BALKAN PRIMARY HEALTH CARE POLICY PROJECT

B P H C P P Quarterly, Issue No 3, January 2008

Dear Readers,

Our newsletter this quarter is full of interesting articles. Since the last newsletter the Primary Health Care Policy Project (PHCPP) hosted the Regional conference "Human Resources for Effective Service Delivery in Primary Health Care" in Banja Luka on October 8 and 9, 2007. A significant part of this newsletter will be devoted to the report from this successful and important event. In addition, an article by Orvill Adams, Project Director provides information about teamwork in Primary Health Care.

Canadian consultant Larry Nestman also writes about different types of incentives and and how they can impact Primary Health Care workers and organizations. On page 8 an article by Saša Savić provides a closer look at institutional mechanisms for gender equality in Bosnia and Herzegovina.

In the last section of the newsletter you can find out more about other important activities und events that are happening within the project.

Enjoy reading

Regional conference "Human Resources for Effective Service Delivery in Primary Health Care"

The Balkans Primary Health Care Policy Project (BPHCPP) and the Ministry of Health and Social Welfare of the Republic of Srpska organised a two-day regional conference "Human Resources for Effective Service Delivery in Primary Health Care", held in Banski Dvor, Banja Luka on 8 and 9 October 2007. Over 150 participants from Serbia and Bosnia and Herzegovina took part in the conference.

Conference presenters were from Croatia, Slovenia, Hungary, Great Britain, Canada, Serbia and BiH. This is the first in a total of three conferences planned as part of the implementation of the Balkans Primary Health Care Policy Project.

"It is with great pleasure that today I open the conference to which we invited our colleagues from the Ministry of Health of FBiH, Ministry of Health of Serbia as well as numerous colleagues from Bosnia and Herzegovina and the region. The primary purpose of this conference is to use the primary health care reform implementation programme to assess the current situation, share experience with other countries, and find out more about the state-of-the-art achievements and primary health care development plans, based on experiences and activities that each of the countries have implemented over the last few years", said Mr Ranko Škrbić, Minister of Health and Social Welfare, on the occasion of opening the conference. Minister Škrbić expressed profound gratitude to the Canadian Ambassador, HE David Hutchings, who he said had found time to devote attention to the very segment that the Canadian Government had extensively supported in Bosnia and Herzegovina and other countries in the region.

"We are in the process of implementing the concept of family medicine thanks to the colleagues from the Queens University, whose educational programme for family medicine doctors and nurses working in the team are a very important segment without which the today's state of family medicine would be far from what it is today. This was also the reason for several study visits to Canada, where we had the opportunity to familiarise ourselves with the Canadian model, which is to a great extent similar to what we are trying to implement here", said Minister Škrbić. When social health aspect is concerned, he pointed out that the Canadian system could completely satisfy the needs of the population in Republic of Srpska. "Here I would like to place emphasis on the beneficiaries of these services, the ones we are doing this for, because all these activities and the reform itself are intended for them.

This project is funded by the Canadian Government, through the Canadian International Development Agency

Queen's University

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Canadian Society for International Health

Our task, in fact, is to make our beneficiaries happy with what we do through reform, in order to enable swifter, more direct, and more adequate health care in Republic of Srpska and the entire region", said Škrbić.

According to Project Director, Mr Orvill Adams, the Balkans Primary Health Care Policy Project is implemented in two countries in parallel – in Bosnia and Herzegovina and the Republic of Serbia. In Serbia, the project focuses on the development and implementation of primary health care policies, whereas in Bosnia and Herzegovina focus is on development of human resources. "Now we are at the onset of the second year of a three-year project and this conference is an opportunity to connect these two parts of the project together, to bring together key experts and look at ways of improving primary health care for the people who need it most.

"So we hope that this conference is going to be an opportunity for people who come from different areas of expertise not only to listen to lectures, but also to share their experience during

discussion. Throughout implementation of this project we have worked in close partnership with the ministries of health in the region, and through ministries this partnership extended all the way down to the very beneficiaries of health care, who are the most important, because it is only if we really talk to people who use health care services that we can find out whether those who deliver these services are really well-trained", said Adams.

The conference was especially significant because of the attendance of HE David Hutchings, Canadian Ambassador to BiH, who emphasised that the issues of family medicine and primary health care were very important to Canada and Canadians.

