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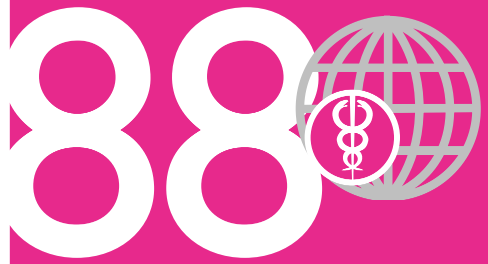

Bulletin

Internationale Zusammenarbeit
im Gesundheitswesen

Coopération internationale
en matière de santé

International cooperation
in Health Care

Nr. 88, April 2003

Gesundheit im Umbruch
Health in Transition

Impressum

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Netzwerk Medicus Mundi Schweiz
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Das Netzwerk umfasst sowohl Organisationen, die sich hauptsächlich im Gesundheitsbereich engagieren, als auch Mehrspartenorganisationen, in denen Gesundheitsprojekte einen Teil der Aktivitäten bilden, sowie unterstützende Organisationen. Medicus Mundi Schweiz fördert die Netzwerkarbeit und den Austausch von Informationen und Expertise zwischen den Mitgliedorganisationen sowie weiteren Organisationen und Fachleuten der internationalen Gesundheitszusammenarbeit und der interessierten Öffentlichkeit.
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Geschäftsstelle und Redaktionssekretariat:
Medicus Mundi Schweiz
Murbacherstrasse 34
Postfach, CH-4013 Basel
Tel (+41) 061 383 18 10
E-Mail: info@medicusmundi.ch
Internet: www.medicusmundi.ch

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Titelbild: Consultation in a family medicine service, Varzob district, Tajikistan. Photo: Nadim Jaganjac

Editorial

Für viele Menschen in den Ländern der ehemaligen Sowjetunion und des Balkans hatten und haben die politischen und ökonomischen Restrukturierungen der letzten 15 Jahre dramatische Auswirkungen auf ihre individuelle Lebenssituation. Die neuen Republiken, welche aus der Neustrukturierung der Region hervorgegangen sind, erleben eine bisher nicht gekannte ökonomische Krise mit wirtschaftlicher Unsicherheit, Massenarbeitslosigkeit und Armut. Der öffentliche Sektor ist durch Budgetkürzungen geschwächt. Fehlende oder ungenügende gesetzliche Rahmenbedingungen sowie weit verbreitete Korruption schaffen ein unsicheres Investitionsklima für den privaten Produktions- und Dienstleistungssektor, so dass mit einer zügigen Übernahme der von der öffentlichen Hand vernachlässigten Aufgaben durch private Investoren nicht zu rechnen ist.
Die dramatischen Vorgänge haben erhebliche Auswirkungen auf die Gesundheitssituation, auf die Gesundheitsversorgung sowie auf das individuelle Risikoverhalten der Menschen. Frustration durch Arbeitslosigkeit und Mangel an Lebensperspektiven führen bei vielen jüngeren Menschen zu Drogenkonsum, Alkoholismus und riskantem Sexualverhalten mit einer Zunahme von sexuell übertragbaren Erkrankungen und HIV/Aids. Unterfinanzierte öffentliche Gesundheitssysteme werden ihren Aufgaben nicht gerecht mit den Folgen zunehmender Zahlen von Tuberkuloseerkrankungen und weiterhin hoher Mütter- und Neugeborenensterblichkeit. In vielen Regionen ist die Zahl nicht normal verlaufender Schwangerschaften erschreckend hoch. Der Verfall öffentlicher Gesundheitsstrukturen bei fehlenden finanziellen Möglichkeiten für die Nutzung der sich entwickelnden privaten Angebote schliesst viele alte Menschen von einer adäquaten Gesundheitsversorgung aus.

Auch die sozialen Netzwerke sind dramatischen Veränderungen unterworfen. Für viele Menschen sind ihr gesamtes soziales Regelwerk und die gesellschaftlich anerkannten Normen zusammengestürzt. Neue soziale Rahmenbedingungen entwickeln sich nur langsam, und viele finden sich in der veränderten Situation nicht zurecht. Wie so häufig sind es Kinder, Jugendliche, alte und psychisch kranke Menschen, die marginalisiert sind und am ehesten durch die grösser werdenden Maschen der sozialen Netzwerke hindurch fallen.
Der Übergang von planwirtschaftlichen Methoden zu Organisationsstrukturen der sozialen Marktwirtschaft ist nicht einfach. Kulturelle Unterschiede zwischen den bisherigen Systemen und den Reformvisionen, vor allem aber auch in der Zusammenarbeit innerhalb und zwischen Organisationen erschweren häufig schnelle Entwicklungen. Überkommende Machtstrukturen, staatliche Zentralisierung und die nur langsame Veränderung traditioneller Unternehmenskulturen erschweren individuelle Initiativen. Die für den rationellen Einsatz von vorhandenen und häufig unzureichenden Mitteln notwendige Informationstransparenz und Zusammenarbeit entspricht nicht unbedingt bisherigen Organisationskulturen.
Die meisten Länder in der Region haben die Notwendigkeit von tief greifenden Reformen nicht nur im Gesundheitssektor erkannt, und in vielen existieren bereits mehrjährige Erfahrungen in diesem Bereich. Schweizerische und internationale Institutionen leisten dazu ihren Beitrag. Partnerschaftliche Hilfe reicht von Spitalpartnerschaften über die Projekte von Nichtregierungsorganisationen bis zu zwischenstaatlicher Entwicklungszusammenarbeit und multilateraler Hilfe. Ein breites Spektrum, und eine hoffentlich interessante Lektüre in dieser Bulletinausgabe.

Manfred Zahorka, Dr. med, MPH
Schweizerisches Tropeninstitut
Zentrum für Internationale Gesundheit, Basel

Netzwerk

Die 34 Mitgliedorganisationen des Netzwerks Medicus Mundi Schweiz:

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Bündner Partnerschaft HAS Haiti
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Christoffel Blindenmission (Schweiz)
CO-OPERAID
DM – Echange et Mission
FMH Verbindung der Schweizer Ärzte
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Secours Dentaire International
SolidarMed
Stiftung Terre des Hommes
Verein Partnerschaft Kinderspitäler Biel-Haiti

Do you read English?
Leider sind in diese Ausgabe nur deutsche und – vor allem – englischsprachige Texte eingeflossen. Wir geloben Besserung, und freuen uns besonders über alle eingehenden französischsprachigen Beiträge, zum Beispiel zur nächsten Ausgabe «Gesundheit und Entwicklung. 25 Jahre nach Alma Ata».

Impact of economic transition on health care in Eastern Europe and the Newly Independent States

Facing the Challenge

For most of the countries of Central Asia and Eastern Europe the transition period from Soviet style governance to a free market economy and democratic governance has brought deterioration in living standards, accompanied by shortcomings in the health and education sectors. There are tremendous challenges for the public health system in Eastern Europe and the need for reform is evident.

