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EVALUATION REPORT

Medical Assistance Project to Patronage and Home Care Services in Vojvodina/Serbia
June 12 – 16, 2001

CARE Austria, Vienna
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I. Preface

Like most other formerly socialist economies in Central and Eastern Europe, the Federal Republic of Yugoslavia had a well developed and centralized health care system. But since the break-up of the former Socialist Federal Republic of Yugoslavia (SFRY) in 1991, the provision of health care services and the maintenance of utilities strongly deteriorated.

The situation in the primary health care centres is characterised by an overall unsatisfactory level of health services. In general there is a lack of patient-centred and continuous care, due to the compartmentalized structure of Primary Health Care Centres (Dom Zdravljas) and the weak role accorded to the general practitioner (GP) and to the nurses. Quite often you will find a low staff motivation due to low salary, low profile value, poor opportunity for career advancement, and a system driven by specialists. Particular home care service and patronage service is not functioning on a regular basis in most of the visited primary health centres. This is caused by lack of vehicles, fuel, medicines, medical equipment and consumables to be used for treatment of patients during home visit and patronage visit. The overall status of medical equipment could be marked as very unsatisfactory (Annex 3) and the buildings that accommodate most of primary health care centres need urgent repairs. The World Health Organization has raised concern that the health services are seriously threatened and that the health of the population is seriously endangered. Those most vulnerable, as identified by WHO, are refugees, IDPs, the elderly and social cases which rely on the State for basic health care needs.

ECHO Belgrade has initiated an assistance programme in the sector of primary health care emphasising patronage and home care services in autumn/ winter 1999. ECHO Belgrade divided the territory of Serbia into several geographical areas and CARE International - Yugoslavia has been allocated the region of Vojvodina (Appendix 2). CARE started in November 2000 a Medical Assistance Project to Patronage and Home Care Services. The project will be finished by the end of June 2001. The medical assistance was provided through eight Primary Health Care Centres (Dom Zdravija). The strategic approach of the CARE Project consisted of

A) Supply of Vehicles
B) Supply of Medical Equipment
C) Supply of Medicines and Consumables
D) Organisation of Two Medical Training Seminars
E) Minor Repairs of the Dom Zdravijas

In Medical Assistance Projects the approach to implementation should ensure quality standards of health care by providing essential packages of training, monitoring and impact evaluation. Strategies should also ensure that professional skills are regularly updated, and that drugs, supplies and equipment are available, bearing in mind the concepts of appropriate technologies, cost-effective interventions and a holistic approach.

Therefore the conclusions and recommendations for the improvement of the Primary Health Care System, place a special emphasis on the Patronage and Home Care Services in Vojvodina/ Serbia and take into consideration the following:

A) Impact on the Beneficiary Population
B) Impact on the Patronage and Home Care Teams
C) Percentage increase in the numbers of patients receiving medical care services:

D) Impact on Dom Zdravlja and Ambulantas
E) Assessment of the use of Equipment, Vehicles, Medicines and consumables
F) Assessment of the two training seminars

The Amendment to the Operation Contract included a request for an extension of the existing deadline until the end of June 2001 (Annex 18). This evaluation, which took place from the 12th to the 16th of June and is actually a meta-analysis of previous intervention and not an "Ex-post evaluation". It examines the intervention effects and overall achievements of the Medical Assistance Project and is based on several of information including but not limited to:

- Project Proposal
- Narrative monthly and quarterly reports
- Field trips to Dom Zdravljas
- Structured interviews with the Medical Director, the Head of Nurses, and staff of the patronage and home care services of three Dom Zdravljas:
    - Bela Crkva
    - Srpska Crnja
    - Zitiste
- Visits of an Ambulanta in Srpska Crnja
- Family visit with the patronage service in Bela Crkva
- Patient visits in a Roma settlement
- Unstructured Interview with the CARE Project Assistant, Tanja Dramicanin
- Unstructured Interview with the CARE Field Monitor, Pedja Rafailovic
- Unstructured Interview with the CARE Project Officer, Djorde Boljanovic
- Briefing and Debriefing with the CARE Country Director for FRY, Carol Sherman
- Meeting with Dr. Gordana Dragutinovic, Institute for Public Health of Serbia,
- Meeting with Dr. Jacky Do Cao Hung, ECHO Medical Coordinator
- Meeting with Dr. Jukka Pukkila, WHO Deputy MoH

I would like to thank everybody who supported and assisted me during my stay in Serbia / Vojvodina. A very special thank goes to Carol Sherman, Pedja Rafailovic and Tanja Dramicanin from CARE Yugoslavia for their great help and professional support.

Dr. Maria Schmidt
Vienna, June 27, 2000

II. Context and Problem Statement

Since the break-up of the former Socialist Federal Republic of Yugoslavia (SFRY) in 1991, the economy has deteriorated rapidly, with declines in production and massive rises in unemployment (estimated rate is 60%). This economic decline and the ongoing mismanagement had a severe knock on effect on the provision of public services and on the maintenance of utilities. The absence of health care planning and the delay of necessary health sector reforms promoted the poor use of resources, the spreading of corruption and the deterioration of health care quality. In addition to the brain drain of health care staff in the 1990s, there are poorly functioning or obsolete equipments and an enormous lack of medicines and consumables. The health care buildings tend to be old (on average 18-25 years), very poorly maintained and therefore in need of rehabilitation. In 1990 the health care budget was per Capita $ 200 and in 2000 only $ 35. This cut in health care funding reduced the ability of the health care system to provide adequate health care services in terms of both access and quality.

