resolved in the course of intervention by FaMI supervisors and implementers supporting the intervention. Final intervention is then performed to evaluate the achievements of intervention in this regard.

5.1.3. Training needs assessment – Group Techniques for Program Planning (DELPHI)

Eventually, with implementation of family medicine concept under way in targeted healthcare institutions, FaMI, as the agent facilitating primary health care reform, needs to commence training of health practitioners to enable them to fulfill their intended responsibilities in a new working environment. Training needs of targeted groups of health practitioners are a big unknown in a setting where completely new type of service is being introduced. Health practitioners drafted in family medicine sector come from various backgrounds, have different expertise, as well as different expectations from their future roles in primary healthcare system. The training therefore needs to address both the deficiencies in professional segment, as well as balance the level of expertise in target group of health practitioners, in order to enable smooth operation of family medicine services.

In order to assess the training needs of family medicine practitioners, FaMI employed the so-called Delphi method, specific adaptation of the Nominal Group Technique (NGT). Unlike NGT, however, Dephi is a group process using written answers instead of working with the examinees directly in a group. In effect, this is the way to collect opinions of certain number of individuals for the purpose of improving the quality of decision making process. It also protects anonymity of participants in the process. Since Delphi does not require face-to-face contact with examinees, it is especially useful for inclusion of professionals, service users, managers, and the like, who are not always easy to bring together, nor is their gathering expected to produce additional benefits for the process. The nature of the process prevents domination of a group by individuals, which is always difficult

to achieve in live exercise, especially if participants are expected to have views which are difficult to reconcile (due to them protecting vested interests, etc.)

Delphi in essence is made up of a number of questionnaires. Questionnaires start with more general ones, where examinees are requested to wide-arching questions. With each subsequent questionnaire, questions are narrowed down, based on answers given in the previous one. The process is considered successfully completed when participants have arrived at consensus, or when sufficient level of exchange of information has been achieved.

Purpose of Delphi process employed in reform processes such as family medicine implementation is to **help in identification of problems, setting of goals and priorities, and defining solutions to the problems**. Delphi is considered as extremely useful tool enabling the facilitating agent to plan the course and content of intervention . However, in order to ensure Delphi is successfully employed, certain preconditions have to be met: 1) Sufficient time available to conduct the exercise in full (experience shows that 45 days is minimum time necessary for implementation of Delphi method); 2) Participants have to be sufficiently skilled in written expression; 3) Participants have to be highly motivated (believing in relevance and usefulness of the method for resolving their problems).

Structural reform process, such as FaMI-led primary health care reform, require three types of examinees to take part in Delphi needs assessment: 1) Top level management and decision makers who will use the results of Delphi exercise; 2) Professionals (health practitioners); and 3) Focus group of participants selected by the previous two groups (e.g. service users, experts in relevant fields, etc.)

Findings of Delphi process feed into reform process and enable facilitating agent to design the next steps which are both relevant and effective in facilitating the reform. FaMI used Delphi to allow crucially important education process to be designed to enable the key reform stakeholders to fulfill their intended roles in primary health care reform. Without carefully managed needs assessment with full participation of key reform stakeholders, training agenda would have to be borrowed from different setting and would therefore not be sufficiently relevant for addressing the capacity gaps in healthcare system targeted for reform.

Accompanying instruments:

- Community assessment
- Assessment forms – PHC and Ambulanta
- Introduction to NGT/Delphi methodology
- Delphi Questionnaire (Doctors)
- Delphi Questionnaire (Nurses)

5.2. Involving community as part of holistic approach to public health

Modern public healthcare system continuously monitors the health and social condition of the community (and family as its basic unit) in order to fully carry out its responsibilities related to the protection of health of individual and general population. As argued in the first section, failure of prevention (for which monitoring is necessary precondition) translates into deteriorated health of population, as well as multiplication of costs through increased burden of treatment of conditions that could have been avoided. The New Public Health concept positions **family at the core of its activities**, while treating it as organic and inseparable part of the community where it lives. Different members of a family do not require healthcare services in continuum and therefore the monitoring and preventive function of the healthcare system cannot be carried out through reference to healthcare institutions alone.

However, family continually interacts with its immediate environment, meaning that every member of a family has established functional connection and involvement with some of the institutions of society. Children attend kindergarten and school; older people could be cared for by specialized institutions; less fortunate families or individuals are beneficiaries of social welfare services, etc. Co-opting these other institutions into functional primary healthcare network would mean that all family members are monitored on continuing basis through their reference to different institutions within the system. This, in turn, immensely benefits the health of the population, and decreases the burden of treatment of health conditions that never arose through effective prevention programs.

Schools for instance, play indispensable role in education of family members from an early age on important health-related aspects of hygiene, nutrition, physical exercise. Cooperation of schools is essential for success of early addiction prevention programs. Community nurse could educate teachers to assist the family medicine team in early identification of preventable, communicable, or inherited medical conditions among children. Cooperation between the family medicine team, schools, and center for social work, could serve to alleviate number of conditions negatively affecting the health of family due to presence of aggravating factors such as history of diseases, poverty, problematic behavior of family members, alcoholism or drug addiction within the family, etc. Failure by the system to address the problems related to individual family members could have serious economic and social as well as emotional implications for remaining members of the family.