By Manfred Zahorka

All the republics of Central Asia and Eastern Europe have witnessed a serious economic crisis, and framework conditions, such as legislation, the judicial and tax systems, and the fight against corruption have not yet been sufficiently consolidated to allow the development of the private sector and small and medium-sized enterprises in particular. Economic decline and social disruption have lead to widespread poverty in the newly independent states (NIS) as the countries of the former Soviet Union are now called. Massive social changes including mass unemployment, economic insecurity and the deterioration of social safety nets influence peoples' lives in the region. Frustration about joblessness and limited future perspectives increase vulnerability particularly of youth and adolescents.

Risking health for a decent live

Widespread poverty, migration and declining health and education services have led to a massive increase in individual high-risk behaviour. Increasing poverty has forced women into sex work as their only source of income. While the rigid social control of the past has eroded, new common norms and values are still flimsy. The lack of common social norms and values has lead to an increase of drug abuse, particularly with injection drugs together with drug production and trafficking, early and unprotected sex and other high risk behaviour particularly of young people. The general lack in sex education together with the ever earlier onset of sexual activities lead to a rapid increase of sexually transmitted infections especially among those under 25 years of age. Unprecedented numbers of young people do not complete their secondary schooling. Several countries have experienced setbacks in the human development index (HDI, used by UNDP for the Human Development Reports) over the past two decades.

Migration to neighbouring countries by parts of the family, particularly for men searching for work, is a common form of income generating activities since the opening of borders in the early 1990s. The increased mobility has as well increased the likelihood for the spread of a variety of diseases including HIV/AIDS and other sexually transmitted infections. In the early 1990s HIV/AIDS made rare appearances in the region, but today 8 from 10 known HIV subtypes are found in an area spreading from Belarus to the Russian Pacific coast.

Collapsing systems and services

Massive budget cuts for social security and public services have lead to a collapse of the public health system, including those components responsible for the treatment and control of infectious diseases like tuberculosis (TB) and HIV/AIDS. An only slowly adjusting health care system and relatively shrinking health budgets have

Photo: IAMANEH Schweiz

Six years after the war, Bosnia is still confronted with huge social problems, poverty and unemployment.

reduced access to quality health care. Preventive care services including health promotion, education and information are seriously suffering from the budget cuts. The public health response to high risk behaviour and increased vulnerability of the population remains weak or non-existent. Centralised structures of health care systems, the reduced capacity for investment and a lack of maintenance systems lead to deterioration of medical infrastructure de-favouring peripheral and rural populations in particular. Many institutions depend on private donations for the renovation and adaptation of structures to changing consumer needs. The increase in consumer prices and low salaries in the health sector have introduced unofficial users fees in many institutions rendering access to health care systems more difficult to the poor. Emerging private health care providers are accessible only to the wealthy. As tax based health care financing is increasingly unable to guarantee health care for all, insurance based schemes are only slowly developing. In recent years health care reform efforts have encouraged decentralisation and a trend away from institutionalised care towards an ambulatory system with several referral levels leaving many institutions with large overcapacities, which increase the burden to the health budget. A tendency away from budget allocation based on the number of beds per institution and towards per capita based or even diagnostic groups related payment systems have put many larger hospitals into a financially volatile situation.

Although there is an increased opening to the international medical community and most countries are reporting to WHO using international disease classification standards (ICD 9 or 10), there are still large differences in quality standards, diagnostic guidelines and even case definitions, which have an impact on the quality of care provided and the international comparability of health care statistics. In the Soviet period reporting within the health care delivery system was largely depending on centrally set plans and objectives and non accomplishment of targets had often serious consequences on budget allocation or even personal carrier perspectives. In order to monitor the system a vast amount of data was collected at central level. However, the information was frequently biased towards targeted val-

ues. Even after several years into health care reform, it is frequently difficult to obtain unbiased information as health care providers fear for personal consequences if the information provided does not correspond to expected values. Today there is a significant lack of reliable information making health planning and monitoring a tedious exercise and renders the establishment of national and international support programs more difficult. Additionally, the low level of computerisation of health records limits the possibility of getting a complete picture.

The patient's name: public health

Despite the changing health care systems the old hierarchical thinking is still predominant in many countries of the former Soviet Union. Clinical procedures and guidelines are often based on single senior experts' views and not necessarily on internationally accepted knowledge or evidence based criteria. In many countries it is difficult for younger physicians to acquire independent knowledge as access to international sources is constraint due to limited access to information technology or simply the lack of English language proficiency.

Civil society organisations like non-governmental organisations (NGOs) in the health and social sectors were non existent in the Soviet period and are now slowly developing. In many countries however, NGOs are managed by civil servants who work at the same time in public institutions and serve as an alternative way to fill the financial gaps in the public system. Nevertheless, many local NGOs receive international support as other alternatives are missing.

Under these circumstances the public health response to emerging or re-emerging epidemics like HIV/AIDS or Tuberculosis remains weak and spurious. Countries in Eastern Europe and Central Asia today have the fastest growing HIV/AIDS epidemic in the world. At the same time there is a near total lack of infrastructure and capacity to provide any HIV/AIDS-related services, whether through prevention programs, voluntary counselling and testing, treatment or care for people living with HIV/AIDS. Tuberculosis as well is on the rise with an average increase of 10% per year in the Russian Federation. The increased number of treatment resistant strains of Tuberculosis due to incomplete treatment forms a particular public health threat not only limited to the region.

There are tremendous challenges for the public health systems in Eastern Europe. Most countries in the region have engaged in some form of adjustment of the health care system supported by national and international efforts. Health education and disease prevention play an important part to reduce the vulnerability of the general population and the youth in particular. Whilst looking for alternative financing mechanisms for health care it is a public health priority to provide equal access to quality health care services for all.

**Manfred Zahorka is a family practitioner, public health expert and epidemiologist by training. He has been working for more than 15 years in public health and health systems development in developing and transitional countries in Eastern Europe, Central Asia and Africa. Currently, he is working with the Swiss Centre of International Health within the Swiss Tropical Institute in Basel. Contact: Manfred.Zahorka@unibas.ch*

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- *UNDP Human Development Reports, http://hdr.undp.org*
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Equity and access in the health sector in Eastern Europe and Central Asia

"To have and have not"

During 2002 a study was conducted examining issues of access to health care services, and related indicators, in five countries from this region – Kyrgyzstan, Tajikistan, Ukraine, Bulgaria, and Romania. The study drew principally on grey as well as published literature, identifying data available on key indicators that reflect access and equity of health systems in these countries.

*By Guy Hutton**

Photo: Kaspar Wyss

Consultation in a family medicine service, Dangara, Tajikistan.

Since the late 1980s, countries of Eastern Europe and Central Asia have experienced unprecedented social and economic transformation. The economic decline that ensued in these countries following the fall of the communist regimes was severe and drawn out, with particularly disastrous consequences for the public sector, whose ministries suffered severe budget cuts. Not surprisingly, the health systems suffered for many years as the health sector reforms and the removal of excess capacity could not be achieved overnight. With the cuts in public spending, the slow pace of reform, as well as the ethnic diversity, there was considerable potential for declines in access to health services for some groups as well as a declining quality of public health services, leading to a widening gap between the "haves" of the new system, and the "have-nots".