III. Access to Health Care in the Federal Republic of Yugoslavia

The health care system in the Federal Republic of Yugoslavia is based on universal and free medical treatment. The financing of the health care system is obtained through taxes paid by wage earners in Yugoslavia. With an unemployment rate of 60% and with many state-owned companies unable to pay taxes, the public health care system is in a very deep crisis. Consequently the World Health Organisation has raised concern that the health services are seriously threatened and that the health of the population is seriously endangered. Those most vulnerable, as identified by WHO, are refugees, IDPs, the elderly and social cases which rely on the State for basic health care needs (Appendix 1).

IV. Assistance to the Primary Health Care System in Serbia

The Federal Republic of Yugoslavia is divided into Serbia and Montenegro. Serbia is divided into Vojvodina, Central Serbia and Kosovo. ECHO Belgrade has initiated an assistance programme in the sector of primary health care emphasising patronage and home care services in autumn/ winter 1999. After consultation with WHO Belgrade and following the approval by the Ministry of Health of Serbia/ Institute for Public Health of Serbia, ECHO Belgrade has decided to divide the territory of Serbia into several geographical areas and to entrust the respective INGOs working in the health sector with the project design and implementation in their allocated areas of responsibility. CARE has been allocated the region of Vojvodina as their area of responsibility (Appendix 2).

V. Primary Health Care Institutions in Vojvodina / Serbia

The Vojvodina (21,506 km2) is located in the North of Serbia with the Capital Novi Sad. It is populated by 2 million people (nearly 20% of the FRY-population). The region is divided into Banat, Backa and Srem.

The Vojvodina faces some unique challenges in terms of ethnic make up and refugees. Vojvodina has the biggest diversity of ethnic groups in Serbia, including Hungarians, Slovaks, Montenegrins, Romanians and Romas. Ten Percent of the population, around 270,000 people, are refugees and IDP´s (Annex 20). They are living in 450 collective centres and private accommodations.

According to the CARE Medical Consultant, the situation in the primary health care centres is characterised by an overall unsatisfactory level of health services. Particular home care service and patronage service is not functioning on a regular basis in most of the visited primary health centres. This is caused by lack of vehicles, fuel, medicines, medical equipment and consumables to be used for treatment of patients during home visit and patronage visit. Therefore, most Primary Health Care Centres did not organise particular home care and patronage services. Upon request, a general practitioner doctor and (or) a nurse who is available at the moment, is being sent to home visit but only in case if there is any vehicle and medical material available needed for treatment of the patient and if the patient was able to pay for the gasoline. The buildings that accommodate most of primary health care centres need urgent minor repairs. An overall status of medical equipment in all of the health centres visited could be marked as very unsatisfactory (Annex 3).

VI. Selection of Municipalities in Vojvodina / Serbia

The selection of municipalities was carried out in close co-operation with ECHO Novi Sad. The assessment was based on the following criteria:

- Vulnerable groups (refugees, IDPs)
- Number of social cases
- Number of elderly population
- State of equipment in primary health care centres

From previous experience of CARE medical programmes it was suggested to provide medical assistance to the most vulnerable population through the existing Primary Health Care Centres (Dom Zdravija), hereby avoiding the formation of a parallel primary health care system.

The Primary Health Care Centre (PHCC) is a health institution providing primary health care services (general practice, mother and child care, dental services, laboratory, home care, patronage etc.). Each municipality has one primary health centre. In municipalities with 10,000 to 30,000 inhabitants the health house provides also public health service, TB control, physical medicine and rehabilitation and occupational medicine services. PHC may have beds if there is no general hospital established in the municipality. The PHCC has a field net of “ambulantas” (primary health care stations) distributed in the territory of the municipality providing general practice services. In general each village has one ambulanta. Altogether there are 45 PHCC in Vojvodina.

The CARE Yugoslavia assessment team identified the following primary health care centres that showed an unsatisfactory level of medical equipment, medicines and consumables as well as transportation means (Annex 4): Srpska Crnja, Plandiste, Zitiste, Secanj, Bela Crkva, Titel, Ruma and Bac with a total number of 200,000 beneficiaries (Annex 5).

As a significant need of all eight Primary Health Care Centres the following items were identified: An all-terrain vehicle including fuel; ECG; Respiratory kit and a Visiting team kit for the Patronage and the Home Care Service (Annex 6).

VII. Objectives of the CARE Project

The **project purpose** is to enable the primary health care centres to provide patronage and home care visits for the most vulnerable people leaving in Srpska Crnja, Plandiste, Zitiste, Secanj, Bela Crkva, Titel, Ruma and Bac with a total number of 200,000 beneficiaries (Annex 4).

The **first objective** of the project is to strengthen the primary health care services for the most vulnerable local population including elderly, children and babies.

The **second objective** of the project is to enable the existing patronage and home care service to provide needed medical care to refugees, IDPs and local population.

A patronage service should visit on regular basis the following groups of patients: pregnant women, women who have just given birth and new-born babies and babies and children up to 6 years of age, TBC patients, refugees and IDPs, persons over age of 65, insulin dependent diabetics and handicapped people. In addition, they should organise and conduct community activities with respect to Primary Health Care issues.

The home care service should visit patients suffering from following illnesses: acute illnesses where no hospitalisation is necessary, chronicle illnesses with acute aggravation, chronicle disabled and incurable patients and patients released from home care.