"Given the fact that Canadians attach great importance to what their primary health care system is like, it is logical that our cooperation in BiH focuses exactly on this particular area. Health care is a very important issue within general policy in Canada, everyone talks about it and everyone finds it important. We are very proud of our health care delivery model, but we know that at the same time there are a lot of other models too. Our aim here is to initiate discussion in order for you to find a model that is the most suitable for you. I think that this is one of the most important things that Canada is doing in Bosnia and Herzegovina and I am glad that this is the case," said the Ambassador in his statement for the media.

Also present at the conference were Assistant Minister of Health of Serbia, dr Ivana Mišić and her associates, who have been working hard over the last few years on improving the health care system and tailoring it to the real needs of the people in the Republic of Serbia. According to dr Ivana Mišić, many strategic documents have been developed so far as part of this process and implementation of these documents is well under way, and the focus of Ministries' action now and in the next few years is primary health care.

"The Serbian Ministry of Health is very active and participates with interest in implementation of this regional project and we are very interested in its positive outcome. When health human resources are concerned, the Ministry of Health of the Republic of Serbia has committed itself over the last few years to solving this problem and we believe that we have enough experience with regard to that matter to share with all those who are set to start addressing these problems," said Mišić.

She added that the Ministry of Health of the Republic of Serbia deemed this first regional conference in Banja Luka to be a very important regional meeting. "This is an ideal place for continuing good cooperation already established between our ministries and a good place for developing the necessary experience and discussing various dilemmas and issues that we all encounter", said Mišić.

Representatives of the Ministry of Health of FBiH thanked the organiser and pointed out that the conference was an important event for all because, as Assistant Minister Mr Goran Čerkez said, "We know that there is no economic development without healthy population, and in order to have healthy population we need to invest in human resources".
He added that when investment in human resources was concerned, more and more people realised ……

.....that investment in health was not expenditure but sound investment and that the conference was an ideal chance to look at the results achieved this far. "It is very important to find out how much we invest in development of human resources and po-

tentials that are supposed to be the carriers of our reform processes in the health care system as well as to get answers to the question at what levels we invest in health care. We should not invest only in human resources at the level of primary health care and the level of doctors, but also at the level of entire management as well as in people who deal with health policy. It is a great pleasure that we do all this with our good partners – the Canadian Government, which is one of the most significant partners of health ministries in Bosnia and Herzegovina", said Goran Čerkez.

"Due to the specific organisational structure of the Brčko District, we started implementing the family medicine project much later than the other two Entities", said the Assistant of the Head of the Health Department Mr Senahid Ibrašimović, who participated in the regional conference on behalf of the Brčko District Government.

"We are especially glad to be included in this programme of implementation of family medicine and enhancement of primary health care. The conference that is held today is an opportunity for us to analyse the work we have done so far in implementing the primary health care policy project as well as to see if we are going in the right direction and whether any mistakes have been made. If we identify any mistakes now, we still have enough time to rectify them in order to reach our ultimate goal, which is in this case full implementation of this programme in the Brčko District", said Ibrašimović.

During the conference exceptional lectures given by the experts attracted special attention of the participants, which included the representatives of the above mentioned ministries as well as the experts of the Faculty of Medicine of the Zagreb University, from the Csolnoky Ferenc Veszprém hospital in Hungary, Faculty of Medicine of the Maribor University, Queen Margaret University from Edinburgh – Great Britain, Serbian Public Health Institute "Dr. Milan Jovanović – Batut", Ministry of Civil Affairs of Bosnia and Herzegovina, as well as the Canadian consultants in the Balkans Primary Health Care Policy Project.

Participants in the conference had an opportunity to take part in the discussion which was organised as part of the roundtable on policy, entitled "Protection of Beneficiaries, Who Is Responsible?", where they talked directly to the health care beneficiaries who also actively participated in the discussions. One of the most important conclusions of this fruitful discussion was that "good communication between patients and doctors as well as cooperation with governments and ministries is one of the key prerequisites for successful development of the health care system in any country".

The Minister of Health and Social Welfare of the Republic of Srpska mentioned that the discussion raised a great number of issues and pointed to participants' strong interest in different approaches to improving the health care system. "Health care system must be developed with a lot of sensitivity towards the needs of the population, while at the same time full attention must be devoted to education of population and timely dissemination of information. Treatment of modern diseases will inevitably fail if the patient does not cooperate and is not fully informed about his/her disease, said Minister Škrbić.