Although Kyrgyzstan, Tajikistan, Ukraine, Bulgaria and Romania are going (or have gone) through similar experiences in the health sectors, the diversity within and between these countries should not be overlooked – in terms of geography, ethnic composition, income, and health status. Such diversity has important implications for each of the three main components of health care access: economic access, physical access and cultural access. Indicators discussed below cover health status, health care financing and resource allocation, and utilisation and quality of care.

Overall health system attainment and performance for all countries in the world has been presented previously in the World Health Report (2000). Among the five countries, the health system attainment ranged between 80% in Ukraine (ranked 60th in the world) down to 67% in Kyrgyzstan (ranked 135th). Health distribution, judged on the basis of child survival, was highest in Ukraine (90%) and again lowest in Kyrgyzstan (70%). Bulgaria had the highest male life expectancy at 61 years, compared to 53 years in Kyrgyzstan.

Photo: Kaspar Wyss

Consultation in a family medicine service, Varzob district, Tajikistan.

In terms of health care financing and resource allocation, Romania has the highest expenditure per capita (US$238), which is around 13% of the European Union average. Tajikistan has the lowest expenditure (US$37), followed by Kyrgyzstan (US$105). Health spending as a percentage of Gross Domestic Product varies between 2.3% (Tajikistan) and 5.0% (Ukraine), compared to an EU average of 8.5%. In terms of the main sources of finances, in all countries the largest expenditures in the health sector were from public sources, and most of this was from tax revenues. Within countries, there has been reported a considerable inter-regional variation in the per capita government spending on health. In terms of private expenditure, out-of-pocket accounted for between 20% of total health sector expenditure in Bulgaria and 43% in Romania. Unofficial payments to health care providers have also been reported widely.

Geographical access to health care is not considered to be a major concern in former communist countries. However, during the 1990s post-Soviet systems were characterised by over capacity in terms of infrastructure, and at the same time rapidly falling quality of care and inability to support recurrent costs such as staff salaries. The number of acute hospital beds per 1'000 population varies from 6.2 in Tajikistan to 7.6 in Bulgaria. Romania has among the lowest levels of health care staff per population, while Tajikistan and Kyrgyzstan have among the highest. In Ukraine, considerable restructuring and rationalisation of health services have taken place since 1990, with reductions in hospitals and number of beds of 35%. There is also significant variation by region in health care resources, with wide rural/urban disparities. For example, in Bulgaria the number of beds vary by region from 45.7 to 99.7 per 10'000 population (average 74.3), and physicians vary by region between 17.0 and 50.2 per 10'000 population (average 33.8).

Health care utilisation is considered to be a good indicator of the impact of the health sector. In all five countries, the number of outpatient visits per person per year is reasonably high, at between 3.4 in Tajikistan and 8.5 in the Ukraine, compared to an EU average of 7.4. In Tajikistan, the richest income groups have higher rates of self-reported acute and chronic morbidity than the lower income groups, and correspondingly higher health service use rates. For women who did not seek antenatal care during pregnancy, 44% said it was due to the cost. In Bulgaria, groups that are judged to use health services marginally less than others include village dwellers, those with secondary vocational qualifications, and families with more than three children. The acute hospital admission rate is also high in all countries, at between 9.7 in Tajikistan and 17.9 in Ukraine per 100 population. Once admitted, the average length of stay is over 10 days per person in all countries. Immunisation rates for measles are high, with at least 94% in all countries. Contraceptive prevalence rate between 60% in Kyrgyzstan and 86% in Bulgaria.

In terms of health outcomes, it has been reported widely that since the fall of communist regimes and transition to market economies, health indicators have deteriorated until the present day. Some health indicators are finally improving again. In Ukraine childhood diseases increased by 18% between 1990 and 1999, with 1.6 cases of morbidity per child. Also, tuberculosis rates and HIV/AIDS are increasing from year to year in Ukraine. Infant mortality varies between 13 (Bulgaria) and 57 (Tajikistan) per 1'000 live births. The maternal mortality rate varies between 27 (Bulgaria) and 130 (Romania, Tajikistan) per 100'000 live births. For Bulgaria, infant mortality varies by region between 5.4 and 24.3 per 1'000 live births, with greater differences between rural and urban areas within each region.

Following international experience in defining and measuring populations' access to health services, it is clear that there are no single indicators that allow judgements about how accessible health services are, nor how much equity is being achieved. Therefore this article has reported briefly a variety of indicators that reflect access and equity. It should be noted that different data sources give different impressions of the situation in these countries, and also many indicators are inflated due to a culture of falsifying official reports.

Health inequalities need to be addressed

The main conclusion of the study: Due to the decline in performance of these health systems during the 1990s, health inequalities within these countries are increasing, and need to be addressed as a matter of urgency.

The health systems are in great need of the reform measures currently being applied. How these reforms are defined, and whose needs they are targeted at, are both critical issues in ensuring they have a positive impact on the populations who most need publicly-provided health services.

Due to the large size of most of these countries, the dispersed populations and income inequalities, decisions about the health care infrastructure (and how populations are to be reached efficiently) and the health care financing mechanisms are crucial in the current health sector reforms. These reforms should be accompanied by a careful process of planning that involves the appropriate stakeholders. Better quality statistics are needed to ensure health planning is based on reliable data.

Different health initiatives should be supported, especially targeting those diseases that have emerged or re-emerged in the last decade (tuberculosis, HIV/AIDS, alcohol-related). Such support should preferably be channelled through the lower levels of the health system as opposed to vertical programmes and hospitals, to improve the overall performance of the health system and promote disease prevention. There should be a renewed focus on basic immunization, management of sick children, maternal and perinatal care, and the promotion of healthy life-styles.

**Guy Hutton, MSc, PhD, works as Health Economist for the Swiss Centre for International Health in the Swiss Tropical Institute, Basel. Contact: guy.hutton@unibas.ch.* *The original study was supported by the Social Development Division of the Swiss Agency for Development and Cooperation SDC. Full versions of this article can be obtained from the author.*

The fastest-growing epidemic in the world

Eastern Europe and Central Asia were largely unaffected by HIV/AIDS up to the early 1990s. As recently as 1994, no country in this region was reporting more than a few HIV infections, with an estimated total of 30,000 infections. A first outbreak with rapid increase in registered cases started a year later mainly in Ukraine, Belarus and the Russian Federation. Since then the situation has dramatically changed. In only two years time the number of infected people has increased more than five-fold with a rapid increase in the incidence[1] of the disease. With an HIV/AIDS prevalence[2] of up to 1% of the general population (Ukraine) the region is currently not experiencing a situation like the one prevailing in some African or South-East Asian countries. The alarming sign however is the dramatic increase of the incidence, the number of new cases per year. The region is now experiencing the fastest-growing epidemic in the world.