In addition to health-related issues, the holistic approach of the modern primary healthcare and family medicine services stress the importance of social

and economic issues that affect or prejudice family function. Poverty, failure to fit in the community, adverse family and community social environment promote family crises and cause long-term consequences for family members and, by extension, community as a whole. Therefore, planning of primary healthcare/family medicine services need to take into consideration this complex matrix of health in the family context. Family medicine team hence integrates various service systems and creates new kinds of linkage between these sectors of society in order to best assist the family to cope with normal family health events and the additional burdens of chronic disease. Within the team, the doctor specializing in family medicine is ideally supported by a community nurse who has a crucial role in monitoring community, creating inter-service linkages, and supporting families. Only by working as a team, and in community, can family medicine service completely address the health-related needs of individual families.

FaMI has practically tested approaches to organization of systemic cooperation between professionals from mental health services, the social sector and civil society with family medicine professionals. The methodology was operationalized through development and adoption of several important practical guiding documents and forms, which seek to formalize and make functional cooperation between relevant stakeholders in community. These include: Communication sheet between centers for social welfare and community nurses, Community file, Family file, Supervision sheets for common visits of social worker and community nurse, Pedagogic frames for education in kindergartens and schools, Guidelines for Prevention and Harmful Alcohol Drinking Reduction in Primary Health Care, Protocol of collaboration between mental health professionals, civil society organizations and family medicine teams.

Practical activities that serve to initiate community-wide action by the family medicine team begin with **wider outreach projects**, such as:

- Education of school children on issues related to hygiene, nutrition, sex education
- Participation of a FM team in country-wide campaigns on e.g. prevention of STD, tuberculosis, vaccination campaigns, environmental protection, etc.
- Health promotion activities on fairs and festivals

Objectives to be realized by implementation of these and similar activities are:

- Establishing contacts with other relevant stakeholders in the particular area of intervention and/or community
- Development of new ideas and reality-check
- Development of theoretical framework/blueprint for intervention
- Implementation of activities themselves

Accompanying instruments:

- Communication sheet
- Community file
- Social worker – Community Nurse supervisor
- Family file
- Pedagogic frames for education in kindergartens and schools
- Protocol of collaboration between mental health professionals, civil society organizations and family medicine teams

5.3. Strengthening the position of family medicine in public health system

Strengthening the position of family medicine in public healthcare system represents crucial step in implementing primary health care reform. It is indispensable for creating the organizational structure of family medicine services and ensuring the reform's sustainability through its full development and incorporation in public healthcare system. Experience of FaMI-facilitated reform process in Bosnia and Herzegovina demonstrated that in order to ensure lasting incorporation of family medicine in primary healthcare system, the agent facilitating the reform has to ensure the accomplishment of the following steps in reform process: 1) Organization of family medicine services; 2) Organization of family medicine teams; 3) Evaluation of the results in the area of family medicine implementation, both in the course and post-intervention.

Public healthcare system in need of reform is not likely to accomplish these steps on its own, despite of the effort by the facilitating agent to promote ('market') the reform and its completion of assessment exercise which amply demonstrate the need for exactly this type of intervention in the system. Reasons have been discussed earlier in this document and elsewhere, and include lack of motivation, complex and overlapping authorities, political obstacles, financial considerations, and the like. FaMI therefore elected to pioneer the reform in accordance with the steps envisioned in the reform blueprint.

5.3.1. Organization of family medicine services

5.3.1.1. Coverage area

Existence of clearly defined coverage area is **essential for family medicine**. Coverage area has to be defined in collaboration between the Primary Health

Center, Public Health Institute, following the plans adopted by ministries of health. Each team should cover around 1800-2000 inhabitants (not patients), which is maximum number for providing quality healthcare. Coverage area is geographically delineated, according to e.g. streets or city blocks in a city, and local communities in a village. These criteria are simple and can easily be explained to the patients. Such delineation of responsibility between the FM teams has to be strictly respected, otherwise those FM teams that are introduced earlier will be swamped with chronic patients, while the others will be allocated mostly healthy population. Registration of only those patients who inhabit the area of coverage also enables equal distribution of high-risk patients among the teams.

In the roll-out phase of the family medicine implementation, some patients will initially fall outside of coverage areas. Solution has to be found for those patients. FaMI developed detailed methodology for dealing with such cases, since receiving patients on ad-hoc basis would undermine the basic preconditions for functioning of the FM system. One of the solutions is to refer them to the the general medicine ward, or emergency medicine ward, where such wards still exist. In case that this is not possible, patient is dealt with immediately in case of emergency; otherwise he/she is referred to the district ambulanta with permanently based doctor, or such patients are received in accordance with pre-agreed and announced schedule (at the end of each working hour or in early morning before appointed intervals).

5.3.1.2. Registration of patients

Patient and his family can be registered on the same registration form, which includes epidemiological data, information on sanitary system and water supply, as well as patients' health status, chronic diseases and disability. There are three types of registration that can be employed in roll-out of family medicine services:

- Active registration:

Community nurse performs home visits in predefined area covered by a FM team. If possible, the entire family would be registered with the same team, but they should be given freedom to select different team. This method ensures that each doctor ends us with similar number of patients, while home visits will also be easier to perform since most patients would be from the same area.

- Passive registration:

Patients are registered during their first visit to the doctor (either according to the coverage area or depending on a patient's wish).

- Combination of active and passive registration:

Passive registration of a patient during first consultation with the doctor, and active registration of his family during subsequent visits. Patient will be asked to interview family members whether they all agree to be registered with the same family medicine team. This manner of registration enable speedy registration of bigger population compared with passive registration, without much effort involved, as well as better distribution of high-risk patients.

5.3.1.3. Introduction of the Appointment System

FaMI considers introduction of the Appointment System as a first viable and visible step in the process of introduction of family medicine in primary healthcare system. The appointment system will result in better organization of work, decreased volume of work, improved quality of services, and increased satisfaction of both patients and health practitioners. Appointment system is considered as a foundation upon which all other aspects of family medicine will be built.