During the conclusion and evaluation of the conference, the organiser and hosts received many words of praise. Participants also offered specific conclusions and solutions.

"I think that this was a very successful conference and an exceptionally productive one as well. If I was to say in short what the message of this conference was, I think it is that we still have a lot to learn, but there are also a lot of things that others can learn from us. This is a highly positive experience because BiH certainly has good potentials and resources and certainly has a good future. I think it is very important that we continue organising such conferences and keep exchanging information with the region and the neighbouring countries, which is very important as there can be no isolated

development if there is no development in the neighbourhood. We are very satisfied with this conference", concluded Goran Čerkez, Assistant Minister in the FBiH Ministry of Health.

Ivana Mišić, Assistant Minister in the Ministry of Health of Serbia, deemed it especially important and fruitful to discuss all key topics pertaining to development and organisation of primary health care.

"Through the host's courtesy and a carefully thought-out thematic conference, we were given an opportunity to discuss key topics such as satisfaction of staff working at the primary health care level and modalities of additionally sensitising people who work at this level. What I think is vital is the voice of beneficiaries – patients and users of health care services, who are the only ones who can realistically assess whether we work successfully and whether we are responsible decision makers and organisers of the health care system. I am saying this particularly from our perspective as it has not been common for us to listen to the voice of the public to a great extent, and here we learned that this was the key issue in formulating responsible health policies. I really think that this two-day conference was very successful and it gave us all an opportunity to do our job in the best and most responsible way", concluded Mišić.

The organisers of this conference were also very satisfied with this successful and highly useful meeting of representatives of the health care sector.

"As my colleagues have already noted, this conference enabled people not only to listen to discussions but also to share experiences and exchange opinions in order to find out solutions that could work best in the given circumstances. I believe that we have managed to find certain approaches which could work best in these conditions. What we have to do is find new ways of improving the current situation, and in order to do that we have to act jointly, and not separately. We have to pay more attention situation in which doctors and nurses will genuinely work as a team, and not just because they are appointed to work as one. We also have to create such a system in which referral of patients from the primary to the secondary level of health care is not complicated and does not create confusion to the patients, but makes them feel comfortable in it. Atmosphere at the conference was very friendly and pleasant, and I am glad that people talked openly and in a friendly way. We hope that through talks and discussions solutions will be found to many problems. From our point of view, cooperation with the ministries has been very good and we hope it will continue to be so in future", said the Project Director Mr Orvill Adams.

When giving final thoughts and comments, Minister Škrbić emphasised that both the organisers and the hosts were completely satisfied with the enthusiasm and interest of all those who participated in the conference. "Over the last couple of days, we have worked on the issues and challenges in the primary health care in the region. We have had the opportunity to hear very interesting lectures and presentations by our colleagues from Serbia, BiH, Canada, Croatia, Slovenia, Hungary and other countries, where we talked about numerous aspects that the health care consists of and where we initiated a very interesting and fruitful dialogue, especially yesterday when we held a roundtable on responsibilities and obligations of all actors in the health care system. We raised a lot of issues, shared experiences, and looked at advantages and possible disadvantages of individual systems in the region. Most importantly, one of the conclusions was that this type of workshops, symposia, conferences should continue. We should focus on some specific issues such as funding, education, the role of chambers, associations, and beneficiaries, etc. To conclude, there are many diseases that we touched upon only superficially and I hope that we will have an opportunity in future to provide more specific answers and make plans which will enable us to check, test and compare systems in the region. I believe that we all share an opinion that we can be very satisfied with the conference and that we gained new experience and knowledge which will be of use for some future steps", said Minister Škrbić.

Human Resources for Effective Service Delivery in Primary Health Care
The Primary Health Care Team

Introduction

Human resources for effective service delivery in Primary Health Care were the theme for the Balkans Primary Health Care first Regional Conference. With respect to health workers the Conference addressed three important areas in human resources management. Motivation and productivity of health workers, working conditions and stress and remuneration[1] and other types of incentives were presented and discussed. The three presentations identified the fact that it is important to understand the challenges that face the different categories of health workers and that the environment in which they work is an important determinant of their performance.