*By Manfred Zahorka**

Approximately one million people in Eastern Europe and Central Asia are currently living with HIV/AIDS, which is more than double the number found at the end of 1999 (420,000). New cases of HIV have been almost doubling annually for several years in the Russian Federation. The total number of HIV infections reported since the epidemic began now stands at more than 173,000 cases – up from the 10,993 reported at the end of 1998. HIV spread is now also evident in Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan. The change in testing procedures from mandatory testing to voluntary counseling and testing (VCT) makes prevalence figures difficult to interpret as scepticism persists about the possibility of discrimination and legal consequences of a positive test result. The estimated number of people now living with HIV/AIDS is thought to be around four times higher than the reported figures. Due to the high costs and budgetary constraints within the publicly funded health systems effective anti-retroviral therapy for people living with HIV/AIDS (PLWHA) is rare in the region. It is estimated that less than 1000 people receive highly active anti retroviral therapy (HAART).

Common Characteristics

The countries of the Eastern Europe and Central Asia region share remarkably common characteristics, which make similar developments in the future very likely. Some of these are:

- There is little reliable data about the magnitude, location, and progress of the epidemic. Due to a change from non-anonymous and mandatory mass testing to VCT, data is inconsistent.
- Homosexual transmission is unclear as homosexuality is forbidden in most of these countries so that voluntary outing is rare.
- Low level of awareness among decision makers and the general public about the disease and its potential impact upon economies and societies.
- Severe stigma and discrimination attached to persons living with HIV/AIDS, combined with a perception that HIV only hits ”undesirable” populations.
- Massive, costly and perhaps unreliable public testing for HIV.
- A near total lack of infrastructure and capacity to provide any HIV/AIDS-related services, whether through prevention programs, VCT or treatment, care and services for PLWHAs.
- The lack of computerisation limits the possibility to get a complete picture to support programs.
- Heterosexual transmission is so far rare.
- There is a rapid trend towards the spread of HIV/AIDS infection in Injection Drug Users (IDU) and a parallel fast increase of Sexually Transmitted Infections (STIs) which increases the risk of an imminent spread of HIV/AIDS into the heterosexual transmission group.
- Few and weak civil society organisations.

Unemployment, poverty and increased injection drug use (IDU) in Central Asia contribute to the spread of HIV/AIDS. All five Central Asian countries serve as drug trafficking routes from Afghanistan to Russia and Western Europe. Local drug consumption patterns are influenced by ready access to drugs. People are switching from alcohol to heroin, which is cheaper, and heroin users are starting to switch from smoking or snorting to injection, because it is a more efficient method of drug ingestion. With easy access to and strong demand for illegal drugs, consumption has increased dramatically, particularly in the Black Sea area, which remains a regional gateway for drugs.

The deterioration of social networks and the economic pressure forces many women into sex work as their only source of income. A growing number of female IDUs are engaging in commercial sex work to fund their addiction. Young people are particularly vulnerable to HIV infection; the majority of drug users and sex workers in the region are under age 30. Official approaches to sex work and HIV prevention among sex workers have so far been either negligent or repressive. Although commercial sex workers are generally well informed about the protective effects of condom use, they are often not in a position to negotiate safer sex practices with their clients. Imported and Russian-made condoms are sold at some kiosks in Belarus, Kazakhstan, Russia, and Ukraine and are often of low quality or not affordable.

Information about HIV/AIDS patterns in men who have sex with men (MSM) groups is generally weak, as MSM who are found to be HIV positive would be strongly inclined to hide their sexual preferences due to social stigmatisation and partner tracing policies in most of the countries in Eastern Europe and Central Asia. Recent evidence from Russian surveys shows that most MSM are bi-sexual and more than one third had female partners in the last three months. The knowledge about critical HIV risk-reduction steps are low and consistent condom use is reported by less than a third of the interviewees. Around 20% of MSM engaged in sex for economic gain with mail and female partners.

While injecting drug use is currently responsible for three-quarters of HIV infections in Ukraine, more and more people (mostly women) appear to be contracting HIV through unsafe sexual behaviour and more pregnant women are testing positive for HIV. Meanwhile, very high rates of sexually transmitted infections continue to be found in Eastern Europe and Central Asia, increasing the odds of HIV being transmitted through unprotected sex.

Confronting AIDS

Historically, there is a cultural reluctance to confront AIDS. In many countries of the region, groups engaging in high risk behaviour are discriminated or even criminalised and the status of PLWHA may not be any better. The still low prevalence of HIV/AIDS in many countries of Eastern Europe and Central Asia and the limited governmental budgets for health and development create the environment for a low level of political awareness of the pandemic. However, recently Government officials asserted that their countries are working to improve national policy frameworks, placing increasing emphasis on promoting coordinated responses to the HIV/AIDS threat.

Predictions on development trends of the HIV/AIDS epidemic in Central Asia and Eastern Eu-

“I always use a condom when I do it: Take care of your health”. Cover of a pamphlet produced by a Ukrainian NGO with support from JHU/PCS. Source: Johns Hopkins Media/Materials Clearinghouse (M/MC), www.jhuccp.org/mmc/

rope depend largely on the spread of the infection from the current risk groups, mainly injecting drug users, to the general population. The window of opportunity to prevent a wide-scale epidemic is rapidly closing. A combination of critical factors fuel the rising HIV rates and provides a perfect breading ground for the spread of the HIV/AIDS pandemic in the region. Countries such as Ukraine and Russia are already beginning to exhibit changes in the dynamics of HIV infection. Without immediate intervention, the potential for a transition from a concentrated to a slower, more generalized form of the epidemic is imminent.
However, the epidemic is still at an early stage in the region and massive prevention efforts could curtail its scale and extent. Such efforts would require a comprehensive response to reduce risky sexual and drug-injecting behaviour among young people, and tackle the socioeconomic and other factors that promote the spread of the virus. An increasing number and variety of projects started from the mid 90s to work on sexual education, risk reduction in high risk groups and condom promotion.

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* *Contact: Manfred.Zahorka@unibas.ch*

Notes:
1. Incidence: Number of annual new cases in a previously disease free population.
2. Prevalence: total number of cases at a given point in time

Resources used and Selected Links
- *USAID HIV/AIDS site for Eastern Europe and Central Asia, www.usaid.gov/pop_health/aids/Countries/eande/index.html*
- *WHO page for the Department of HIV/AIDS, www.who.int/HIV_AIDS/first.html*
- *The world bank HIV/AIDS site www.worldbank.org/aids*
- *The Determinants of the HIV/AIDS Epidemics in Eastern Europe, MAP report 1998, www.hsph.harvard.edu/fxbcenter/MAPreports.htm*
- *UNAIDS HIV/AIDS update for Eastern Europe and Central Asia, www.thebody.com/unaids/update1201/eastern_europe.html*
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Carrying forward health sector reform in Tajikistan

Sharing responsibility for better health care

The Swiss Agency for Development and Cooperation supported “Health Sector Reform and Family Medicine Support Project” helps the Ministry of Health of Tajikistan to develop affordable and sustainable models for Primary Health Care and family medicine services, ensuring increased access for the poor. Activities concentrate on the two pilot rayons Dangara and Varzob. The project is designed to complement a World Bank financed PHC reform project and other projects focusing on the strengthening of family medicine services. SDC funded activities aim at increasing human resources capacities by enhancing staff skills and abilities rather than by making investments in infrastructure and equipment.