The expected **project outcomes** are:

I. Strengthening of local health care services particularly home care and patronage services. The indicators for this project outcome are:

- Provision of medical equipment to the health care services
- Provision of vehicles to the health care services
- Use of delivered equipment and vehicles

II. Increase access to medical services for refugees, IDPs and other vulnerable people Residing in remotely located villages. The indicators for this project outcome are:

- # of patients who received medical care services
- # of patronage visits
- % increase in the number of patients receiving medical care services

III. Additional training of medical personnel (home care doctors and medical and patronage nurses) through seminars. The indicators for this project outcome are:

- # of organised training seminars
- # of participants attending the seminar

VIII. Strategic Approach of the CARE Project

According to the Operation Contract, the implementation period for this project is from 1 November 2000 to 31 May 2001. Over this period, eight nominated Primary Health Care Centres (PHCC) in Vojvodina shall receive one four-wheel drive vehicle each, fuel, medical equipment and medicines and consumables needed for patronage and home care services. In addition, medical training seminars and minor repairs of the PHCCs will be organised.

A) Supply of Vehicles
During the first CARE training seminar (9th of March 2001), patronage and home care teams from the eight PHCCs, received a four-wheel drive vehicle each and gasoline coupons (Annex 7).

B) Supply of Medical Equipment
During the first CARE training seminar (9th of March 2001), patronage and home care teams from the eight PHCCs, received the first consignment of medical equipment (Annex 8).
In addition, the teams of PHCCs were provided with medical documentation for keeping evidence of their visits in the field (Annex 9).

C) Supply of Medicines and Consumables …
The PHCCs received the first delivery of medicaments and consumables in March 2001and started with the provision of patronage and home care visits (Annex 11). The second delivery arrived on May 2001 (Annex 12).

D) Organisation of Two Medical Training Seminars
Two medical seminars should be organized for all medical and management staff involved in this Medical Assistance project. The objectives of these seminars were to enable the improvement or reactivation of patronage and home care services (Annex 13).

E) Minor Repairs
The general condition of the buildings and equipment in a number of primary health care centres are significantly poor and they are greatly in need of repairs. Insulation, including repairs to roofs, windows , have been identified as major priorities (Annex 14).

IX. Implementation Plan and Timeframe of the CARE project

The anticipated duration of the project is 7 months (Annex 15). This includes provision of humanitarian assistance and service provided for the period November 2000 to May 2001 inclusive and one month for residual monitoring, evaluation and reporting.

Date of start up:
Following formal approval by ECHO, the anticipated start-up date of the project was 1st November 2000.

Different phases:
The implementation of the operation were in five phases.

(i) Preparation of an implementation plan following a detailed assessment of the humanitarian requirements of each Primary Health Care Centre. (October 2000)

(ii) Simultaneously, CARE initiates a competitive tendering process as per ECHO guidelines, for the procurement of humanitarian supplies and services. (October 2000)
(iii) Procurement and distribution of supplies and services. (October-November 2000)
(iv) Provision of medical service and monitoring (November 2000 – March 2001)
(v) Organisation of medical seminars (October 2000 – March 2001)

Reporting:
All reports (narrative and financial) will be as per the guidelines of Article 23 of the ECHO Framework (Annex …).

X. Performance Monitoring and Reporting of the CARE Project

In the project proposal the following activities for reporting and monitoring were presented (Annex 16)

1. Constant presence of CARE Field Assistants and the Medical Consultant in the field.
2. The Patronage Team will fill in a formatted report for the treatment of each individual patient including the diagnoses and medicines prescribed. Data about the provision of medical services will be regularly controlled by CARE field Staff.
3. The Reports from the Patronage Team will be evaluated from the Medical Consultant and crosschecked against the monitoring reports from CARE Field Assistants.
4. The PHCCs will submit a monthly report to CARE
5. There will be an Inventory of the medicines used
6. CARE will monitor the proper execution of the project on an "ad hoc" basis (see Project Proposal 9.6)
7. The financial resource will be monitored by Fund Accounting

XI. Changes to the Strategies and Timeframe of the CARE Project

Due to delay in signing the Memorandum of Co-Operation and Donation with the Ministry of Health (Annex 17), the majority of the planned activities had to be postponed. The Request for Amendments to Operation Contract (Annex 18) included the request for necessary time extension and re-allocation of funds.

A) Changes to the Strategies of the CARE Project

In the project proposal, the budget for medicines were EUR 150,000.00 and EUR 32,000.00 for medical equipment. These amounts were based upon an assessment carried out by the CARE Medical Adviser in April/May 2000. In the meantime, the following changes have occurred:

1. Presence of new donors, such as European Agency for Reconstruction, who focused a part of their activities on the urgent needs for essential drugs within the health sector in Serbia (a project implemented through PSF).

2. As a result of the previously mentioned changes the project beneficiaries have reported that their present necessities for drugs are less urgent than their needs

for medical equipment.

B) Changes to the Timeframe of the CARE Project

According to the Operation Contract, the implementation period for this project is from 1 October 2000 to 31 May 2001. Over this period, eight nominated Primary Health Care Centres (PHCC) in Vojvodina shall receive one four-wheel drive vehicle each, fuel, medical equipment and medicines needed for patronage and home care services.

	Planned Delivery	**Executed Delivery**
Four-wheel drive vehicles	Nov 2000	March 2001
Gasoline coupons	Nov 2000	March 2001
Medical equipment	Nov 2000	First part: March 2001 Second part: four PHCC´s in April, four in May 2001
Medicines and Consumables	Nov 2000	First Delivery: 21 March 2001 Second Delivery: 15 May 2001
Provision of Patronage and Home Care Services	Jan 2000	12 March 2001

The reasons for the changes of the timeframe were:

1. Obstacles in regular liaison with the Ministry of Health of Serbia, which occurred in the period of political changes (5 October – 22 December 2001), caused a two-month delay in signing of Memorandum of Understanding with the Republic Ministry of Health as the Operation start-up precondition.