Teamwork

This short paper will try to advance a related theme; that of teamwork in primary health care. The type of providers of services in PHC varies across countries in Europe. There is variation in the type of professionals and in the scopes of practices, how they are regulated and their relationship to each other. According to Juan Gérvas[2] in Western Europe the core of European PHC workers consists of general practitioners (Family Medicine Practitioners in some countries), nurses, pharmacists, managers, auxiliaries and other professionals. Other professionals include: dentists, social workers, physiotherapists and occupational therapists as in Spain and Sweden and Finland. The Centre for Primary Health Care Research at the University of New South Wales in Australia, suggests that Primary Health Care Providers includes: General Practitioners, nurses, allied health professionals, multicultural health workers, health education/promotion and community development workers.

PHC in the countries of the Balkans have a history of including doctors, nurses, dentists and pharmacists in their PHC institutions. In Bosnia and Herzegovina the PHC policy is centred on the Family Physician and the nurse as the Primary Care Team (one doctor one nurse in the Federation of Bosnia and Herzegovina and one doctor two nurses in the Republic of Srpska). In Serbia primary health care is led by the chosen doctor (general practitioner, paediatrician, obstetrician, dentist working at the PHC level).

In the Republic of Srpska the Ministry of Health and Social Welfare has decided to train approximately 400 Family Medicine Teams to improve their work as teams.

The concept of Primary Care/ Primary Medical Care or Primary Health Care defines the scope of health actions and, therefore, the members of the Team. Starfield[3] *defines* ***Primary Care*** *as the provision of first contact, person focused ongoing care over time that meets the health related needs of people, referring only those too uncommon to maintain competence, and coordinates care when people receive services at other levels of care.*

Primary Health Care *is defined as care applied on a population level. As a population strategy, it requires the commitment of governments to develop a population oriented set primary care services in the context of other levels and types of services.*

The Alma-Ata WHO declaration of Primary Health Care (PHC) defines PHC as "Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation…."

This definition expands on Starfield's by including the full participation of individuals and families. The consumer is, therefore, considered a member of the PHC team. A Report entitled "Team working in Primary Health Care – Realising Shared Aims in Patient Care" (Royal Pharmaceutical Society and the British Medical Association, 2000)[4] recommends that the Team should recognize and include the patient, carer, or their representative, as an essential member of the primary health care team at individual patient-centred level or at practice level.

The Report adopts the WHO definition of teamwork: *"Co-ordinated action carried out by two or more individuals jointly, concurrently or sequentially. It implies common agreed goals, clear awareness of, and respect for others' roles and functions. On the part of each member of the team, adequate human and material resources, supportive co-*

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[1] The three presentations can be found on the Project Web- Site at www.canbhp.org

[2] Juan Gérvas, Georgia: Primary Health Care Reform Project – Primary Health: Western Europe Best Practice of Institutional Involvement and Responsibilities in Human Resource Policy; Oxford Policy Management, 2005.

[3] B. Starfield, Super course lecture, September 2004.

[4] Published by the Royal Pharmaceutical Society of Great Britain and the British Medical Association, "Team working in Primary Health Care—Realising Shared Aims in Patient Care, October 2000, UK.

operative relationships and mutual trust, effective leadership, open, honest and sensitive communications and provision for evaluation"[5]

It is clear from the definition of teamwork above that it is more that professionals working alongside each other. It requires investment in building the team, in education and the development of procedures, methods of communication and interpersonal relationships.

The aforementioned Report concludes that a review of research evidence finds the following six benefits of teamwork in primary health care:

- A more responsive and patient sensitive service;
- A more clinically effective and/or cost effective service;
- More satisfying roles and career paths for primary health care professionals;
- Aspects of improved organization and planning;
- Avoiding duplication and fragmentation;
- Developing more comprehensive databases leading to better identification of health problems, leading to;
- Developing better and more comprehensive health care plans.[6]

If we are to realize these benefits in the primary health care systems in the Balkans there must be significant and concerted efforts made in identifying the relevant team members and providing the resources necessary to develop and sustain teams. This requires guidance from Ministries of Health and understanding, commitment and leadership of managers.

We will publish a Case Study on experiences with team work in a leading Dom Zdravlja, Kraljevo, Serbia, in a future Newsletter.

By Orvill Adams

Types of Incentives and Their Impact on Primary Health Care Workers and Organizations

"...And so...keep alive the incentive to push on further, that pain in the soul which drives us beyond ourselves."

