



BALKAN PRIMARY HEALTH CARE POLICY PROJECT



Dear Readers,

The second newsletter in 2008 brings you the information on planning for health human resources in Bosnia and Herzegovina written by Vern Hicks. The article by Susan Phillips explains what evidence based medicine is. It also provides information for decision making in primary health care policy development by David Allison.

In this issue of the newsletter you will also find an update of the most important project related events in the first quarter of 2008 and the announcement of future events as well as a Recommendation of the Council of Europe Committee of Ministers to member states on the inclusion of gender differences in health policy adopted by on 30 January, 2008. We hope that you will find this newsletter informative and interesting and we remain open for all your suggestions.

Enjoy reading

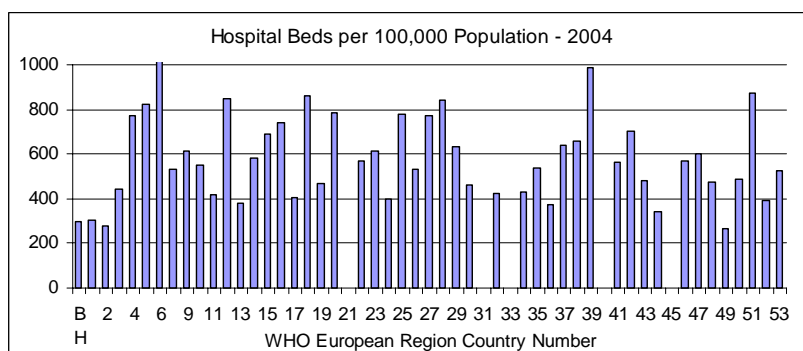
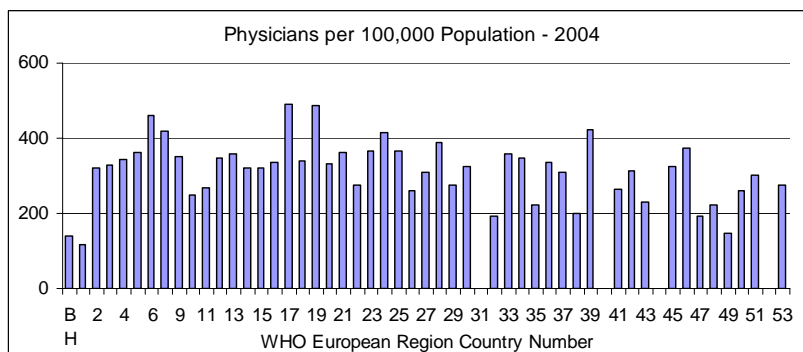
Information for Planning Human Resources for Health in Bosnia and Herzegovina

Two of the key challenges in our work to develop human resource plans for BiH are to understand current levels of service utilization and to be able to predict future changes in the demand for health care. Utilization is one of three considerations in understanding the use of health care in future years and in making realistic predictions about future utilization and requirements. Current activities include an analysis of comparative indicators of (1) health care resources - specially the size of the workforce; (2) health services utilization and (3) health care expenditures, both public and private.

Indicators of resources and utilization are available from the WHO European Health for All database¹. The value of using a multi-dimensional approach to the analysis of indicators is illustrated by the four graphs below, which compare BiH to all 54 countries in the WHO database². Indicators of resources, in the form of hospital beds, physicians and nurses per 10,000 population are among the lowest in Europe. Yet health care expenditure as a percent of GDP ranks relatively high in BiH, averaging 8.3% of GDP in 2004.

At first glance, these appear to present a paradox, since relative expenditure as a percent of GDP would normally be expected to follow relative expenditure for the resources that provide

health care. The explanations for the seeming disconnect between health resources and health expenditure lies in the fact that GDP per capita is relatively low in BiH. It appears that health is a priority in national expenditure, but capacity is very low relative to other European countries.