2. Delay in getting the importation licence for the four-wheel drive vehicles.

3. Severe lack of medicines and medical consumables in the local market

C) Consequences

As a consequence of the reasons mentioned above, CARE International-Yugoslavia requested in May 2001, the following Amendment to Operation Contract and to the re-allocation of funds:

1. The operation termination date to be changed to 30 June 2001

2. Approval for reallocation of EUR 75.000. Instead of Medicines CARE International-Yugoslavia was proposing to purchase Medical Equipment for the Primary Health Care Centres and to execute minor repairs (Annex 19).

XII. Evaluation on the impact of the CARE Project

The Amendment to the Operation Contract included a request for an extension of the existing deadline until the end of June 2001 (Annex 18). This evaluation, which took place from the 12th to the 16th of June, is actually a meta-analysis of previous intervention and not an "Ex-post evaluation". It examines the intervention effects and overall achievements of the Medical Assistance Project and is based on several of information including but not limited to:

- Project Proposal
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- Meeting with Dr. Jukka Pukkila, WHO Deputy MoH

A) Intermediate Impact on the Beneficiary Population

The beneficiaries of the CARE Project Proposal are refugees, IDPs and social cases in the municipalities of Srpska Crnja, Plandiste, Zitiste, Secanj, Bela Crkva, Titel, Ruma and Bac. The total number of beneficiaries is estimated at around 200,000 people (Annex 5). Five forms for monitoring the home care visits have been developed (Annex 9).

<u>Number of patients who received medical care services:</u>
During the period of March 12 to June18, 2001, 2223 patients received patronage and home care services. Some of the patients were visited several times.

1. Bac 148
2. Bela Crkva 300 (estimated by the medical staff)
3. Plandiste 224
4. Ruma 790
5. Secanj 290
6. Srpska Crnja 51
7. Titel 150
8. Zitiste 270

In the project proposal the size of the beneficiary population was assigned the rounded figure of 200,000 people. We had no information regarding how this number is broken down among IDPs, refugees and social cases. Also, there was no target group description pertaining to the health status and needs for patronage or home care services. Finally, we have no information about the age structure of the people, the number of newborns, number of pre-school children, pregnant women, chronic ill or bedridden people.

Therefore, in measuring the health impact on the beneficiary population, we are restrained by lack of adequate information regarding the following:

- morbidity patterns
- health care needs
- health seeking behaviour
- quantity and quality of the provided patronage and home care services

B) Intermediate percentage increase in the numbers of patients receiving medical care services:

The assessment of needs completed in May 2000, revealed that most Primary Health Care Centres had great difficulties to provide patronage and home care services. Diagnostic interventions as well as health promotion and health prevention related interventions targeted to high-risk groups were particularly unviable in a system which focussed the scarce resources entirely on therapeutic services. Therefore, it was assumed that the CARE Medical assistance project will lead to a 100% increase in the number of patients receiving patronage and home care services.

However, in practice the division between emergency care (permanent service), and home care services are indistinguishable. One explanation for this is likely the inadequate number of medical staff in the PHCCs, thereby often requiring for example medical staff from the permanent services to take on tasks of other services such as home care services. Although the evidence of each of the services are kept separately, at the time of the evaluation Plandiste, Secanj and Titel were unable to deliver data on the quantifiable raise (as a percentage) of the patronage and home care service provisions. In three PHCCs the Patronage and Home Care Service were completely reactivated (100%) and in Bac there was a 80% increase.

1. Bac 80% increase
2. Bela Crkva 100%
3. Plandiste n.a
4. Ruma 25%
5. Secanj n.a.
6. Srpska Crnja 100%
7. Titel n.a.
8. Zitiste 100%

Prior to the start off of the CARE project, patronage medical staff performed the patronage services on bicycles and in the past, especially in emergency cases, some PHCCs asked

patients to pay for gasoline for their home visits. Thus, the four-wheel vehicles together with the gasoline coupons enabled the PHCCs to also visit patients in remote areas, to offer free medical service (no charge for gasoline) and thereby improve or reactivate the patronage and home care service.

C) Intermediate impact on the Patronage and Home Care Teams

The assessment of needs, which was completed in May 2000, revealed that most PHCCs lacked, home care and patronage services, due to shortages in an appropriate vehicle, gasoline, medical equipment, medical staff, medical material and consumables.

Through the CARE Medical assistance project the patronage and home care services were revitalized and during the period of March 12 to June 18, 2001, 2223 patients received such services. Some of those patients were visited several times. Altogether the two teams provided patronage and home care services 8753 times. This suggests an average of four visits per patient during this period. Zitiste could not provide data about the visits.

Number of patronage visits:		**Number of home care services:**	
1. Bac	128	Bac	274
2. Bela Crkva	522	Bela Crkva	530
3. Plandiste	162	Plandiste	406
4. Ruma	3064	Ruma	856
5. Secanj	344	Secanj	784
6. Srpska Crnja	*1297* (both, patronage and home care services)		
7. Titel	213	Titel	173
8. Zitiste	n.a.	Zitiste	n.a.

In Practice, emergency, and home care visits, are done by the same group of health professionals, (as mentioned afore, due to the lack of staff, meaning doctors - in some PHCCs they are in lack of more than 10 doctors.).