Traditionally, situation in this regard has been as follows: general medicine ward is opening, whereby a number of waiting patients bursts in and demand consultation with a doctor. Sorting out problems among waiting patients (triage) is impossible in this case, as those who waited for a long time would not allow other patients to be admitted earlier. Typically there are long queues and a lot of stress incurred both by patients and the staff. Patients complain about insufficient quality of care, while staff is overworked and sometimes outright frustrated due to perpetual chaos prevailing in a ward.

Introduction of the appointment system in family medicine and primary healthcare in general shall produce the **following effects**:

- Decreased volume of work for health practitioners due to organized arrival of patients
- Better organization and ability to plan one's activities, which leaves more time for other activities to be performed in structured manner, e.g. home visits, health promotion activities – individual and group education of patients, work meetings, continuing education, training, etc.
- Improved quality of services as a result of clearly defined time available for patients and decreased stress
- Increased satisfaction of covered population due to shorter waiting times and more attention given to individual patients
- Increased satisfaction of health practitioners due to possibility to monitor patients' health and more time that could be dedicated to each patient. This, in turn, enables FM practitioners to treat health problems that would otherwise warrant patients' referral to secondary healthcare level

What is necessary in order to introduce the appointment system in family medicine?

- Family medicine team defines who and how will implement introduction of the appointment system (it has been suggested that the best person to take care of running the appointment process is a dedicated nurse)
- Define period of time dedicated to individual patients (standard time for usual check ups and longer time required for first visits and complicated cases)
- There has to be only one appointment book per team, located always in the same spot
- Phone line dedicated to a FM team nurse, with extension in doctor's room
- Appointment cards available for scheduling patients' visits
- FM teams whose patients have scheduled visits have to be available in scheduled times

Practical steps for introduction of the appointment system in family medicine:

There is no single universal recipe to introduce the appointment system in different locations and settings. It is important to be flexible regarding the proposed steps for introduction of the appointment system and bear in mind that it cannot happen overnight, rather it is a process which requires certain period of time (typically 3-4 months). Role of the facilitating agent (FaMI) is therefore crucial to assist the family medicine teams with expertise and transfer of experiences from other locations in order to enable introduction of the appointment system which satisfies the needs of particular location. The following are therefore preliminary steps for introduction of the appointment system, which are adapted to suit each individual setting:

STEP 1:

Set the date and inform the population that the appointment system shall commence from that date. These information can be disseminated using different means:

- Announcements are posted in ambulantas and PHC family medicine ward, containing the following information: starting date and telephone number of ambulanta/PHC. Announcements have to be posted in very visible spots, such as entrance doors, waiting rooms, etc.
- In addition, announcements are posted in visible spots frequented by inhabitants of particular community (e.g. local bakery, local community office, etc.)
- Doctors and nurses have to dedicate some time to explain the patients the essence of the appointment system, stressing the benefits for patients

STEP 2:

Commence appointment of patients visiting for medical checkups (patients with diabetes, hypertension, tuberculosis). They should be scheduled for checkups in late morning hours (e.g. after 10AM) since the waiting rooms are likely to continue to be crowded early in the morning until the system is fully up and running. It would be useful to schedule chronic sufferers of the same type on the same days, enabling easier monitoring of their health over time.

STEP 3:

Patients have to be thoroughly informed on advantages of the appointment system. Working in crowded waiting room, nurse(s) should put in additional effort to motivate some of the patients requiring extensive treatment to schedule an appointment later in the day or in coming days. This proposal should be put forward in clear terms: patient has the choice to keep on waiting and then have only few minutes with a doctor, OR, schedule an appointment and receive the best care without waiting. Approximately 10-20 minutes is realistic proposal for treatment of one patient.

STEP 4:

Over time more and more patients will opt to use the appointment system. However, this will definitely be gradual process, with certain number of patients ignoring the system, willingly or otherwise. Once the majority of patients are used to the system, those who continue to ignore it should be slowly sanctioned for doing so. Except in emergency cases, their consultations should be put off until all the appointments are sorted out, and they should continually be warned to use the benefits of the appointment system.

Some things that have to be kept in mind:

- As noted earlier, plan for an average of 10-20 minutes per patient (or more for complex problems). Limit the number of patients to the maximum of 4-5 patients per hour.
- Some time has to be left aside for dealing with emergency patients, who would otherwise leave your schedule in disarray.
- Don’t be disheartened by the sight of your waiting room being as full as always while the system is being introduced. Even later, first hour or hour and a half can be kept open for dealing with emergencies and lesser problems. Patients are given only few minutes of time during this hour.
- Use appointment cards to remind the patients, especially older, of their scheduled appointments
- Don’t forget to ‘schedule’ your coffee or meal breaks, set time aside for continuing education, etc.

Implementation of the appointment system is a process requiring several weeks to begin functioning. Its success depends on ability of a doctor and a nurse to work as a team. Doctor should support a nurse who rejects to admit patient with lesser health problem, instead insisting on him/her scheduling an appointment first.

One of the important benefits of introduction of the appointment system is ability of a FM team to successfully monitor patients with chronic diseases and adjust and plan their long term care accordingly. Once the system is up and running, FM team will have more time to dedicate to individual patients and be able to resolve more complex cases without referral to secondary and tertiary services. More time is available for community health care promotion and group and individual education. Also, time is available for home visits, without disrupting the work with patients visiting the PHC (for instance dedicating the last hour or more for home visits).