Dag Hammarskjöld (1905 - 1961)
Swedish Statesman and Diplomat

The urge to improve and change the health system of all countries is constant and is reflected in public discourse, in scholarly and in health care reports. Improvement is a central quest for health professionals and policy makers.

What one finds common in this quest is the focus on the use of incentives, particularly financial incentives, as a driving force to steer the process. What one also finds is that attempts at making improvements by the use of incentives has been met many times with disappointment; in fact, in many cases the incentive program has resulted in unintended consequences (Nestman, 1992). The purpose of this article is to provide some light on why the use of incentives sometimes does not produce the desired changes that are expected.

What are Incentives?

Basically, incentives are tools or devices that encourage or motivate a person, a group, an organization, or an entire health care system to move to some desired action or change (Nestman, 1992). A higher rate of pay is an example of an incentive that is used to motivate a work force to provide increased productivity. Incentives can be categorized into two types (Wikipedia, 2007):

1. **Personal Incentives**. These are incentives that motivate an ***individual*** through their tastes, desires, duty, pride, personal drives to artistic or professional creation or accomplishment.
2. **Social Incentives**. These are incentives that motivate an **individual or organization** through the practices, rules, norms and polices established at a social level, e.g. organizational etc.

Personal incentives are essential to understanding why a specific person acts the way he/she does. Social incentives, provide support in motivating workers to adhere to management processes that attempt to produce various forms of desired social interactions in an organization. Human resource policies for example that are employed by PHC Organizations are a form of social incentive. In most cases the focus by health care policy makers is on social incentives. This is not because personal incentives are not important in understanding human behavior. Indeed, the effectiveness of social incentives are tied to personal incentives, in that social incentives can only be

[5] Kekki P. (1990) Teamwork in Primary Health Care. World Health Organization, Geneva
[6] Ibid 4.

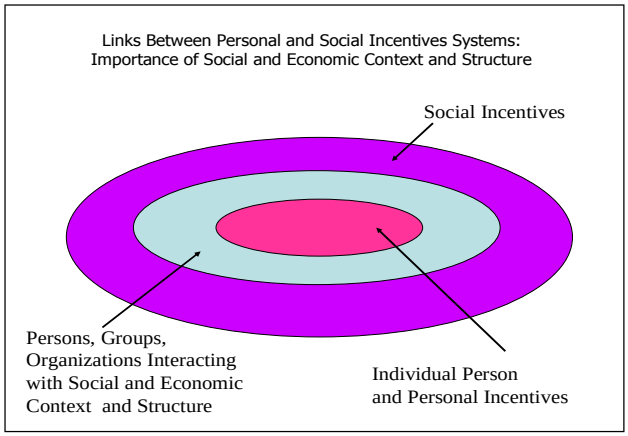
effective by virtue of the impact they have on the motives and actions of individual persons.

Bauman et al for example have noted that effective working conditions are important in motivating workers. Reasonable work demands, high level of predictability in the work situation, strong social support, fulfillment in tasks and a feeling of influence at work are important components in motivating workers (Baumann A, 2001). While these working conditions may seem ideal they will not have the same impact on all workers. It will depend on the context and situation the individual workers will be confronted with at various points of time in their personal and professional lives. In others words, some individuals may not be impacted by a new social incentive to change their behavior because their personal incentives motivate them to maintain their current behavior.

It is important for those promoting new social incentives to understand how personal incentives impact on the behavior of a specific person.

In addition, consideration must be given in the way any individual, group or organization will react in a given situation within a given environment. In other words examining the practices, rules and norms that exist at the social level is a crucial step in introducing a new social incentive scheme (Nestman, 1992). The relationship of personal and social incentives context is noted in Figure 1.

Figure 1



Importance of the Socioeconomic and Cultural Context and Structure

The evidence is clear that an analysis of introducing new social incentive schemes cannot be separated from the general context and structure with which the new incentives are going to interact (Hicks & Adams, 2000). For example, the possibility of introducing a capitation method of payment in primary health care is directly dependent on the socioeconomic and cultural context and the structure of the financing mechanism. This is why the experience and results within one country with capitation will most likely not be repeated in another country unless significant structural reforms are undertaken. Indeed, different results for the same incentive have been found, because the context and structures were different.