D) Intermediate impact on Dom Zdravlja and Ambulantas

Since the break-up of the former Socialist Federal Republic of Yugoslavia in 1991 and the four wars together with the sanction period, the economy has deteriorated rapidly and the provision of public services were paralysed. As a consequence, the quality, effectiveness and efficiency of Primary Health Care Centres were strongly impaired by an enormous budget decrease, a 40% reduction in the number of health professionals, unsatisfied patients, lack of maintenance capacities, medicines and consumables and old fashioned equipment. There have been no training programmes offered in the last 10-15 Years. The salaries of the health care staff have been reduced to around 10% of their former salary.

One of the main reasons, why the patronage and home care services have been discontinued was a shortage of means of transport and gasoline, which effectively prevented the doctors

and nurses from reaching even the most needy patients. Although the largest part of the region of Vojvodina is a flat area, the target beneficiaries of the projects are located in remote distant villages with no asphalt roads for access. The provision of patronage and home care services was further impaired by the lack of medical equipment, medicines and consumables. With the support of the CARE Medical Assistance programme both services could be improved or reactivated in all eight Primary Health Care Centres. 2,223 patients were visited between March 12 , 2001 and June 18, 2001. The ambulantas got also medicines and consumables needed for patronage and home care visits. The two medical training programs enabled the medical staff to become familiar with the “New theories and concepts of Primary Health Care”. In addition, minor repairs of the PHCCs are planned for the end of June together with a delivery of medical equipment according to the individual needs of the PHCCs.

XIII. Intermediate Assessment of the use of equipment, vehicles, medicines and consumables

Previously, the former Republic of Yugoslavia produced more than 80% of its pharmaceutical supply at 16 specialized enterprises located throughout the country, and distributed them to the various republics at subsidized prices. There was consequently an over-usage of drugs and, in 1990, drug expenditure amounted to 17% of all health expenditures. During the four wars and the sanction-period, the local pharmaceutical industry was reduced and only able to provide a fraction of needed drugs. Pharmaceuticals had to be imported at world market prices or provided as foreign assistance. The four-wheel drive vehicle, the gasoline coupons, the medical equipment and the medicines and consumables helped all eight PHCCs to increase the quality, efficiency and effectiveness of their health care services.

Vehicle and medical equipment:
Procurement of four-wheel drive vehicles was initially planned for January 2001 and occurred on the 9 March 2001. Together with the **first** consignment of medical equipment, portable ECG apparatus and ECG gel, was delivered to the teams during the medical seminar on 9 March 2001. The first consignment of medical equipment consisted of glucose analyser and tests, blood pressure instrument and oto/ophtalmoscope. The **second** delivery consisted of the following articles: leather medical bag, leather technician bag, paramedical bag, scissors for bandage, surgical scissors, pean, tissue forceps, lancets, vacutaner for haematology, vacutaner for SE, vacutaner for PTT, vacutaner blood collection needle, needle holder, stethoscope, neurological hammer, thermometer, respiratory emergency kit, scalpel holder, scalpel blades, barrel for sterilization, box for instruments, mechanical scale for babies, length measurer for babies and milk pump. This equipment was delivered to four PHCC in April. The other four PHCC´s received their equipment during May 2001. It is estimated that for the normal functioning of patronage and home care services approximately 500 litres of gasoline are needed per month. Each PHCC has been provided with gasoline coupons for those 500 litres (Annex 7)

Medicines and Consumables:
The first delivery of medicines and Consumables to PHCC´s was performed on 21 March 2001. The quantities were planned according to a two-month need estimated by PHCCs. The second delivery took place on May 2001 (Annex 11 and 12).

XIV. Intermediate Assessment of the two Medical Training Seminars

The medical training programmes have been discontinued in the last 10-15 years. The two seminars were a great opportunity to expose the medical and management staff to the promotive and preventive aspects of Primary Health Care and to initiate their interest and support for reactivating the patronage and home care services within their Primary Health Care Centre.

The medical training seminars were organized for all medical staff involved in the project. The objective of these seminars was to improve the patronage and home care services and to promote the coordination of the proposed activities (Annex 13).

First Medical Training Seminar:
CARE International-Yugoslavia organised a medical seminar in "Park" hotel in Novi Sad on March 9, 2001 (12 am to 3 pm). The seminar was attended by 40 medical and management staff members from the eight PHCCs involved in the project. Three doctors from the Public Health Institute of Serbia were contracted as lecturers. The following topics were presented:

1. Home Care Service and Health Care (Prim. Dr. Tatjana Stankovic)
2. Organisation and function of the Patronage Service (Dr. Natasa Lockic)
3. Health conditions of refugees in FR Yugoslavia (Dr. Gordana Dragutinovic)

All the managers of the assisted PHCCs signed a Memorandum on donation. A sample of this Memorandum is enclosed as annex 21.