Accompanying instruments:

- Blueprint Reorganization
- Blueprint Coverage Area
- Appointment System Handout
- Appointment PHC forms
- Active registration form, Canton Zenica-Doboj

5.3.2. Organization of family medicine teams

Functional family medicine teams are crucial for the success of family medicine model. Doctors and nurses which make up the team have to possess relevant competencies, which are product of basic and continuing medical training. However, despite the level of competence of health practitioners, success of their work depends on ensuring that the family medicine team is organized in a way that allows it to fulfill its intended functions. This is especially true when the team is working on community outreach projects, which presume involvement external stakeholders in the team's activities.

FaMI adopted methodologies to ensure proper organization of a family medicine team and realization of team activities. First of all, a team has to hold regular weekly meetings. Meetings have to be scheduled on the same day and hour, and this schedule has to be maintained in order to allow the planning and feedback exercises to be implemented within the intended framework.

FM team meetings serve the following purposes:

- Organization and planning of activities of a family medicine team
- Drafting work schedules and allocating tasks between doctors and nurses
- Planning short and long-term activities (especially important for allocating time to service delivery in primary healthcare center and work in community)
- Evaluation of work of family medicine teams
- Revision of cases and discussions on need for house visits
- Planning and realization of involvement of local experts for projects in communities (as resource persons, lecturers, organizers, monitors, supervisors, etc.)

To operationalize this methodology, FaMI developed **practical steps** to be followed to ensure the success of FM team work. These steps were then imparted on participating health practitioners as part of the Training of Trainers exercise.

Introductory remarks:

- It is important that the decision is not preconceived, i.e. that the meeting is convened genuinely for the purpose of making the most appropriate decision. Impression among the members of the team that the decision has already been made will ruin the trust between the participants and convener(s) and remove the very reason for existence of such meetings.
- Moderator should occupy the position from which he/she can maintain visual contact with all participants.
- Discussion should be organized in the form of process, whereby the moderator regularly synthesizes the opinions voiced, emphasizing that some of the participants might have different opinion. In this way, persons who choose to differ could voice their opinion on the matter and feel that it will be incorporated in the decision making process.
- Once the decision has been made, do not reopen the process, as this can cause frustration among the participants

Ethical considerations governing the group work in FM team meetings:

- Everyone has the right to voice his/her opinion
- Decision making is a process, not an authoritarian exercise
- Check whether everyone in the group agrees with the proposed decision. If some of participants disagree, allow the other participants to hear their dissenting opinion
- Use the decision making process to get the participants to get to know each other. If the group cannot make the decision, proceed to the next item on the agenda, and revisit the difficult part later. Try to brainstorm the difficult decision – invite participants to voice their ideas on how to resolve the dilemma. Moderator is not the one who is tasked with always finding

solutions, but has the important task of keeping the decision making process going. Moderator does not make the decisions on behalf of the group, instead he/she involves group in making the decision. It is sometimes better to adopt less ambitious decision instead of decision that does is not supported by some
- Do not criticize those participants who dissent from the majority opinion
- Making decision supported by all participants contributes to the strength of the decision

How to organize the meeting:

- Choose a moderator (usually head doctor/nurse)
- Stick to the timing (respect everyone's time)
- Clarify the objectives of the meeting to everyone based on the agenda which was distributed to all participants beforehand. All participants must agree on the agenda and the steps required to make the decision
- One of the participants should serve as note taker
- Persist in involving all participants in decision-making process in order to ensure subsequent support for the resolution(s) adopted in the meeting
- Ensure that the resolution adopted in the meeting is acceptable to all participants
- Distribute the minutes from the meeting to all participants (immediately after the meeting, if possible. In any case prior to the next meeting)

Steps to be undertaken to break the impasse:

- Reformulate the dissenting opinion and request from other participants their support, then make general synthesis
- Once those who support the decision voice their opinions, request from the dissenting participant to comment their opinions (following which the dissenting participant changes his/her mind, seeing that the decision is product of majority opinion, not just moderator's)
- Request opinion from participants not taking part in discussion: it is very important to hear their opinion and involve them in discussion
- Do not waste time on practical details (e.g. timing, etc.)
- Is a participant disagrees, understand this as his/her personal opinion, not something aimed against you

How to wrap up the meeting in the last 15 minutes:

- Summarize the decisions made
- Summarize the decisions that remain to be adopted
- Allocate the tasks
- Fix the date and time of the next meeting (next week, same time, same place,

if at all possible)
- Summarize the objectives of previous and next meeting
- Thank all the participants

Accompanying instruments:

- Blueprint Team Meetings

BOX 1.3: DIVISION OF TASKS WITHIN THE FAMILY MEDICINE TEAM AS DEVELOPED BY FaMI

NURSE	DOCTOR	COMMUNITY NURSE
• Reception • Patient's File • Finding Patient's File • Nursing anamnesis • Necessary nursing intervention • Triage (need for consultation with the doctor) 2. After the consultation with the doctor • Writing down patient's data in doctor's prescription/referral slips • Entry of patient's data into the Data Protocol • Nursing interventions (injections, bandage...) • Scheduling appointments for next check-ups, if needed	• Consultations • 80% of health conditions are resolved on the level of his/her center • Cooperation and communication with other disciplines (specialists, nurses) • Responsible for referrals and health files of his/her patients • Responsible for contacts with specialists at the hospital and PHCC level to which he/she refers patients and makes appointments for them • Attends workshops, makes use of selected guidlines, conducts presentation of themes, attends to meetings of working groups • Attends staff meetings	• Home/community visits (medical interventions, prevention and health promotion, individual/group community education) • Home Visit Schedule Log and development of Nursing Care Plan • Assists to nurses in the ambulanta • Attends staff meetings • Reports to the FM Team about the status in the field • Multidisciplinary cooperation, including social workers, mental health professionals if necessary