*By Kaspar Wyss and Mouazamma Djamalova**

Since independence in 1991, the Republic of Tajikistan was exposed to civil war, natural disasters, and economic failure. Results are the Republic being economically the poorest of the former Soviet states, with increasingly poor health outcomes. Although no definitive numbers exist, infant mortality rate, under-five mortality rate, and maternal mortality rate are very high and worse than in other countries of Central Asia. These are due principally to the high incidence of acute respiratory infections (ARI), diarrhoeae and parasitic diseases among children, as well as haemorrhage and eclampsia around delivery (a majority of women deliver at home without assistance through a formally trained health care provider). These indicators hide huge differences between rural and urban areas, with worse conditions in rural settings.
The health sector in Tajikistan puts emphasis on in-patient care with an important number of hospitals and doctors. In principle, services are being provided free, and are thought to be easily accessible through a network consisting of over 3,000 facilities. However, in reality most of the patients have to pay, be it through the purchase of their drugs and dressings in hospital, or through tipping of doctors. With a public expenditure of around US$ 2 per capita and per year corresponding to about 2% of the Gross Domestic Product, the health sector is completely under funded and of poor quality. It is generally acknowledged that health workers have an extremely low pay, are not well trained, and that there is a lack of medical equipment and drugs.

Supporting the health sector reform
Health sector reform is seen as a priority of the Government of Tajikistan. To achieve the reform, a comprehensive plan, the SOMONI plan, has been elaborated with the support of World Health Organization. Important elements of the reform are the strengthening of Primary Health Care (PHC) through the promotion of family practice models, a shift in budgeting and allocation

Photo: Kaspar Wyss

Medical house in Dangara district.

Photo: Nadim Jaganjac

Consultation in a family medicine service,
Varzob district, Tajikistan.

of public resources towards more regional equities and the rationalisation of services through a reduction in the number of facilities and hospital beds as well as the number of specialist doctors being trained in medical universities.
In the area of Health Sector Reform and family medicine, the Tajik Ministry of Health (MoH) is assisted by a series of bi- and multilateral donors and NGOs, among them, the Swiss Agency for Development and Cooperation (SDC) and the World Bank (WB). Activities funded by these two agencies assist Tajik efforts in carrying forward the health sector reform. Both agencies recognise that the combination of rapid economic change, resulting in a substantial decline in living standards, and the far-reaching changes resulting form the process of transition from a planned to a market economy, has highlighted the deficiencies of the existing health services at rayon (district) level. Particularly noticeable are the absence of efficient first contact services, and problems of access for poor people. A key challenge is to help to improve the equity of health services and their accessibility by developing PHC and family medicine services at district level.

The World Bank financed "PHC reform project" began its activity in August 2000 and is planned to last four years. There are four main components of the project:
(1) PHC development and staff training, including the development of curricula for family practitioners and nurses, the establishment of disease management protocols, the upgrading of teaching facilities and the retraining of physicians and medical personnel;
(2) Rationalization and development of health facilities, including the construction of around 30 new PHC facilities in the two pilot regions and the infrastructural strengthening of the cold chain for the vaccination program;
(3) Development of a methodology for funding health care at the oblast (regional) level, using a capitation system adjusted for age, sex and disease incidence; and
(4) Improvement in project management, consisting of training of staff in health sector management, and improvements in the health management information system. Project management is being handled by a Project Implementation Unit which assists the Ministry of Health in carrying forward the reform process.

The SDC supported "Health Sector Reform and Family Medicine Support Project" started in 2003 and has three objectives, which are:
(1) access to high quality PHC services is improved and tested models for health promotion are available;
(2) tuberculosis control using the DOTS strategy is designed and implemented in selected pilot areas;
(3) skills needed to plan, manage, monitor and evaluate health services are improved.
The project supports activities on both demand and supply sides and at various levels of government. On the supply side, the project works with the Ministry of Health to improve the way in which PHC services are delivered, by supporting the improvement of the skills of the providers, and by improved supervision and management. On the demand side, the project aims to work with communities and user groups to address the problem from the users' perspective. Community participation and the mainstreaming of HIV/AIDS and gender concerns are addressed as cross-cutting issues.

World Bank, SDC and Ministry of Health: Collaboration and complementarity

The World Bank and SDC supported projects collaborate closely with the Ministry of Health and especially with its Department for Planning, Coordination and Implementation ("Somoni group"). The tripartite agreement (SDC-MoH; WB-MoH; SDC-WB) stipulates that activities are, whenever possible, harmonised between the two projects. Joint half year monitoring and supervision missions involving the World Bank, SDC, the Swiss Tropical Institute as implementing agency on behalf of SDC, and the Tajik Ministry of Health are carried out.
Both projects concentrate activities in the same two pilot districts which are Dangara and Varzob. Furthermore, they closely collaborate at the level of the "Project Implementation Unit" on planning, managerial and administrative aspects of the projects.
While World Bank assisted activities having started earlier, the SDC funded project is designed to complement the on-going World Bank supported PHC reform project and other projects focusing on the strengthening of family medicine services. SDC assisted activities are also introducing new components in the area of the promotion of healthy lifestyle, monitoring and evaluation skills, TB control and DOTS, and mainstreaming HIV/AIDS and quality management into the Tajik reform process.
But more importantly: World Bank support are mostly used for investments in the health sector infrastructure, through the construction of new PHC facilities and a cold chain for vaccines, as well as PHC equipment including vehicles and computers. Based on this background, SDC assistance primarily focuses on investments in human resources ("humanware") and not hardware in order to ensure that Tajik health workers are skilled managers, administrators and health providers.

** Mouazamma Djamalova is trained physician with a post-graduate diploma in management and planning of health service delivery. Currently she is National Programme Officer at the Swiss Cooperation Office in Tajikistan. Kaspar Wyss is epidemiologist and public health specialist at the Swiss Centre for International Health of the Swiss Tropical Institute. He is coordinator of the "Tajik-Swiss Health Sector Reform and Family Medicine Project". Contacts: mouazam@swisscoop.tojikiston.com or kaspar.wyss@unibas.ch*

More on health sector reform in Tajikistan: European Observatory on Health Care Systems. Tajikistan – Health care systems in transition. European Observatory on Health Care Systems, 2000: 69 pages, download at www.who.dk/document/e69820.pdf

Würdig leben im hohen Alter

Sie sind alt, mittellos und haben kein familiäres Netz. Im Zentrum der Organisation Odamiyat in Duschanbe, der Hauptstadt Tadschikistans, finden betagte Menschen in Not Unterstützung. Sie erhalten Mahlzeiten und gesundheiliche Pflege. Freiwillige machen zudem Hausbesuche.