1 Health for All database (HFA-DB), Copenhagen, WHO Regional Office for Europe, (<http://www.euro.who.int/hfadb>).

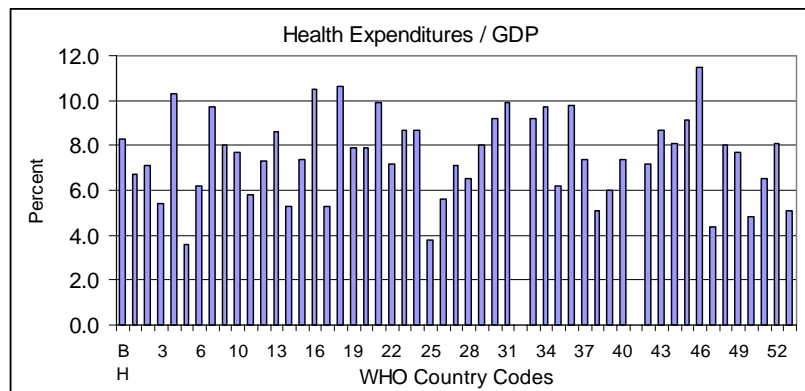
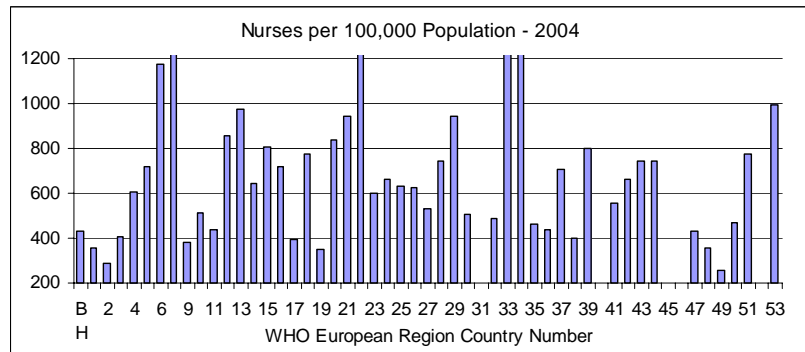
2 WHO European country code numbers are used for comparator countries. These code numbers are defined in the database.

Some local observers have suggested that the comparisons might be skewed by uncertainty about population data, since there has been no census since before the war and there were large movement of population during the war years. Sensitivity testing has shown that the relative position of BiH in the WHO indicators would not be likely to change as the result of errors in population estimates.

For example, the estimate of physicians per 100,000 population is 140 in BiH. If we assume there is as much as a 20% overestimate of population, the indicator would increase to 175. In relative terms, that adjustment would move BiH ahead of only one country, Turkey, in the comparisons. Other observers have expressed opinions that GDP is understated due to an active underground economy and the tendency of many employers to pay minimum salary levels and supplement wages with cash payments, a tax avoidance strategy that benefits both employer and employee. It follows, however, that if GDP is understated, health expenditures would also be likely to be understated and the health expenditure to GDP comparisons might not be affected by corrections to the national accounts estimates. As interesting as these analyses are, they would not affect the fundamental reality that BiH has low levels of health resources and financial capacity. Health care utilization per capita is also low in BiH, as shown in the table below. Service utilization data is reported by the Public Health Institutes in the Federation of Bosnia & Herzegovina (FBiH) and in the Republic of Srpska (RS). Both entities publish a comprehensive annual report of health statistics. These statistics will be one of the key sources of data for our analyses of present resources, utilization and productivity of physicians.

A survey of health care institutions has been carried out by the project in both FBiH and RS. In FBiH all institutions were surveyed, while in RS the survey focussed on primary care facilities. The survey included 100% of target institutions and was carried out by PHI – a unique endeavour that is proving to be an exercise in capacity building. The survey adds information about the health workforce that is not available in annual statistics, such as distributions of professionals by age and sex. The survey data will be used in conjunction with other PHI databases to create profiles of the present workforce and understand how demographic changes may affect the capacity to provide health care in future.

Utilization of private sector providers is not well covered in annual statistics. The project is seeking to develop information from a variety of sources. These sources include the Health Insurance Funds (HIF), which insure certain private sector services; PHI inspection reports in RS, which collect information on private practitioners; a 2000 health expenditure survey in RS, private provider associations and key informants familiar with health care activities in both entities.