• Registration for home visits if necessary • Conducts prescribed lab analysis in case a basic laboratory is available • ECG • Individual/gruop education in community 3. Miscellaneous • Answers telephone calls/schedules consultations with the doctor/provides advice by telephone/does telephone triage • Resposible for placing orders of materials and equipment • Conducts instrument sterilization • Writes daily and monthly reports • Responsible for the cash collected through participation fee and its handover to the Finance Administration of PHCC • Attends team meetings (every two weeks) • Responsible for ambulanta equipment • Responsible for support staff		

5.3.3. Evaluation of results in the area of family medicine implementation

5.3.3.1. Continuing supervision and evaluation

This is an essential precondition for success of any reform process. Without supervision and evaluation methodology in place, it would not be possible to measure the extent to which a reform has achieved the preset objectives. Lack of supervision will also likely make it difficult for an agent facilitating the reform to take corrective action to address the issues arising during intervention. FaMI used two sets of instruments to ensure that reform process is developing according to the schedule and to provide professional support to involved stakeholders when need arises.

To this end, FaMI drafted a set of general questions related to family medicine, to be used by an appointed supervisor as a sort of guidelines during the continuing supervision and evaluation process in the course of implementation. Questions relate to:

- The process of change
- Patient-oriented approach
- Resolving one problem at a time
- Medicine based on solid scientific proof
- Rational prescription of medicines
- Decreasing unnecessary referral
- Decreasing the use of injections
- Emancipation of nurses

FaMI is in the process of developing methodology to be employed by supervisors to address the issues identified by the supervision process. The methodology uses the following methods for corrective action together with key stakeholders:

- Additional training in groups
- Individual supervision (when necessary)
- Case discussion
- Developing local protocols for medical treatment
- Facilitating access to medical literature with the help of books and internet

5.3.3.2. Patients' satisfaction

FaMI recognized that the ultimate measure of success of any reform in healthcare sector can only be measured in reference to the patients' satisfaction with provided services. In line with this, FaMI employed the **EUROPEP** method as referential tool for evaluation of family medicine implementation in Bosnia and Herzegovina. Grol and Wensing designed the EUROPEP tool believing that 'at the

end of the day it is the patient who determines whether care provided helped to improve their health status or quality of life.' More importantly, from the viewpoint of an agent facilitating the reform, it is 'not only the outcomes of care in terms of health gains or needs met are important in this respect, but also the ways in which care is provided: the accessibility of care, the organization of services, the attitude of care providers, and their education of and communication with the patient.'

Modern healthcare services are patient-oriented, placing the patient in focus as the ultimate arbiter of quality of provided services. Although patients tend to be subjective in their estimates of situation in healthcare sector they are depending on at the moment, their opinions are collated to produce valuable input to healthcare providers. Modern healthcare also places great emphasis on ethical dimensions of care, which also translates into patients' satisfaction as the ultimate measure of success.

Preliminary studies conducted in the design phase of the EUROPEP questionnaire suggested that patients valued the following aspects of family/general practice medicine services the most:

- Getting enough time during consultations
- Quick service in case of emergencies
- Confidentiality of information on patients
- Telling patients all they want to know about their illness
- Making patients feel free to talk about their problems
- Appointment at short notice
- GPs attending courses regularly
- Offering preventive services

In accordance with the preliminary findings and cognizant of the importance of structuring the measure of patients' satisfaction for developing family medicine services, the EUROPEP instrument was developed to enable **comparative quality measurement of family medicine care** across different countries. Such comparative measurements between countries with different healthcare systems allow decision makers and other key stakeholders to understand relative quality of care in their own countries. EUROPEP was also designed to indicate the health practitioners themselves what kind of improvements could and should be made to improve the quality of services and ensure patients' satisfaction. For family medicine practitioners EUROPEP can also provide important indicators of the capacity gaps to be addressed through continuing education, which is one of the key aspects of FM reform as facilitated by FaMI. Feedback derived from the EUROPEP questionnaires could thus provide valuable input for designing the continuing education curriculum in cooperation with health practitioners and continuing education centers.

To facilitate introduction of EUROPEP into family medicine sector in Bosnia and Herzegovina, FaMI worked with health practitioners and decision makers alike

to demonstrate the usefulness of this questionnaire in improving the quality of care. It was also emphasized that the ultimate purpose of such questionnaires is not direct evaluation of individual health practitioners or institutions, but rather providing input for overall improvement of patients' satisfaction and raising quality of care to another level. Regarding the patients, FaMI stressed the message that the feedback received indeed feeds into the system and that patients will on longer run be able to see the corrective action undertaken in response to their concerns expressed in EUROPEP. FaMI also prepared short introduction to the questionnaire for the patients, bearing in mind that in BiH patients typically were never asked to provide this kind of feedback to their healthcare providers. It was important to make patients understand that this is not pass/fail type of exam, but rather a helping tool for practitioners and patients alike to improve overall quality of care and patients' satisfaction.

Accompanying instruments:

- Evaluation methodology
- Methodology checklist
- EUROPEP questionnaire
- Instructions for the patients answering the questionnaire
- Supervision form (PHC Sarajevo) – Community nurse

5.4. Strengthening the role of nurses in family medicine

Recognition of the role that nursing profession plays in healthcare is an important indicator of the stage of development of health sector in any country. Nurses play crucial and indispensable role in all levels of healthcare, including primary and community health services. However, traditionally, nursing received far less recognition both in society and within the health sector, when compared to high prestige enjoyed by doctors. In addition, nursing is profession dominated by women, which in many instances causes an additional layer of prejudice.