Second Medical Training Seminar:
CARE International-Yugoslavia organised a second medical seminar in the PHCC of Ruma, on May 31, 2001 (9.30 am to 15.30 pm). The second seminar was attended by 75 medical and management staff members from the eight PHCCs involved in the project. The following topics were presented:

1. Asthma in Children (Dr. Predrag Minic)
2. Nutrition and Physical Activity (Dr. Budimka Novakovic)
3. Home Care of Dialysis (Dr. Slavenka Vodopivec)
4. Physical Treatment in Home Care (Dr. Svetlana Popovic-Petrovic)
5. Treatment of Dekubitus in Home Care of Bedridden Patients (Dr. Zvezdan Stefanovic)
6. Treatment of Neurology Immobile Patients in Home Care (Dr. Marija Zarkov)
7. Treatment of Cardiovascular Diseases (Dr. Dejan Sakac)

XV. Conclusions and Recommendations for supporting the Primary Health Care System, and particularly the Patronage and Home Care Services in Vojvodina / Serbia

The conclusions and recommendations for the improvement of the Primary Health Care System, place a special emphasis on the Patronage and Home Care Services in Vojvodina/ Serbia and take into consideration the following:

A) Impact on the Beneficiary Population
B) Impact on the Patronage and Home Care Teams
C) Percentage increase in the numbers of patients receiving medical care services:
D) Impact on Dom Zdravlja and Ambulantas
E) Assessment of the use of Equipment, Vehicles, Medicines and consumables
F) Assessment of the two training seminars

A) Intermediate impact on the Beneficiary Population

Conclusions:

During the period of March 12 to June 18, 2001, **2223 patients** received patronage and home care services. In the project proposal the size of the beneficiary population was estimated to the rounded figure of 200,000 people. An estimate that was not broken down to IDPs, refugees or social cases. There was no adequate target group description that could provide useful information regarding health status and needs for patronage or home care services. There seems to be no information about the age structure of the people, the number of newborns, number of pre-school children, pregnant women, chronic ill or bedridden people.

Therefore, measuring the health impact on the beneficiary population is constrained by lack of information regarding the following:

- morbidity pattern
- health care needs,
- health seeking behaviour
- quantity and quality of the provided patronage and home care services

This project has produced five forms (Annex 9) to help monitor the provision of medical services during home care visits. No similar have been developed for the patronage visits yet.

Recommendations:

Based on the experience gained with the CARE Medical Assistance Project, the following recommendations might be helpful in designing future health projects:

- The analysis of the context and relevance of the operation's objectives can benefit significantly from baseline data on the socio-economic situation of the beneficiaries, their health care status, their health seeking behaviour, their access to primary health care services and their needs for primary health care services.

- For an analysis of the effectiveness of the operation the objectives should be quantified. Regular follow / up visits to monitor the quantity and quality of the medical services rendered should also be integrated.

- Need for promotive and preventive health care services: Diagnostic, health promotive and preventive interventions to high-risk groups were particularly unviable in a system which directs the scarce resources entirely towards therapeutic services. Therefore there is a strong need to support health promotion and disease prevention programs.

- Indicators for future health assistance projects: To measure the impact of health interventions on beneficiaries three types of indicators could be used for future projects:

    - The classic indicator of **outcome or health impact** like:
      - Maternal and perinatal mortality
      - data on volume and structure of health needs,
      - indicators on morbidity and health status such as eclampsia, breast-feeding, decubitus.

    - Some indicators of **process or activities** (coverage, frequency, types of delivery, …)

    - Some indicators of **quality of care**, including data on the course and results of a patient's treatment, patient and family satisfaction, use of treatment guidelines, rational use of drugs and consumables, communication and counselling skills of the care giver.

- Documentation: Forms for patronage and home care services should include indicators for monitoring the quantity and the quality of care as well as the rational use of medicines and consumables.

- The field monitoring should be systematic, standardised and documented in a written form (not on an ad hoc basis, over the phone, or reported in a narrative way without exact numbers). In addition, problems and best practices from fieldwork should be documented.

- For measuring the impact of health care services on the health status of the beneficiaries the narrative report approach should never be used exclusively.

- New Beneficiary Group: The visit in the Roma settlement proved that Roma people should be a preferred target group of any community development or health care projects. The enclave is practically a ghetto. Although inhabitants are entitled to welfare support the resources of the welfare system are limited and as a result the Roma people receive very limited, if any financial support.

The children attend only the first 2 or 3 classes of elementary school and are exposed to discrimination and suppression. Compared to other children of their age group they seem to be physically less developed.

Humanitarian aid has been occasionally provided by local Red Cross, one visit during the last six months. On April 2001, Europe`s first case of poliomyelitis was confirmed in an unvaccinated 13-month-old Roma child in the Burgas Region of Bulgaria. None of INGOs has visited the settlement prior to March 2001. The life quality and health status of the Roma people are impaired by lack of regular income, food and hygiene supplies, sanitation facilities and access to water, as well as by the poor conditions of their built-of-mud dwellings. Recent Public Health Studies (Wilkinson, 2001) indicate that the social-economic status, the quality and stability of social networks and the early childhood development are significant determinants for the development of health risks and for the adoption of a destructive health seeking behaviour. We therefore suggest that the Roma people should be considered as a preferred group of beneficiaries for any community development or health care projects.

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- Target Group: In August 2001 all refugees will have the opportunity to apply for the Yugoslavien citizenship which will qualify them to apply for "welfare assistance". Future projects in the Vojvodina should target "social cases" which will include refugees as well as IDPs.

- Argument for Supporting the Patronage Services: WHO estimates that perinatal mortality in FRY is unnecessarily high, at over 22 per 1000 deliveries, and that short-term humanitarian intervention is therefore warranted to reduce perinatal mortality towards the European mean, of less than 10 deaths per 1000.

- New health care needs: The health care professionals of the PHCCs observed the following changes in the health profile of their patients:

  - Higher prevalence of Respiratory and Cardiovascular Diseases
  - Higher rate of Smoking and Alcohol intake, especially among men
  - Increase in the prevalence of Psychiatric Disorders
  - Increase in the prevalence of Asthma

B) Intermediate impact on the Patronage and Home Care Teams

Conclusions:

In general there is a lack of patient-centered and continuos care, due in particular to the compartmentalized structure of Dom Zdravljas and the weak role accorded to the general practitioner (GP) and to the nurses. Quite often you will find a low staff motivation due to low salary, low profile value, poor opportunity for career advancement, and a system driven by specialists.