Source: WHO Health for All database (HFA-DB)

	In-patient admissions per 100	Outpatient contacts per person
Bosnia and Herzegovina	7.9	3.1
European Region	18.8	7.8
EU members since 2004 or 2007	20.7	7.8

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Preliminary estimates, which need to be verified, indicate that private sector providers account for about 10% of health expenditure in BiH, and that they are concentrated in the pharmacy and dental sectors. There are some private physicians, but most physician activity in the private sector appears to take place in the form of joint public and private practice by physicians employed in the public sector. Both entities have recently undertaken to ban joint public and private practice, a strong statement of support for public provision that is just one example of the dynamic nature of health policy development in BiH.

Information on service utilization, resources and health expenditures will all be used in the service target projection model being developed by the project. This model will project HR requirements to 2015. Initial testing of the model indicates that economic growth, which has averaged over 8% annually for the last two years, will be a major factor in predicting future resource requirements. Productivity increases, if realized, will keep HR growth below rates of increase in the economy. Nonetheless, increases in human resources required to meet future demand will be substantial. This fact provides an opportunity to plan for future changes in the way care is delivered without massive dislocations that could threaten the success of HR policy initiatives.

By Vern Hicks

What is Evidence Based Medicine?

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens.

(Sackett, DL, et al, BMJ 1996;312(7023):71-72)



The practice of medicine is both an art and a science. The science of medicine should be informed by research findings. The strongest, or most robust research is the randomized controlled trial (RCT). In an RCT subjects (all of whom have the disease being studied) are randomly divided into groups. One group might receive a particular treatment for a disease while the other group receives a placebo. Ideally, none of the participants know whether they are in the treatment or the "control" group. This is called "blinding". If those running the trial also don't know which group is receiving treatment then the study is said to be "double blind". Many studies that do not involve RCTs and are, therefore, not as robust

scientifically, still provide useful evidence. Some of these designs include case control studies, cohort studies and case reports. Using results from whatever studies are available many groups around the world have developed guidelines for specific diseases or medical conditions. One of the best sources of such evidence is the Cochrane Collaboration (www.cochrane.org).

Are all guidelines equal?

There are all sorts of documents produced that are called guidelines. Many, however, are not evidence based. Some are developed by drug companies or written by doctors paid by drug companies. Although it is possible that an author with such a "conflict of interest" could write an unbiased guideline, documents written by authors who have not and will not benefit in any way from the promotion of a particular treatment are generally considered more valid. Other sources of bias in guidelines may include:

- failing to do a complete review of the relevant studies, that is, selecting only some studies for inclusion in the review

- applying results from studies done on one group to other groups, for example, assuming that the results of research done on men are applicable to women

Not all guidelines are equally accurate. It is, therefore, reasonable to only use guidelines that have been written, reviewed or approved by reputable groups such as the Cochrane Collaboration.

The key to evidence based medicine: the patient centred approach

Although clinical practice guidelines summarize the evidence for particular diseases or treatments, they cannot be used effectively unless each patient's unique circumstances are considered as well.

Information for Decision Making in Primary Health Care Policy Development

Often, practitioners and governing bodies find themselves trying to make decisions with no apparent information upon which to base those decisions. What starts out as a an interesting idea takes on shape as decisions are made to support a change, advance money to establish a direction and deliver services. But when information for decision making is scanty, the consequences can be unpredictable.

The problem is that all too often we rely on our expert opinion to guide decisions, and that expert opinion may or not be well-informed by knowledge and experience. We need to make sure that "evidenced-based decision making" is used for policy development just as those of us practicing medicine use the evidence to decide on treatment alternatives for the individual patient.

There are well known examples of how epidemiology is used in medicine to rationalize treatment decisions. The hierarchy used by numerous standard setting groups in developing clinical practice guidelines is one way of focusing attention on the strength of evidence. Associations between suggested causes and effects become clearer as greater methodological rigor is applied to study a

Table 1: Increase Methodological Rigor to Demonstrate Strength of Association

- Expert Opinion
- Case study
- Cross Sectional Survey
- Case Control Study
- Cohort Study
- Randomized control study

This is what Sackett means when he highlights the importance of linking evidence to: *more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care.* (see box)

Diseases cannot be separated from the people who have them, that is, without using a patient centred approach to diagnosis and treatment medical expertise, alone, will be ineffective.