Nursing is also playing different role in organization of healthcare sector across the globe, which is result of differing attitudes and philosophy of healthcare espoused by key decision makers. In some countries, chiefly the developed ones, nurses outnumber doctors by four to one or even more. In some other countries though, nurses more or less equal doctors in numbers. In latter case, nurses are often perceived as little more than doctors' helpers, almost manual workers performing even the most mundane tasks only under close supervision. Over a long run, such attitudes waste huge potential contribution that nurses could make in healthcare sector.

Also, even more importantly on the short run, preventing nurses from making more meaningful contribution to healthcare results in significantly more expensive and less efficient healthcare system. Overburdened doctors on the primary level, lacking support from highly professional nurses, resolve their inability to fully dedicate themselves to patients by referring them to secondary and tertiary care doctors. Such health system cannot dedicate sufficient number of qualified personnel (as doctors are always in short supply) to operate efficient primary care services, including community outreach services. Modern medical science is in agreement that lack of highly professional nursing is one of the biggest contributing factors adversely affecting functioning of healthcare system in countries where nurses fail to achieve proper recognition.

5.4.1. Education

One of the biggest obstacles to proper positioning of the nursing profession in healthcare system is the issue of education. While in more developed western countries nursing education long ago moved to university level, in other countries, including Bosnia and Herzegovina, nurses are mostly trained only up to a high-school level. There are two problems that severely impede any attempt at reform of health sector that are result of insufficient qualification structure of nurses. First is that it impedes their recognition by other health practitioners (doctors) who are vastly more educated and therefore tend to look down at high-school educated nurses. In such setting, nurses can never be recognized as peers in healthcare system, hence preventing them from assuming more prominent role in planning and implementing healthcare services, including family medicine.

Second problem is that education at below university level is indeed insufficient to equip the nurses with all the knowledge and skills required if they are to be given more responsibilities in providing medical services. Medical schools in developed countries train nurses at bachelor's, or even higher level. As such, nurses enjoy better recognition among other health practitioners, and are able to assume greater share of responsibilities in working with patients. Healthcare systems operating under ever-increasing strain due to rising needs and limited resources are keen to accord nurses more prominent role, allowing them even to assume many of the tasks which were earlier performed only by doctors. Thus nurses could now diagnose and treat a range of medical conditions, involving doctors only in limited supervisory role, if at all. In more sparsely populated and poorer areas, where it is difficult to provide sufficient number of doctors, health services are increasingly performed by nurses, provided with means to communicate with medical consultants in bigger medical centers, who in turn can provide professional and supervisory support to nurses.

Nurses are indispensable for operation of family medicine services in community. They assist doctors in coping with large numbers of patients who at

this first level of healthcare threaten to overload the system, if not properly registered, examined, diagnosed, treated, and monitored. There will never be sufficient number of doctors to perform all of these tasks, hence the need to support them with a minimum of two nurses in each FM team. Population trends across the world, including Bosnia and Herzegovina, suggest the family medicine and primary healthcare in general, are coming under increasing strain due to the need to treat for an ageing population, suffering from range of professional and chronic diseases. Such diseases require permanent monitoring and involvement of external stakeholders in community in order to treat them satisfactorily. These are all very labor intensive activities, and large numbers of dedicated health practitioners are required to implement them. This is where the key role played by nurses is most visible to patients and external observers alike.

5.4.2. Practical steps

In order to operationalize the family medicine concept, it is necessary to intervene to promote and strengthen the role of nurses in a family medicine team. Preparatory activities to make this sort of intervention possible – retraining, continuing training, working together with doctors in workshops and seminars – create foundation for acceptance of nurses as indispensable and key stakeholder in family medicine. However, institutional resistance, lack of precedence, or simply prejudice, may stall further development of nursing concept, unless measures are taken to operationalize it.

FaMI approached this problem in rational manner. Even though blueprint for development of nursing up to the western standards does exist and could easily be copied, FaMI understood the reality of BiH healthcare system, which would render any attempt at all-out reform a failure. At best, the system would last while the project supports it, but would eventually fail to build local ownership of the concept, and cause an even bigger gap between doctors and nurses. Sustainability of intervention would therefore obviously be compromised.

5.4.2.1. Nursing Care Plan

Instead of forcing top-down unrealistically ambitious concepts, FaMI opted for development of the so-called Nursing Care Plan (NCP), governing nursing services provided to specific categories of patients. This standardized instrument in developed countries applies to all patients in primary healthcare system, but FaMI's estimate was that introduction of such radical change in BiH primary healthcare system would not be realistic at this stage. Instead, it was proposed that the NCP should be gradually introduced to cover increasing number of categories of patients. FaMI suggested that at initial stage, the NCP should be applied to the following categories:

- Monitoring newborns' health – especially among vulnerable categories of population (with implications for development of community nursing)
- Terminally ill patients (where the impact of nursing is most demonstrable in the short run)
- Multiple pathologies necessitating intensive house visits (high impact, potential for development of community nursing, plus involving and building synergies with other stakeholders in community)

Nursing Care Plan forces nurses to think through, plan, and implement their activities strategically, as well as to systematically evaluate their activities. Over relatively short period of time, it can be reasonably expected that the NCP will contribute to emancipation and improving of the nurses' position in family medicine teams. For the family medicine beneficiaries, it is of importance that the NCP is considered an effective tool for achieving continuity and coherence in healthcare service provision.