Hicks et al. have noted providers' responses to incentives are mediated by professional values, norms and experience and relationships between providers, employers and paying agencies. As a result, specific behavioral responses cannot be certain or predicted with the enactment of a specific incentive without the knowledge of the context within which they will exist. A brief example of these concepts will be illustrated in Figure 2.

Figure 2: Financial Incentive Package for Human Resources for Rural Health Care For Ghana, Nepal, Mongolia, Estonia, Kyrgyzstan

Objectives	Incentives	Complementary Measures	Constraints	Results
Recruitment and Retention in Rural Areas	Higher Salary and Location	Decentralization	Staff Shortages	Very little to no Identified Success
	Allowances	Freedom to Allocate	Budget Limitations	
	Pay Based on Workload	Funds to Incentives	Professional, Lifestyle Disadvantages	
		Improved Infrastructure and Staff Competence	Better Earnings in Urban & Private Market	

Source: Hicks, V., & Adams, O. (2000). *The Effects of Economic and Policy Incentives on Provider Practice*. Geneva: World Health Organization

One of the most difficult problems health care systems face throughout the world is the recruitment and retention of health professionals to practice in rural areas. In this example, financial incentives were developed and employed by using higher salaries, location allowances and providing pay based on workload in a number of countries (Hicks & Adams, 2000). Some complimentary measures were introduced to support and enhance the impact of the financial incentives and are noted in Figure 2.

The expectation was that these extra changes were sufficient to make the financial incentive effective. However, the constraints that were inherent in the context of the social system and structure of financing health services were overwhelming the incentive scheme. The constraints that were present were: staff shortages, budget limitations, professional and lifestyle realities and the attraction of private market in larger urban areas. The end result was that incentive scheme in all countries showed very little to no identified success (Hicks & Adams, 2000).

The literature is clear that the way in which physicians are paid is associated with particular patterns of clinical behavior (Marshall & Harrison, 2005). For example, doctors paid under fee-for-service schemes produce more volume. In contrast, there is a less convincing causal link between incentives and the behavior of individual physicians, and little is known about the effects on behaviors of others that to the are not targets for the incentives. The evidence points conclusion that incentives do not induce the rational response that some would have us believe.

Indeed when one considers financial incentives, there is a reason rational responses do not come forth. There is evidence that with physicians the economic component of a financially based incentive scheme is not what totally motivates professionals. There is something more than personal financial gain that is driving professional behavior. A more convincing explanation perhaps lies in the relationship between social incentives, such as material rewards, and personal incentives, the internal "moral" motivation of health professionals. Moral motivation is a force, which encourages people to behave in ways that have no obvious advantages to the individual may even prove contrary to their interests. Every day health professionals will make extra efforts with their patients with no thought of financial reward.

Need for Framework to Use in Incentive Analysis

Because of the complexity of introducing social incentive schemes, it is important to do a thorough incentive analysis beforehand. To aid this process the WHO has developed a framework to analyze the impact of incentives. It is recommended to utilize this framework when changing incentive schemes (Hicks & Adams, 2000).

Summary, Conclusions and Lessons Learned

One lesson learned about incentive management is that introducing incentives and getting desired results is very difficult. Performing an incentive analysis on the context and structure of the socioeconomic system is necessary. Introducing an incentive system is like an insect pushing on a spider's web at one or a few points. There will be resistance to the pressure from the whole web and chances of it getting caught in the sticky ingredients are high and changing its mind may not be helpful once it commits itself to move to the web. Policy makers who offer and promote new incentives are in most cases unable to predict the way individuals or organizations will respond. Incentive schemes are always more tricky than they first appear and once one moves to implement a new incentive system one should always expect a process of continual adjustment for a long period of time and unintended adverse results. While these are highly cautionary notes about changing incentives schemes, the reality is that there is a great deal of enthusiasm by policy makers for using incentives (financial particularly) as a way of improving the health system. This is understandable given the healthcare cost pressures that most countries face. To focus on targeting resources to buy desirable behaviors from health professionals and producing beneficial outcomes for patients makes a great deal of sense. It is important therefore to have a thorough examination of both personal and social incentives and their impact on the socioeconomic and cultural context and structure before one proceeds with introducing major changes to primary health care systems.