Through the CARE Medical assistance project the patronage and home care services, consisting of GP and medical and patronage nurses, were improved or/and revitalized. During the period of March 12 to June 18, 2001, 2223 patients received patronage and home care services. Some of them were visited several times. Jointly the two teams provided their services 8753 times which suggests that each patient got four visits on average. Zitiste could not provide data about the visits.

In Practice all emergency, patronage and home care visits, are done by the same group of health care professionals. Therefore, and despite the PHCC health staff keep separate records of the services it was difficult at the time of the evaluation to identify the exact number of visits done by the patronage and home care staff. At the same time, it was pinpointed that the medicines and consumables, that were provided as part of the CARE project, were exclusively used for patronage and home care services.

Recommendations:

Based on the experience gained with the CARE Medical Assistance Project, the following recommendations might be helpful in designing future health projects:

- In most PHCCs, the profession of Patronage Nurse, has been extinct partly due to changes in the curriculae of the local universities. To the degree that if there is still a need for patronage services, they are rendered by midwifes or medical nurses. Given the different profile of these professions we recommend that midwifes or medical nurses should attend a "patronage training" before rendering patronage services to patients.

- In order to standardise the monitoring process forms should be developed for all medical services, not only for home care services. The forms should include indicators for measuring the quality and quantity of medical services.

- The job description of patronage nurses includes "community activities". To successfully perform such activities the patronage nurses should be equipped with materials, folders, posters, stickers, videos and a videos equipment. In addition, they should receive a training on the methodology and content of community activities. The interviewed health professionals reported that they are often confronted with questions about home violence, family planning, TBC, Diabetics, psychiatric disorders, STDs and AIDS. They are currently not able to provide relevant information and counselling in a scientific, systematic way.

- At the local level, the primary community council is the Mesna Zajednica. They expected to represent the interests of the community and initiate community development activities. There is currently a law before Parliament aimed to reform this institution so that it will exist with "the purpose of satisfying direct mutual needs of citizens residing in that area". If this reform process proves successful, these institutions might be in a position to play a more meaningful role in identifying social and health care trends, influencing the health seeking behaviour of the inhabitants and participating in health care activities. The cooperation with the Mesna Zadjednica should be promoted in all social and health care projects.

C) Intermediate percentage increase in the numbers of patients receiving medical care services:

Conclusions:

The CARE project funded by ECHO, which encompassed the four-wheel vehicles and the gasoline coupons enabled the medical staff of the PHCCs to visit those patients who lived in remote areas and to offer free medical services (without payment for gasoline or medicines). In Bela Crkva, Srpska Crnja, Zitiste, the Patronage and Home Care Service were completely reactivated (100%) and in Bac there was a 80% increase. Three PHCCs (Plandiste, Secanj, Titel), at the time of the evaluation could not give any data about the percentage increase.

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Recommendations:

Based on the experience gained with the CARE Medical Assistance Project, the following recommendations might be helpful in designing future health projects:

- In order to measure the effectiveness of a project, it is quite useful to collect baseline data with respect to the need for services and the actual provision of patronage and home care services.

D) Intermediate impact on Dom Zdravija and Ambulantas

Conclusions:

The scope of health services normally provided by the DZ decreased during the war and the sanction period. These circumstances caused a dramatic decrease in all kinds of resources available to the health care system and supported the negation of the promotive and preventive aspects of primary health care service, like the patronage and home care services.

Based on the CARE Medical Assistance programme both services could be improved or reactived in all eight Primary Health Care Centres and 2223 patients could be visited within the 12 March 2001 and the 18 June 2001. In addition, medicines and consumables, needed for patronage and home care service, were provided to the Ambulantas. The two medical training programs enabled the health care professionals to become exposed to "New theories and concepts of Primary Health Care". Furthermore, the structural quality of the PHCCs will be improved by minor repairs (by the end of June) and the delivery of medical equipment (by the end of June).

Recommendations:

Based on the experience gained with the CARE Medical Assistance Project, the following recommendations might be helpful in designing future health projects:

- The reconstruction needs of DZs are significant, the quality of buildings and equipment has deteriorated due to a lack of maintenance and repair. Therefore minor repairs of the PHCCs are strongly recommended.

- For the majority of DZs the equipment is quite old and some of the DZs are without any appropriate equipment. The provision of medical equipment seems to be crucial for improving the effectiveness, efficiency and quality of care.

- To enhance the cooperation of the health care professionals, regular staff meetings should be organised with a clear agenda. These meetings should allow health care professionals to contribute own ideas regarding the provision of patronage, home care services and community activities.

E) Intermediate assessment of the use of Equipment, Vehicles, Medicines and consumables

Conclusions:

Previously, the former Republic of Yugoslavia produced more than 80% of its pharmaceutical supply at 16 specialized enterprises located throughout the country, and distributed them to the various republics at subsidized prices. There was consequently an over-usage of drugs and, in 1990, drug expenditure amounted to 17% of all health expenditures. During the four wars and the sanction-period, the local pharmaceutical industry was reduced and only able to provide a fraction of needed drugs. Pharmaceuticals had to be imported at world market prices or provided as foreign assistance. The four-wheel drive vehicle, the gasoline coupons, the medical equipment and the medicines and consumables helped all eight PHCCs to improve or reactivate the patronage and home care services and to increase the quality, efficiency and effectiveness of their health care services.