*Von Ania Biasio**

Während in den übrigen Ländern der Region der Übergang zur Unabhängigkeit nach dem Zusammenbruch der Sowjetunion weitgehend gewaltlos verlief, entbrannte in Tadschikistan 1992 ein bewaffneter Konflikt. Der Bürgerkrieg dauerte bis 1997, forderte Zehntausende von Todesopfern und machte Hunderttausende Menschen zu Flüchtlingen. Tadschikistan ist nun jenes Land in Zentralasien, das neben der sozialen, wirtschaftlichen und politischen Erneuerung einen labilen Prozess der Versöhnung und der Traumabewältigung durchläuft. Die unsichere Lage im Nachbarland Afghanistan stellt eine zusätzliche Belastung dar.

Über 90 Prozent Tadschikistans sind Berge, für den Anbau von Produkten wie Getreide oder Baumwolle stehen nur gerade sieben Prozent der Fläche zur Verfügung. In den Jahren 2000 und 2001 herrschte die schwerste Dürre seit 75 Jahren.

All diese Faktoren tragen dazu bei, dass Tadschikistan nach wie vor zu den ärmsten Ländern der Gemeinschaft Unabhängiger Staaten (GUS) gehört. Davon besonders betroffen sind die schwächsten Mitglieder der Gesellschaft: Alte, Behinderte, Waisen und Witwen.

Medikamente und Nahrungsmittel

Die beiden Ärztinnen Rosiamo Ashurova und Saodat Kamalova begannen im März 1996, Kriegsveteranen und betagten Invaliden in Duschanbe Betreuung anzubieten. Das war der Anfang vom «Humanitären Rehabilitationszentrum der Vereinigung Odamiyat».

1700 Personen besuchen heute das Zentrum regelmässig. Ziel ist, ältere Menschen ohne Familienanschluss und Einkommen zu unterstützen. «Gerade in der Hauptstadt gibt es viele Betagte ohne soziales Netz», sagt dazu Nicole Stolz, Tadschikistan-Programmkoordinatorin bei Caritas Schweiz. Odamiyat bietet im Zentrum medizinische Behandlungen und psychologische Beratungen an. Um Krankheiten vorzubeugen, verteilt das Zentrum Nahrungsmittelpakete und Hygieneartikel wie Seife und Zahnpasta.

Zusätzlich zum Zentrum betreibt Odamiyat eine Art Spitex-Dienst: 120 Personen besuchen rund 200 Betagte täglich zuhause, versorgen sie mit dem Nötigsten und unterstützen sie bei ihren Aktivitäten. Das Pflegeteam setzt sich aus staatlich angestellten Sozialarbeiterinnen und -arbeitern und aktiven Freiwilligen zusammen.

Odamiyat ist auch dafür besorgt, dass die Betagten ihre Rechte kennen und durchsetzen können. Eine Rechtsanwältin bietet im Zentrum täglich Konsultationen an. Die Organisation betreibt zudem Lobbyarbeit für die Betagten und ist zum Beispiel im «öffentlichen Rat» des Präsidenten Rachmonow vertreten. Zudem besteht eine enge Zusammenarbeit mit staatlichen Institutionen wie Polykliniken und dem Sozial- und dem Gesundheitsdepartement des Distrikts.

Photo: Caritas Schweiz

Nur wenig zum Überleben.
Besuch bei einem alten Mann in Duschanbe.

Photo: Peer Appius für Caritas Schweiz

Nur im Zentrum Odamiyat erhalten mittellose alte Menschen nicht nur zu essen, sondern auch Beratung und Betreuung.

Rente reicht nicht zum Überleben

«Die Situation von allein stehenden Betagten in Duschanbe hat sich seit Projektbeginn nicht gross verändert», bilanziert Nicole Stolz. «Nach wie vor gehören die Betroffenen vor allem den ethnischen Minderheiten an, es handelt sich zum Beispiel um Russen, Tataren, Ukrainer oder Deutsche. Doch der Schwerpunkt der Dienstleistungen von Odamiyat hat sich leicht verschoben. Die psychosoziale Komponente ist wichtiger geworden. Das heisst, dass mehr Zeit für Gespräche mit den Betagten zur Verfügung steht oder dass die Möglichkeit geboten wird, aktiv bei der Pflege von anderen Betagten mitzuwirken. Vermehrt kommen auch alternativ-medizinische Methoden zur Anwendung, zum Beispiel Akupunktur oder Kräutermischungen für Bäder und Tees.»

Im Prinzip wäre die Altersvorsorge Sache des Staates. Tadschikistan bietet Männern und Frauen ab 60 Jahren zwar eine monatliche Rente. Meist beträgt sie aber nur gerade fünf bis sieben Somoni, was rund drei bis vier Franken entspricht. «Im Gegensatz zu den Zeiten der Sowjetunion reichen die Altersrenten nicht mehr zum Überleben», erklärt dazu Nicole Stolz. «Das Bewusstsein für die Lage von älteren Leuten ist zwar gewachsen, doch die Situation von Rentnerinnen und Rentnern ohne Familienanschluss bleibt kritisch. In solchen Fällen ist Überlebenshilfe wie jene von Odamiyat dringend nötig.»

** Wiederabdruck eines Beitrags von Ania Biasio in der Caritas-Zeitung NR. 1/2003, mit leichten Modifikationen. Weitere Informationen zu Odamiyat finden sich auf der Website von Caritas Schweiz: http://web.caritas.ch/pdf/weka/Tadsch_D_Wuerdig.pdf, Caritas Schweiz dankt für die Spenden auf das Konto 60-7000-4, Vermerk Odamiyat.*

"Under Construction"

The past decade of economic, political and social transformation has severely affected Ukraine's health services and the health status of the population. An Ukraine – Swiss cooperation aims at facilitating the changes necessary to achieve international standards.

*By Andrei Solodarenko and Martin Raab**

In 1991, Ukraine began moving towards building an independent state. The country declared its intents to the world community to build a democratic society based on a market economy and social guarantees for the population.

In the first decade of its independent history, Ukraine, like nearly all former USSR republics, had experienced a persisting and painful crisis caused by the dismantling of former political and socio-economic structures. The crisis was certain to affect the health care system as well. The most 'telling' implications of the deteriorated situation had been a strong increase in morbidity and mortality.

The striking rise in Ukrainian mortality is beyond the peacetime experience of industrialised countries. Many factors appear to be operating simultaneously, including social instability, high rates of tobacco and alcohol consumption, poor nutrition, depression and a deterioration of the health care system. Overall, cardiovascular diseases, infectious diseases (pneumonia, tuberculosis) and injuries (motor vehicle crashes, suicides, homicides) account for most of the mortality increase. Of particular concern is the high incidence of HIV-infection which ranks top among the Eastern European countries. Another major source of concern is the significant decrease in birth rates.