Baumann A, O. B.-P., et al. (2001).
TheWorking Environment and Health of the Nursing Workforce: A Policy Synthesis: Canadian Health Services Research Foundation.
Hicks, V., & Adams, O. (2000). T
he Effects of Economic and Policy Incentives on Provider Practice. Geneva: World Health Organization.
Marshall, M., & Harrison, S. (2005). It's About More Than Money: Financial Incentives and Internal Maintain. Quality Safety Health Care, 14(4), 4-5.
Nestman, L. J. (1992). Management Control and Funding Systems: For Canadian Health Services Executives (Second Edition ed.). Ottawa: The Canadian College of Health Services Executives.
Wikipedia. (2007). Incentive (Publication no. http://en.wikipedic.org/wiki/incentives#References).
Retrieved 09/27/2007, from Wikipedia:

By Larry Nestman

Institutional Mechanisms for Gender equality in Bosnia and Herzegovina

Bosnia and Herzegovina had ratified a set of international conventions and accepted a number of UN and Councile of Europe human rights declarations that can provide respect for basic human rights and fundamental freedoms. Moreover, these declarations forbid discrimination on different basics and suport all efforts of human kind to build democratic and civilize society with equal opportunities and social justice for all. The most important international human rights convention for women that entered into force in Bosnia and Herzegovina is UN Convention that eliminates all kinds of discrimination against women - CEDAW.[7]

Bosnia and Herzegovina is composed of two entities, ten cantons and Brcko District and has 14 constitutions, parlaments and governments. According to this state structure Bosnia and Herzegovina made a model of institutional mechanisms in order to provide implementation of human rights and gender equality, particulary Law on Gender Equality in B&H.[8]

Model is functioning as a network of institutional mechanisms for gender equality founded in 2001after Bosnia and Herzegovina is accepted to the Councile of Europe. One of the pos-treception conditions was obligation for Bosnia and Herzegovina to establish institutional mechanisms for gender equality. First founded gender centers were Gender Center of Republic of Srpska and Gender Center of Federation of B&H.

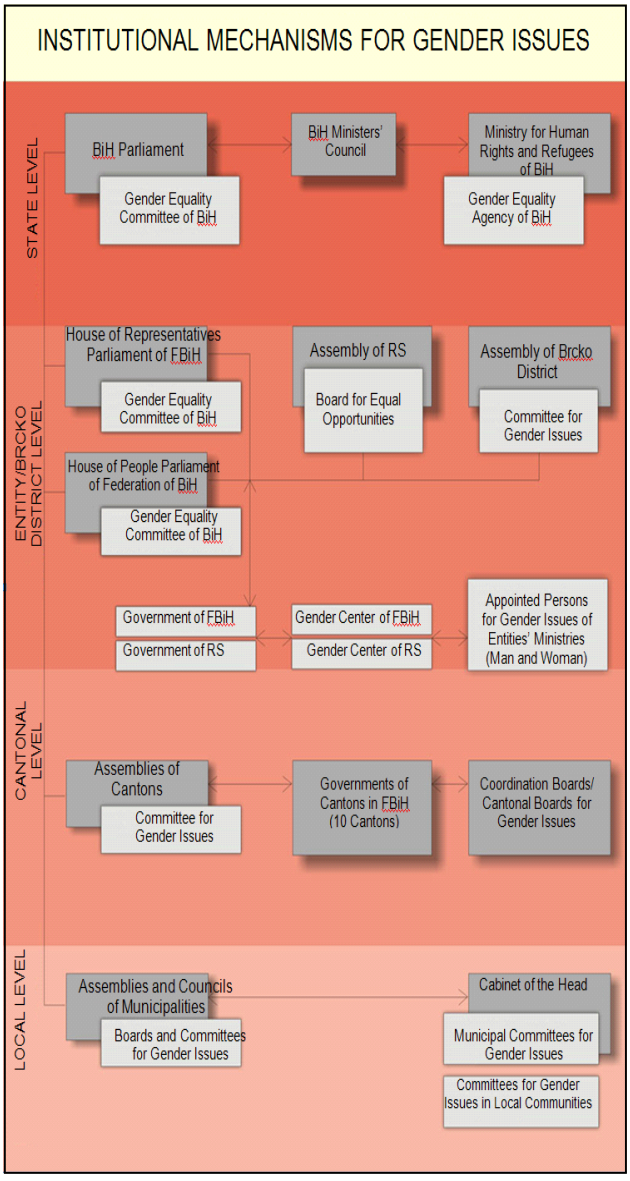
Law on Gender Equality in B&H entered into force in June 2003. and enabled establishing Agency for Gender Equality B&H within Ministry for Human Rights and Refuges B&H. Agency is functionig as a monitoring body of Law on Gender Equality in B&H. Moeover, Agency is competent for work on B&H Gender Action Plan, reporting and monitoring on international human rights bodies on regular basics (1st, 2nd and 3rd Combine B&H Report on CEDAW-CEDAW/C/BIH/1-3), preparing reports for Council of Ministers of B&H and harmonizing legal acts with Law on Gender Equality in B&H.