So, to summarize, the highest quality medical practice combines unbiased research findings with a patient centred method. This approach is the standard of practice in Europe, North America, Australia, and much of the developing world.

By Susan Phillips

particular preventive measure, intervention or treatment.

The association between cause and effect is strengthened with multiple studies that demonstrate consistent results; of course when the impact of the intervention makes a large difference in the outcome facing those being studied compared to others the evidence is even more convincing

We need to learn to take these principles and use them to understand how and why primary health care services are delivered the way they are. Perhaps the first important point to recognize is that the key to understanding primary health care services is that if we focus only on the individual we will lose sight of the environment within which we work. It is essential to find ways to broaden our view to include other patients, practitioners and activities to obtain a better look at the system. Individuals live and work within a community, and primary health care policy decisions should be made keeping the whole community in mind, not just the fate of the individual.

Primary health care practice at its most fundamental level deals with the diagnosis and treatment of an individual. The principles of clinical practice guidelines should be well understood by all practitioners. And it is in the patient record that we see the cornerstone of information for decision making.

Information systems develop around the patient record. Paper record keeping systems are giving way to electronic health records. A clear vision is required to ensure that systems develop in such a way that records can be analyzed to provide information about the individuals in a practice, the

practice population or practices at a community level. Assuming that competent practitioners record patient data correctly with clear measures of input, the process of care and the outcome of intervention, there is a wealth of information in any practice setting.

By recording the episodes of care with a common code such as the ICD-10 or ICPC2, and coupling that information with data obtained from vital statistics or a census it is possible to create a picture not just of health, but of all the factors that influence health. Combined then with specially designed surveys or other kinds of studies, we will achieve a deeper understanding of the communities served by primary health care.

Through the Balkans Primary Health Care Policy Project, we have recognized that policy makers at many levels understand the need for information. Several opportunities have been created for decision makers to share their understanding of the primary health care system (the Regional Conference on Human Resource Planning in October 2007 and the Study Tour to Finland) and steps have been taken to assist in the gathering of specific data (the Human Resources Survey in Bosnia and Herzegovina). As the project progresses we expect these kinds of experiences will strengthen the recognition of the importance of cooperation and encourage the utilization of quality information in decision making processes.

Table 1: Sources of Information for Health Policy Development

Source of Information	Type of Data	Purpose	Examples of Indicators
Vital Statistics	Births, Deaths, Census	Baseline population	Population changes, Causes of death, PYLL
Registration Information	Population denominators, Basic determinants of health	An alternative to census information	Enables rates and ratios
Patient Record	Diagnosis, nature of visit, determinants of health, risk factors	Health profiles, needs assessment	Prevalence of conditions, reasons for encounters, proportions of risk factors
Mandatory Reports	Communicable Disease, Cancer, Chronic disease, Occupational disease	Surveillance, trends, establish priorities	Incidence and prevalence rates
Human Resource Reports	Individual records, training records, facility or service aggregates, job satisfaction	Comparison to norms and standards, comparison to other work units at the DZ or country level, Succession planning, factors related to recruitment and retention	Age/sex, income, migration, workers to population ratios, occupations, years to retirement, number of trainees
Monthly, Quarterly, Annual Service Reports	Aggregate and collated data	Measurement of processes. Feedback and review	Trends
Financial Reports	Unit costs	Services, procedures and time allocations	Unit costs, costs/population
Population or Household Surveys	Point in time determinants of health, risk factors, issues		Trends, proportion of risk factors, Proportion of self-reported health

Recommendation CM/Rec(2008)1 of the Committee of Ministers to member states on the inclusion of gender differences in health policy

(Adopted by the Committee of Ministers on 30 January 2008 at the 1016th meeting of the Ministers' Deputies)