Maternal and child health in focus

Amongst current problems in maternal and child health (MCH) of Ukraine, sterility comes to the front (currently there are around 1 million sterile married couples in Ukraine), as well as miscarriages and premature births (nearly 10%), a high number of "pathological pregnancies" (1 in 3), maternal mortality, birth defects, birth trauma and other neonatal disabilities. The rural areas are confronted with insufficient health services such as inadequate efficiency of family planning services, perinatal screening, vaccination, lack of general practitioners-paediatricians and problems with transportation of neonates to hospitals. Disease prevention and health promotion activities are funded inadequately.

Since independence, the country reaffirmed its adherence to UN fundamental declarations and instruments on human rights (e.g. UN Convention on the Rights of the Child), with a right to health services being a key one. Ukraine approved a number of legislative acts designed to address the most critical health issues and committed itself to reform the health system (including MCH). Up to now, a number of Presidential Decrees have been issued to improve MCH. Also, a law "On Child Welfare" was adopted in 2001. As a result, several national programmes have been implemented or are still under implementation ("Family Planning", 1995; "Children of Ukraine", 1996; "Genetic Monitoring", 1999; "Reproductive Health", 2001, etc.).

Despite all these efforts, the results are far below the expectations of politicians, health professionals and the population. One obvious reason for this is inadequate funding of the health system. Another important reason that impedes health system reforms and improvement are inadequate management skills and capacity. Parallel service structures, irrational utilisation of resources (e.g. equipment, pharmaceuticals, facilities, personnel), the disproportion between urban and rural health services, and weakness of health

Photo: STI/SCIH

Proper diagnosis is essential for effective treatment and economic use of resources.

information systems and related meaningful statistics are all factors that limit health system performance.
In order to succeed in reforming maternal and child health services, a combination of prerequisites is needed: the availability of a modern legislative framework, sufficient funding, a well trained workforce, an appropriate infrastructure, an adequate supply of materials and drugs as well as adequate management systems including modern quality assurance systems.

Maternal and child health services: A slow but steady improvement

Despite all the problems listed above, the situation for maternal and child health services is not static and decision makers and health professionals are making constant efforts to improve the system. Some indicators are listed to document a positive trend in health outcomes:

- Neonate mortality rate (per 1000 live births): 14,7 (1995) – 11,3 (2001)
- Perinatal mortality rate (per 1000 births): 14,2 (1990) – 11,3 (1998) – 6,6 (2000)
- Infant mortality rate (per 1000 live births): 12,2 (1995) – 9,6 (2001)
- Number of abortions: 1 million (1990) – 0,4 million (2001)

Economically, there have been positive developments in recent years. Ukraine ranks first among the Eastern European countries in terms of GDP growth rate. As the national economic indicators increase, so will health funding capacities.
The Ukrainian health system is financed through two major funding sources: a central budget and local or regional budgets. The central budget finances programmes with a high national priority, e.g., vaccination, diabetes, tuberculosis, oncology, haematology, AIDS control. The local budgets add funding to national programmes and cover the running costs for the local health services. However, it is obvious that these current domestic funding sources are not sufficient. Health insurance systems have not yet been introduced.
The Ukrainian MCH system receives assistance through international cooperation programmes and maintains partnership relationships with international bodies such as UNICEF and WHO. The UNICEF "Breast Feeding" programme had a significant positive impact on neonatal health indicators.

Ukraine – Swiss collaboration: Towards a multi-centred project

The Swiss Centre for International Health (SCIH) of the Swiss Tropical Institute (STI) can look back on five years of collaboration with Ukrainian partners, mainly with the Ministry of Health. In 1997, a project financed by the Swiss State Secretariat for Economic Affairs (seco) was launched to improve neonatology services in the five regions of Kiev, Ivano Frankievsk, Rivne, Volyn and Donetsk. In the scope of this project, appropriate clinical equipment for 141 first, second and third line health facilities was procured. Also, a number of clinicians and nurses received training in Switzerland and Poland. This project succeeded in increasing the capacities and the quality of services for new-borns.
In 2001, a new project, financed by the Swiss Agency for Development and Cooperation (SDC), was started to build on the achievements of the neonatology project. Whereas the neonatology project had a strong bias on hardware and infrastructure, a new follow-up project, the Perinatal Health Programme, was designed to include further aspects that impact on mortality and morbidity of new-borns. As a result, a multi-centred project combining the fields of neonatology, obstetrics and gynaecology was set-up and agreed upon.
The principal components of the Perinatal Health Programme focus on knowledge and "Skills Upgrading" for clinical staff, on disease prevention and health promotion, on public health training, on appropriate equipment and maintenance systems and on health systems management.
Work is underway on many "construction sites" such as the development of clinical guidelines, the conception of a training plan for clinical and public health training, the implementation of campaigns for healthier lifestyles, the improved integration of neonatal and obstetric services and the set-up of medical equipment maintenance systems. Also, an innovative telemedicine approach to engage a partnership between a Swiss and a Ukrainian hospital will be conceptualised and tested. An internet based telemedicine platform will be used to exchange information and diagnostic images, to get a second opinion and to diagnose diseases.

Photo: STI/SCIH

Setting the course of action: Participants from all participating regions and institutions take part in a project planning seminar.

Different cultures, different views

The first neonatology project was more straightforward in the sense that agreement concerning approaches and strategies between the two partner sides was relatively easy to reach due to the bias towards hardware orientation and the limited number of training courses. The new Perinatal Programme is different since it focuses much more on training contents, on behavioural issues, on quality standards of health services and directions of reforms. All those issues imply change in the way of practising medicine, of planning and managing systems, and of setting priorities. Naturally, the Swiss and Ukrainian partners have different views reflecting their different cultural settings and socio-economic backgrounds. During the first year of implementation, it became therefore clear that an intense dialog between Ukrainian and Swiss experts was required to agree on common approaches, strategies and ways to tackle problems. This ongoing process is rarely an easy one – but definitely challenging and stimulating for both sides.

** Andrei Solodarenko is the head of the Project Implementation Office for the Swiss-Ukrainian Perinatal Health Programme. Martin Raab is a scientific collaborator at the Swiss Centre for International Health (SCIH) of the Swiss Tropical Institute (STI) and the project manager for the Perinatal Programme. Contact: http://www.sti.unibas.ch/personel/RAABM.htm.*

Quite an unhealthy environment

Prisoners very often originate from the most vulnerable groups of society: the poor, the mentally ill, those dependent on alcohol or drugs. These groups have an increased risk of diseases such as tuberculosis (TB) already before entering the penitentiary system. Once in prison, the risk of being infected or falling sick is amplified by poor living conditions, overcrowding, poor ventilation, poor nutritional status, physical and emotional stress, including an atmosphere of violence, humiliation and disempowerment. Since TB is transmitted by airborne spread of infectious droplets, tuberculosis thrives in prisons, where inmates share rooms with many others and overcrowding is a prominent problem. Prisons are also a locus of HIV infection, a significant risk factor for acquiring and developing TB and for dying of TB.

*By Manfred Zahorka**

Photo: Sergei Gitman © 1998 PHRI, Photo quoted from www.who.int/gtb/policyrd/TBPrisons.htm

Prisons provide ideal conditions for the spread of Tb through overcrowding, poor ventilation, weak nutrition, inadequate or inaccessible medical care and others.