Recommendations:

Based on the experience gained with the CARE Medical Assistance Project, the following recommendations might be helpful in designing future health projects:

- In August 2001 the list of essential drugs will be reduced from 1000 to 400 products. This means that the patients will have to pay out of their pockets for those medicines which are not included in the list. Therefore there is a great need for the provision of medicines, given that 60% of the people are unemployed and that starting on the 11th of June 2001 every patient has to pay a participation fee of 20 Dinar.

- The Health Care Staff expressed the wish that each team should have their own "bag" and that the staff working in the Ambulantas should also be equipped with bags, uniforms, jackets and stickers.

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- The Health Care Staff also suggested to get one more vehicle and also mobile phones for planning the field visits in a more efficient way.

- All staff members should be trained to use medical equipment, incl. proper maintenance, change of attachments, replacement of paper, cleaning guidelines, etc. For instance, the Health Care Staff could not use the respiratory kit because they did not learn how to use it.

- Cooperation with YRC or local NGO´s: A new law imposes a 20% tax on aid items purchased in-country (due to the latest developments, the Ministry of Finance gives tax exemption and to International NGOs, but per project). If such items are distributed to beneficiaries through the YRC or a local NGO the aid then becomes tax exempt.

The health care professionals reported that they need a higher quantity of glucometer, Sol.NaCI 0,9%, Aminophyllin, Berodual, Nitroglicerin, Nifelat and Predian, Insulin and

syringes. This has been taken into consideration by CARE in the modification request submitted to ECHO. The medical items are expected to be delivered in July.

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- Based on the delay in getting an importation licence for the four-wheel drive vehicles and the severe lack of medicines and consumables in the local market, the amendment for changing the operation termination to the 30th of June 2001 was a necessary step and should be recommended in similar situations. Also, the reallocation of EUR 75.000 to purchase medical equipment for the primary health care centres and the planning of minor repairs at the PHCCs should be strongly supported.

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F) Assessment of the two Medical Training Seminars

Conclusions:

The medical training programmes have been discontinued for the last 10-15 years. Therefore, education and training programmes for physicians and nurses are vital to foster the quality and the provision of patronage and home care services. The two medical training seminars were a great opportunity to expose the medical and management staff to the promotive and preventive aspects of Primary Health Care, as well as to win their support for the reactivation of patronage and home care services within their Primary Health Care Centre. One patronage nurse mentioned that she never heard before that stress and Hypertonia are risk factors for getting a Heart Attack. During her education only nutrition was mentioned as a risk factor.

Recommendations:

Based on the experience gained with the CARE Medical Assistance Project, the following recommendations might be helpful in designing future health projects:

- More interactive and bed-side teaching was requested. No frontal lectures without discussion time should be offered anymore (first seminar).

- All staff members should be trained to use medical equipment, incl. proper maintenance, change of attachments, replacement of paper, cleaning guidelines, etc. For instance, the Health Care Staff could not use the respiratory kit because they did not learn how to use it.

- Outdated and mandatory treatment guidelines with respect to Patronage and Home Care Services should be discussed during medical training seminars. Topics about care standards, quality of care and rational use of resources should be included too.

  During the first training seminar one lecturer recommended drugs which were not provided within the project. All lecturers should be informed in detail about the project before their presentation

- During the first training seminar one lecturer described the health care provision of a Primary Health Care Centre, located in Belgrade. For the purpose of our project, it would be better to choose examples which are related directly to the working situation of the participants (= like a PHCC in a remote, agricultural area).

- The job description of patronage nurses includes “community activities”. For this part of their duty the patronage nurses need to be trained on community involvement, patient empowering, group discussions and patient counselling. The medical staff

reported that they are confronted with questions about home violence, family planning, TBC, Diabetics, psychiatric disorders, child abuse, STDs and AIDS. Right now they are unable to provide relevant information and counselling in a scientific based and systematic way.

- At the end of the training seminars there should be an evaluation of the participants´satisfaction level with respect to the lecturers and the management of the seminar. In addition, recommendations for future seminars could be collected.

- New Health Care Law (August 2001): The new health care law will establish a new system of "Family Doctors", this group of people will cover patronage and home care services too. The present practice of the general practitioner and nurse will undergo important changes. Therefore there will be a need to organize programmes to train GP´s and specialists in the family medicine approach, including guidelines for patronage and home care services.

XVI List of Attachments

Annex 1: Health Map of Serbia

Annex 2: Serbia health Map – Vojvodina Region

Annex 3: Network of Health Institutions in Vojvodina

Annex 4: List of Required Medicines and Sanitary Materials

Annex 5: Profile of the eight Primary Health Care Centres

Annex 6: List of Required Medical Equipment

Annex 7: Vehicles and Medical Equipment Delivered

Annex 8: Contents of Doctor´s, Med. Technician's, Patronage Nurse's Bag

Annex 9: Five forms for Home Care Services

Annex 10: Project Location Map

Annex 11: First Delivery of Medicines and Medical Consumables

Annex 12: Second Delivery of Medicines and Medical Consumables

Annex 13: Two Medical Training Seminars

Annex 14: Survey of Health Care Institutions in Serbia

Annex 15: Implementation Timetable

Annex 16: Project Proposal

Annex 17: Memorandum of Co-Operation and Donation

Annex 18: Request for Amendments to Operation Contract and Re-Allocation of funds

Annex 19: Indicative List for second Procurement of Medical Equipment

Annex 20: Vojvodina Population Breakdown

Annex 21: Memorandum on Donation