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe (ETS No. 1),

Considering that the aim of the Council of Europe is to achieve a greater unity between its members and that this aim may be pursued, inter alia, in particular by the adoption of common rules in the health sector;

Bearing in mind the Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No. 5) and its Protocols, in particular Protocol No. 12 (ETS No. 177);

Recalling Article 11 of the European Social Charter (ETS No. 35) on the right to health protection, and recalling that Article 3 of the Convention on Human Rights and Biomedicine (ETS No. 164) requires that Contracting Parties, taking into account health needs and available resources, take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality;

Having regard to Recommendation No. R (2000) 5 of the Committee of Ministers to member states on the development of structures for citizen and patient participation in the decision-making process affecting health care;

Considering that the principle of equality between women and men is an integral part of human rights and that discrimination on the ground of sex constitutes an impediment to the recognition, enjoyment and exercise of human rights and fundamental freedoms;

Recalling the work of the Council of Europe in the field of gender mainstreaming and in particular the message of the Committee of Ministers in 1998 to encourage the Steering Committees to implement gender mainstreaming in their work, and its report on "Gender mainstreaming: conceptual framework, methodology and presentation of "good practices"" (EG(99)3);

Convinced that, the objective to produce both equality, equity, respect for human rights and for the dignity of the individual in the health sector requires that the effects of gender differences are taken into account in health policy planning, delivery of health services, and monitoring of these;

Recognising that European countries face still in different degrees unacceptable gender inequalities between men and women and that health policy makers, health care providers and health professionals are increasingly challenged to understand and address the different needs of women and men;

Considering that many differences and inequalities between men and women's health status stem from social, cultural (including religion) and political arrangements in society, gender (which is a social construct) as opposed to sex (which is a biological attribute) should be considered as a key determinant of health;

Acknowledging that genders are not homogeneous groups and that different social circumstances may all distinctly affect health needs, interests and concerns of each gender and within genders;

Convinced that health policies should take social determinants of health into account since socio-economic factors, such as income, employment, education, living and working conditions, occupational hazards and lifestyles are unevenly distributed among the population and result in inequalities which may account for many of the health disparities, including those between men and women;

Being aware of increasing evidence from all fields of health research (concerning both biomedical and psycho-social mechanisms) that risk factors, clinical manifestation, causes, consequences and treatment of disease may differ between men and women and that, in such cases, prevention, treatment, rehabilitation, care-delivery and health promotion need to be adapted according to women's and men's differing needs;

Noting that gender inequalities can result in problems of access to health services, including to information, and noting also the lack of resources to promote gender sensitivity in health care providers, which may all constitute structural barriers to quality of health care;

Concerned also, in this context, that gender differences and inequalities can be an obstacle to communication between health care providers and patients' to the detriment of patient's rights;

Convinced that the recognition of gender differences and inequalities would add to the efficiency and effectiveness of health policies and health care services for both women and men;



Convinced that the development of a gender sensitive social and health policy requires the integration of a gender dimension also in broader societal policy,

Recommends that the governments of member states,

1. in the context of protection of human rights, make gender one of the priority areas of action in health through policies and strategies which address the specific health needs of men and women and that incorporate gender mainstreaming;
2. promote gender equality in each sector and function of the health system including actions related to health care, health promotion and disease prevention in an equitable manner;
3. consider issues related to the improvement of access and quality of health services as these relate to the specific and differing needs and situations of men and women;
4. develop and disseminate gender sensitive knowledge that allows evidence-based interventions through systematic collection of appropriate sex-disaggregated data, promotion of relevant research studies and gender analysis;
5. promote gender awareness and competency in the health sector and ensure balanced participation of women and men in the decision-making process;
6. establish monitoring and evaluation frameworks on progress on gender mainstreaming in health policies;
7. adopt and implement the measures presented in the appendix to this recommendation;
8. ensure that this recommendation is brought to the attention of all relevant political institutions and health related bodies and inform the Council of Europe on the follow up under taken at national level to the provisions of this recommendation.