Objectives of introduction of the Nursing Care Plan in family medicine in community are:

- Development of standardized Nursing Care Plan by primary health centers targeted by the reform
- Implementation of the Nursing Care Plan through care for designated categories of patients

Methodology for implementation of the Nursing Care Plan

- Initiate establishment of a working group for development of standardized Nursing Care Plan, with obligatory participation by the head nurse and Family Medicine Coordinators
- Lecture on the Nursing Care Plan
- Identification by the family medicine team of specific patients whose condition allows them to become focus of the Nursing Care Plan
- Supervision of implementation of the Nursing Care Plan

Timeframe: several months (less than a year)

Accompanying instruments:

- Community nurse's interventions
- Nursing care plan
- Nursing anamnesis
- Supervision form (PHC Sarajevo) – Community nurse

5.5. Introduction of lifelong learning in family medicine

Rapid advances in knowledge, technological progress, unprecedented ability to accumulate and share the wealth of expertise and experience, make continuing education a must if health practitioners and services are to maintain the standard of care. It is not only health practitioners who are given the opportunity for professional advancement that benefit from this process, but also healthcare services and a society as a whole, due to their propensity to new knowledge and ability to reform and improve. Acquisition of new knowledge also raises the profile of medical workers and benefits their reputation due to their ability to better tackle various issues in their everyday work. More complex problems could accordingly be resolved by practitioners at primary healthcare level, without reference to (costly) clinical services.

It is not only direct medical practitioners who could benefit: managers of healthcare institutions, supervisors of services and processes, as well as staff in relevant public institutions and ministries, all benefit from increasing their knowledge pool and better ability to identify and tackle the problems in healthcare services. Continuing education has become permanent feature of modern healthcare. It is regular, but not fixed exercise. Continuing education sessions are organized in response to the need to communicate new advances in science; share the experiences between health practitioners; equip the beneficiaries with necessary skills to utilize latest technologies, tools, and protocols; acquaint medical staff with applicable legal regulations, codes, guidelines, and the like. Continuing education also does not have permanent form. It can be organized in the form of conferences, seminars, presentations, workshops, short brown-bag in-service learning exercises, etc.

Even more importantly, emphasizing the need for continuing personal improvement should impute understanding of the necessity of individual learning process. A health practitioner's individual study of relevant literature, for example, also counts as continuing education, and should be accorded appropriate recognition. Most advanced healthcare institutions in the world therefore allow their staff to dedicate some of their official working hours to home study.

Cognizant of the importance of continuing training of family medicine practitioners, FaMI from the earliest stages of intervention placed greatest emphasis on this aspect of the primary health care reform in Bosnia and Herzegovina. To this end FaMI supported establishment of **four training centers**, in Sarajevo, Zenica, Doboj and Foča. At the beginning of the family medicine implementation process, emphasis in the training was placed on retraining of health practitioners (doctors and nurses), so that they could be introduced to this, hitherto unfamiliar, concept of primary healthcare. Training was given by external experts who were already familiar with the concept of family medicine in their respective countries. Greatest care was, however, put in ensuring that the needs

and specifics of healthcare system and health practitioners in Bosnia and Herzegovina are taken into consideration when designing the training curriculum.

One of the biggest obstacles at this stage of the training was that relevant authorities responsible for healthcare system in BiH did not possess accurate assessments or even estimates of training needs in the country. Therefore, in the areas covered by the FaMI project it was difficult to estimate the numbers of staff that need to be retrained to allow introduction of family medicine in primary healthcare system. Additional problem was that regulated numbers of healthcare practitioners that were supposed to form family medicine teams (one doctor and two nurses, including community nurse, per 2.500 inhabitants in the catchment area) is rarely met, due to shortage of doctors who completed residency in family medicine, migration from rural to urban areas which left rural and poorer primary healthcare centers perennially understaffed, and especially insufficient number of trained nurses, dedicated exclusively to work in FM teams. Due to combination of these factors, it has not been possible to produce an accurate assessment of the extent to which retraining needs have been covered by FaMI in the course of the project. Large number of doctors and nurses were retrained, however, and it proved in due time that FaMI managed to create critical mass of trained health practitioners, which enabled effective and sustainable introduction of family medicine in primary healthcare in BiH.

Retraining of healthcare practitioners in order to facilitate introduction of family medicine was followed by development of continuous medical education, along the lines mentioned above. This type of training was piloted by the training center which was the first one to be established – in Cantonal Primary Health Center Sarajevo, which organized first ‘refresher courses’ for family medicine practitioners who have earlier undergone retraining. It was hoped that piloting this practice would initiate the process of lifelong professional development and continuing education among the family medicine practitioners.

One important feature of this training was that it was **organized jointly for both doctors and nurses**, which represents pioneering effort to bridge the gap between the two professions. The idea behind such structuring of the training was to create synergies and better understanding and coordination between all members of a family medicine team. This approach has been generally commended by trainees, and external evaluators and partners alike.

At early stages of implementation of continuing training, most trainers were sourced from external partners, as local health practitioners lacked necessary expertise, and were also not familiar with the methodology and requirements of continuing education process. However, FaMI stressed the need to gradually transfer the knowledge to local partners, with the result that at latter stages the continuing education process has completely been taken over by the local experts, through inclusion of Training of Trainers (ToT) in the training process.

5.5.1. Training of trainers and supervisors

Training of trainers (ToT) courses intensified towards the middle phase of family medicine implementation. It was realized that local capacities have to be developed in order to ensure local ownership and sustainability of the family medicine concept. To this end, courses were organized to transfer the training capacities in the area of family medicine to selected local resource persons. These resource persons were selected bearing in mind geographical coverage of the project (so that they be fully deployed in their areas), their learning and development potential (based on their performance in earlier trainings), and their fields of expertise and work positions (so that they could be accepted as resource persons by their peers). Typically, participants were family medicine practitioners who attended earlier trainings and their names were put forward by one of the training centers supported by FaMI. Participants of the ToT were principally educated in training methodologies, how to transfer the knowledge they already possessed or will acquire in the future to their peers.