Gender centers of entities are also monitoring implementation of Law on Gender Equality in B&H, harmonizing legal acts with this law, working on awareness of gender equality subject, through education, public campaigns and research. Gender centers are competent to investigate breaches of Law on Gender Equality in B&H upon request of ministries, citizens, NGOs or through their own initiative. They act as a Gender Equality Ombudsman.

Gender centres have started an intiative for establishing gender focal points within ministries for more effective coordination in implementation of Law on Gender Equality in B&H. In all ministries in both entity governments there are gender focal points that help activities in gender centries. Gender institutional mechanisms exist on a local level within municipality parlaments (comisions or boards for gender equality), as well as in parliaments at state, entity and cantonal level. Main task of these commissions and boards(for gender equality) is to harmonize all legal acts in parliamentary procedure with Law on Gender Equality in B&H.

[7] CEDAW adopted 1979. Bosnia and Herzegovina accepted Convention with succession 1993. / Annex I – Dayton Peace Agreement / Optional Protocol 2000. B&H accepted in 2002.

[8] Law on Gender Equality in B&H ("Official Gazette of Bosnia and Herzegovina»", No. 16/03).



By Sasa Savicic

NEWS & EVENTS

OCTOBER

Update from Serbia

The meeting of the Working group for Policy Development, held in October, was chaired by dr Ivana Misic, Assistant Minister and Project Director Orvill Adams. Project Consultants, Karen Gibbons, Sally MacLean and Malcolm Peat facilitated the work. It was agreed that the Project would draft the Vision Statement and PHC Policy Goals that would be circulated for comments. Project Activities were presented and the work of other working groups was described.

The first series of meetings with Belgrade Institute for Public Health were conducted by Lawrence Nestman on developing the Framework for PHC System Performance for Serbia. Initial work should be done for PHC System in Belgrade in order to serve as a pilot for the whole country.

Update from BIH

A workshop was organized for 16 members of the working groups for chambers, associations and unions in RS. The main goal of the workshop was to present the outline of the capacity building program for professional organizations which was based on the priorities identified by these organizations at the meeting in June 2007. S. MacLean, S. Phillips, L. Nestman, M. Peat and K. Gibbons presented the outlines of five modules of this capacity building program. It was suggested that each organizations should send two participants to attend this program.

The first Module of the HRH Master's program was delivered by Peter Hornby of Keele University from October 24 to October 31, 2007.

NOVEMBER

A two day Workshop on PHC Policy for Serbia was organized in Zajecar on November 26th and 27th. Participants included management teams from the 10 dom zdrvlja Demonstration Sites, Assistant Minister of Health, dr Ivana Mišić, with the Ministry of Health team, representatives of local governments in Serbia and PHC consumers groups. The workshop was also attended by the team leader of DFID/Norway supported project "Support to the Implementation of Social Protection Strategy". It was an opportunity for different stakeholders to discuss the issues of PHC in Serbia and in particular organizational changes in regards to legal requirements for PHC centers, decentralization, consumers' participation etc. Th workshop was attended by 62 participants (38 women and 24 men).

Lawrence Nestman led the first in a series of workshops for Chambers and Associations of Health Professionals on Business Planning on November 29th. The workshop was followed by half day meeting with management of all the Chambers to work more in depth on business plans.

Four representatives of the consumers from Serbia and Bosnia and Herzegovina participated at the 14th CSIH Annual Conference in Ottawa. Belma Gorolija, Tanja Mandić, Jasmina Lechleitner and Dejan Dimitrov presented the consumers' view of health system in two countries and they were supported by Malcolm Peat and Djenena Jalovcic, Project Manager.

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