Appendix to Recommendation CM/Rec(2008)1

Specific measures

1. Place responsibility for driving and implementing gender sensitive health policies at higher national, regional and local levels and ensure gender balanced representations in decision-making positions and establish posts for gender trained health experts;
2. Produce regular gender based health reports including systematic scientifically based gender analysis in order to increase knowledge of the health of populations and to introduce gender awareness in the health sector:
 - a. ensure that in health services and in the most relevant health surveys and programmes all routine data recording and collection systems are sex-disaggregated according to the health priorities of the country (e.g. taking into account patterns of mortality and morbidity);
 - b. promote gender sensitive information systems and performance indicators for accountability purposes in the health system;
 - c. include sex disaggregated information related to other social determinants that interact with gender: i.e. income, poverty levels, labour force participation, educations, housing;
 - d. promote the use of gender sensitive indicators (e.g. World Health Organisation) in the process of data collection for national health reports;
3. Promote the inclusion of gender aspects of health in the training and continuing education of all health and related social professionals at both undergraduate (e.g. medical and nurse training) and continuing education levels (in-service training) for all health workers including policy makers;
4. Promote the education of health and social professionals on specific situations:
 - a. on the consequences of domestic and other forms of violence for health;
 - b. on the needs that affect the health of vulnerable groups;
5. Promote scientific-based programmes and prioritise developing gender sensitive research programmes which will have an impact at the national level. The aim is to implement evidence-based public policies, anticipate challenges facing society, and develop adequate health promotion programmes;
6. Initiate and promote the evaluation and monitoring from a gender perspective of the policies, programmes and actions undertaken in their country to address inequalities in health;
7. Promote international networking between governmental and non-governmental organisations active in the domain of gender mainstreaming in health policy;
8. Support an active targeted dissemination of this recommendation, accompanied where appropriate, by a translation into local languages;

Recently implemented activities

BOSNIA AND HERZEGOVINA

Nursing Association at the State Level - Working Group

The meeting of the State Nursing Association Working Group was held on February 8 - 9, 2008 with 14 representatives from Bosnia and Herzegovina. The main purpose of this two day meeting was to review and discuss a proposed draft statute for a state nursing association. The Project will support harmonization of draft statute with ICN requirements. Parallel to this, nursing associations in Federation of BH will be established. Next steps are approval of the proposed statute by all three nursing association in BiH and establishment of an umbrella association which will be registered as a State Nursing Association.

Strengthening the Capacity of Professional Organizations

Professional Regulation: What it is and How it Works?

The first of five modules in the Capacity Building for Professional Organizations - '*Professional Regulation: What it is and How it Works*' was presented by Sally MacLean in Sarajevo and Banja Luka on February 12 and 15, 2008. Fifty eight participants were representatives of chambers, professional associations and trade unions and the Ministry of Health from both entities. The group included medical doctors, dentists, pharmacists, nurses/medical technicians and physiotherapists. The concept of professional self-regulation and training itself will be further presented the Journal of the RS Medical Chamber and the Popular Medical Journal in RS.



“Planning of human resources in health” Sarajevo, February 27, 2008

On February 27, 2008, a workshop “Planning of human resources in health” was held in Sarajevo with participation of 30 representatives of Ministries of Health and PHIs of both entities, Ministry of Civil Affairs, and CIDA. The main goal of the meeting was to review the progress of the activities, and discuss the HRH planning models, select the comparative indicators and present the simulation of needs by using physician’s model.

EU Standards in Education of Health Professionals

Round Table “Education of Physiotherapists” was held in Banja Luka on March 28, 2008, with participation of representatives of Association of Physiotherapists, PT Programs at the University Level, Ministry of Education and Ministry of Health.

SERBIA

Strengthening Management Capacities in Demonstration Sites

Module on Human Resources Management, within the Strengthening Management Capacities of Demonstration Sites Program took place in Nis, February 4 – 6, 2008. The training was delivered for 55 participants (20 men and 35 women) from all 12 Project Demonstration Sites in Serbia. Training was delivered by “Bonex”, Biljana Maletin, Local Gender Consultant and Orvill Adams, Project Director.