It has been concluded by FaMI, training supervisors, and participants alike, that the ToT represented successful transfer of training methodology from the Swiss to local experts. Early on, FaMI in cooperation with local stakeholders decided to strengthen the capacities of local medical practitioners by gradually involving them in training activities. Gradually, local partners went on from supporting roles, e.g. relating issues from practice, to preparation and execution of the most complex and advanced topics. In final phase of Family Medicine Implementation Project in Bosnia and Herzegovina, this approach led to complete takeover of the continuing training of medical practitioners by local experts, with only occasional backstopping by FaMI.

In order to ensure sustainability of continuing education, FaMI established close collaboration with public health institutes and schools of medicine in order to develop the training curriculum, assess the training needs, plan future improvements to the training process, and also to introduce supervision and quality control in continuing training in the area of family medicine. Special tools were developed to systematically introduce these measures to continuing education organized by training centers.

5.5.2. Training of managers

Training of managers of healthcare institutions forms an important part of continuing education in the area of family medicine. FaMI pioneered this form of education early into its intervention in primary health care reform, judging that success of the reform depends greatly on ability of management of primary healthcare institutions to understand, accommodate, and support introduction of family medicine. As part of the training, working groups were formed of

participating managers to serve as forums where examples of good practices could be related and acted upon. In addition, general topics of importance for family medicine were discussed. Working groups also served as networking tools that contributed to synergies between key stakeholders who could influence the outcome of the reform processes. Training of managers did not continue for long, however, as the exercise was costly and FaMI did not manage to have this training included in the respective health sector budgets. However, it was judged success by the involved parties and considered valuable, so it should be considered again in the future.

Accompanying instruments:

- Curriculum for education of community nurses FBiH/RS
- TOT Curriculum 8 Units/30 Units

BOX 3.5: Family doctors and nurses enrolled in training centers supported by FaMI

2001 - 2006			
Training Center	**Doctors**	**Nurses**	**Total**
Sarajevo	166	180	346
Zenica	71	101	172
Foča	26	52	78
Doboj	83	117	200
Total	**346**	**450**	**796**

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FaMI family medicine reform instruments

Sub-sections in the handbook and accompanying instruments

3.3.1. „Marketing" of the family medicine concept

- *Methoodology – Check list*

4.1.1. How to involve NGOs in a sectoral reform?

- *Curriculum for education of the community nurse Federaton of BIH*
- *Clinical supervision*
- *Guideline - Smoking cessation*
- *Flow of the patients*
- *Assesment form - DZ and ambulanta*

5.1.3. Training needs assessment – Group Techniques for Program Planning (DELPHI)

- *Community assessment*
- *Delphi group technique*
- *Questionnaires - Delphi Doctors and Nurses*

5.2. Involving community as part of holistic approach to public health

- *Comunication form - Health and Social sector*
- *Community file*
- *Job description - Social worker-supervisor*
- *Blue print - Family medicine patient file*
- *To the doctor without fear - pedagogical frame*
- *The influence of drugs on health*
- *Risk factors for cardiovascular disease – pedagogic frame*

5.3.1.3. Introduction of the Appointment System

- *Blue print - How to organise or re-organise our clinic*
- *Blue print - Coverage area - registration of patients*
- *Patient reminder card – Appointment*
- *Appointment ambulanta - example*
- *Registration form*

5.3.3.2. Patients' satisfaction

- *Check list*
- *EUROPEP*
- *Supervision form in PHC Canton Sarajevo*

5.4.2.1. Nursing Care Plan

- *Community nurse interventions*
- *Form for nursing assesment*

5.5.2. Training of managers

- *Curriculum for education of the community nurse of Republic of Srpska*
- *TOT and TOS Curriculum - 12 units*
- *TOT Curriculum - 32 units*

Additional instruments

- *Pedagogical frame - Evaluation*
- *Pedagogical frame - Patient file*
- *Pedagogical frame - Task division and team meetings*
- *Pedagogical frame - Health promotion – Smoking Cessation*
- *Pedagogical frame - Registration of patients and coverage area*
- *Pedagogical frame - Telephonic advices*
- *Pedagogical frame - Individual and group education of patients*
- *Pedagogical frame - Home care and palliative care*
- *Pedagogical frame - Prevention of accidental exposure to blood*
- *Pedagogical frame - Rational drug prescription*
- *Pedagogical frame - Appointment system*
- *Pedagogical frame - Assessment of Dom zdravlja or ambulanta and FM indicators*
- *Telephone chart - Acute diarrhoea*
- *Telephone chart - Acute sore throat*
- *Telephone chart - Acute otitis media*
- *Telephone chart - Children with fever*
- *Telephone chart - Worms in stool*
- *Telephone chart - Herpes - lip*
- *Telephone chart - Winter hands and feet*
- *Telephone chart - Urinary tract infections*
- *Telephone chart - Influenza*
- *Telephone chart - Coughing*
- *Telephone chart - Bleding nose*
- *Telephone chart - Constipation*
- *Telephone chart - Diapers - rash*
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- Medication chart for patient
- Examination and Referral list
- List of active medical problems
- Continuously used drugs
- List of telephonic advices
- List of problems
- Performed patient education

Doc. dr Ešref Kenan Rašidagić
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