Accreditation of PHC Centers in Demonstration Sites:



Training workshop for accreditation surveyors and accreditation coordinators in PHC centers took place in Subotica, January 9 – 12, 2008, for teams from 7 PHC Centers in Demonstration Sites. The training was delivered to 32 participants (12 men and 20 women) by Local Consultants for Quality Improvement and Accreditation, Dr. Snežana Manić and Dr. Olivera Jovanović, following the same methodology and procedures established by the Ministry of Health of Serbia.

Strengthening the Capacity of Professional Organizations

Second module in the Capacity Building for Professional Organizations on professional regulation and protection of public was presented by Sally MacLean in Belgrade on February 26, 2008. Workshop was attended by 22 participants (7 men and 15 women). mainly directors and management teams of all five Chambers in Serbia (medical doctors, nurses, dentists, pharmacists and biochemists) and leading professional associations.

Voice of Consumers

Working Group for Voice of Consumers had a meeting on February 14th in Canadian Embassy in Belgrade. Karen Gibbons facilitated the meeting. Discussion took place in order to agree on the survey on consumers' view on access to PHC services in Serbia. As previously agreed, NGO "Partner" representatives from Banja Luka, BiH attended the meeting and shared experiences from their work.

Lepojka Čarević Mitanovski, representative of the Voice of Consumers WG and Dr. Mirjana Živković Šulović, representative of the Institute of Public Health of Serbia participated at the International Conference *Quality of primary health care: the perspective of patients* in Ljubljana, Slovenia, March 28th – 29th, 2008. Both participants submitted the papers on BPHCPP activities in regards to consumers' voice that are accepted by the Conference.

BPHCPP Working Group for PHC Policy Development and Education

Project Working Group for PHC Policy Development in Serbia had a meeting on March 14th, 2008 in Belgrade, chaired by the Assistant Minister of Health for Health Services Organization and Health Inspection, dr Ivana Misić. Background Papers developed in the Project were presented and discussed by the Working Group. Following discussion facilitated by Karen Gibbons, on proposed vision, goals and principles for PHC system in Serbia also took place in order for the members to reflect and comment on submitted draft.

Project Working Group for Education had a meeting on March 18th, 2008 in Belgrade. Meeting was facilitated by Susan Phillips. She presented the draft "Road map" for Patient Centered Practice and facilitated the following discussion. The objective of this activity is to develop the education tool that would be institutionalized in Serbia in the coming months.

Local Self-governance Task Group

Local self-governance task group had series of workshops in February and March 2008, in order to develop the Guide for an effective collaboration between the municipal authorities and providers and consumers of the primary health care services. Members of the Task Group are representatives of local self-governances, providers, consumers, Standing Conference of Cities and Municipalities of Serbia and the Project. Draft of the aforementioned Guide will be presented for comments during the Policy Dialogue Series 2, in Zrenjanin on April 7th and 8th, 2008.

Upcoming Events

Bosnia and Herzegovina

Business Planning for Professional Organizations, Module 2 of the Capacity Building for Professional Organizations will be held on April 2, 2008 in Sarajevo and April 4, 2008 in Banja Luka.

The first module of the human resources for health capacity building for planners, policy makers and practitioners focusing on Principles of Human Resources Planning will be held on 14 and 15 April, 2008 in Sarajevo and 17 and 18 April, 2008 in Banja Luka.

Serbia

Policy Dialogue *Understanding and Improving Access to PHC Services in Serbia* will take place in Zrenjanin on April 7th – 8th, 2008. This Policy Dialogue will bring together representatives of providers (DZs), Ministry of Health, Local Government, and Consumers to discuss the key factors affecting access to PHC services in Serbia. The purpose of PHC policy dialogues is to provide opportunities to discuss some of the critical issues in PHC from the perspectives of different stakeholders.

Gender Policies in Professional Organizations, next module of the Capacity Building for Professional Organizations will be held on April 15, 2008 in Belgrade for the Working Group for Chambers and Associations of Health Professionals.

The fourth module on Team Building and Conflict Resolution, within the Strengthening Management Capacities of Demonstration Sites Program will take place in May 2008.

BALKAN PRIMARY HEALTH CARE PROJECT

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