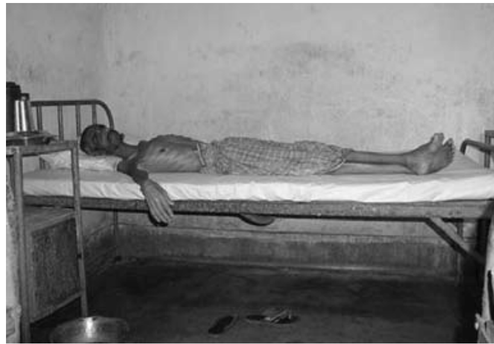
An estimated number of 8 to 10 million people are incarcerated on any given day world wide and their numbers are increasing. Since many are detained for short periods of time, the rates of admissions and releases are almost equivalent so that the actual number of people passing through the prison system each year is potentially four to six times higher. Prisoners are mostly male (90 to 95% worldwide) and young. Russia has the world's highest per capita prison population with 690 prisoners per 100 000 population closely followed by the United States with approximately 630 prisoners per 100 000 inhabitants. In most low-income countries prisons are full beyond capacity, with prisoners from impoverished unhealthy backgrounds living in an even unhealthier environment.

Prison health is often forgotten or given a low priority. Prisoners are stigmatised, hidden and rendered voiceless. The public is often ambivalent about providing quality care to those accused or convicted of wrongs against society, particularly where national resources are scarce due to the economic decline during the post soviet period.

Thus, prison health services generally have serious shortcomings. Under-funding and demoralisation are common. In many transition countries, rates of active tuberculosis amongst prisoners are known to be up to 50 times higher than the rates in the civilian population. It is estimated that Russia has approximately 75 000 new TB cases annually for a civilian population of 150 million, whereas in the Russian penitentiary system 40 000 new TB cases are registered annually for a population of only 1 million. Approximately 10% of the one million detainees in Russia have active TB.

In most cases health care in prisons is under the responsibility of the ministry in charge of prisons, usually the Ministries of Justice, and not of the Ministry of Health. This results in different authorities being responsible for the health of an individual arrested, detained and eventually released, with little co-ordination between them. The number of TB cases in prisons is often not included in the data of the ministries of health, even though in many countries prisoners with TB form a considerable proportion of the overall number of cases.

Tuberculosis is a major cause of sickness and death in prisons. Directly or indirectly, these threats apply not only to prisoners, but also to all who come into contact with prisons and ultimately the community as a whole. Prison gates may be closed for prisoners. However, they cannot stop infectious droplets to penetrate into the outside world. Prisons act as a reservoir for TB, pumping the disease into the civilian community through health personnel, staff, visitors, and inadequately treated released inmates. Too often prisoners and former inmates fall through the gaps in the provision of health care. For instance, in Russia approximately 13 000 prisoners under treatment for TB are released every year. But only 7 000 to 8 000 of them seek treatment once in freedom. In many cases, released prisoners cannot afford to pay for drugs and services, which officially are still given out free, but for which in reality unofficial user fees have been introduced. Stopping TB treatment before the completion of the full course often results in the development of drug-resistant tuberculosis, which needs even more complex treatment protocols at prohibitive cost.



Health care in prisons is often forgotten or has low priority.

TB is not contained within the prison system. The infection can easily spread through released inmates with uncompleted treatment cycles and contact persons of infected prisoners.

Photos: Bangladesh 2001, WHO/TBP/England. Source: Stop TB partnership image library

With so many TB cases in prison and with such a high rate of imprisonment, it is not surprising that tuberculosis has become the single leading contributor to increased mortality among young Russian men. TB has spread rapidly in Russia and the former Soviet States over the past decade. In Russia, for example, TB incidence – the number of new cases in a previously healthy population in a given time period – is climbing by 10% every year.

There are many obstacles to effective treatment of TB in prisons. An unofficial internal hierarchy exists frequently within the prison population. The rules and laws within this system have direct implications for the control of TB. Unfair selection of patients for treatment and trafficking of medicines can occur. Patients in the lower strata of the hierarchy may be pressurised by their bosses to hand over their TB drugs. Other patients may sell their drugs to the guards, give them to their relatives during family visits or use them as currency for gambling or for paying their debts. Poorly paid prison health staff may tolerate exchanges of sputum, taking bribes from wealthy prisoners. Some prisoners may avoid diagnosis because they are afraid their release may be held up until they complete treatment. Other inmates may try to get on TB programmes even if they do not have the disease or may deliberately expose themselves to infection, because of the perceived – and in some cases quite real – benefits of better care in a hospital. Education of patients is difficult in prisons. Prisoners have more immediate worries than the allusive dangers of not receiving a full course of treatment.

Communication between prison health services and civil TB programmes is lacking. Together with the stigma of coming from a prison, this lack of communication makes it difficult to ensure that released inmates can continue treatment when released. There also is a lack of information to prisoners about availability of TB services in the civil society. Additionally, adequate treatment is not always available or financially accessible. Amnesties, such as the release of nearly 350 000 Russian prisoners in March 2001, may pose a huge burden on the public health system due to the sheer number of people suddenly in need for TB treatment and make collaboration between the prison and the civilian TB programmes even more important.

Tuberculosis control in prisons is a public health urgency. Governments have an obligation to provide minimum levels of health care, accommodation and food for every prisoner. Health service providers should recognise the disproportionate health needs of prisoners, and services should be provided on the basis of equity or at least equivalence. TB treatment in prisons should follow the widely recognized WHO standards (Directly observed treatment, short course; DOTS). However, considering the special prison conditions some additional precautions have to be taken.

TB control in prisons demands firm political support, strong leadership, and adequate financial resources. International resources and expertise is needed in support to overcome the serious problem of TB in prisons. In terms of case detection, the usual case finding through self-referral should be complemented by active case finding (cases are actively sought by TB services) and screening on entry to prison. Giving of sputum should be directly observed so that trade with sputum samples does not occur.

Many TB patients find adherence to treatment difficult. This is even more the case in prisons, where generally the environment is not supportive and problems such as alcohol/drug abuse and psychiatric diseases are more common. TB education should be part of an integrated package of health education and health promotion for prisoners. Issues such as HIV/AIDS prevention, prevention of drug abuse, alcoholism and violence need to be included. It is crucial that not only prisoners with TB, but also healthy prisoners, staff, visitors and policy makers are well informed about the disease and the necessity of early detection and complete treatment. Peer educators can play an important role in educating patients. Cured TB patients or their relatives can often be more convincing and committed than health personnel.

**Manfred Zahorka is a family practitioner, public health expert and epidemiologist by training. He has been working for more than 15 years in public health and health systems development in developing and transitional countries in Eastern Europe, Central Asia and Africa. Currently, he is working with the Swiss Centre of International Health within the Swiss Tropical Institute in Basel. Contact: Manfred.Zahorka@unibas.ch*

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Heilpädagogische Aufbauhilfe und Integrationshilfe für behinderte Kinder

Eine traurige Erfolgsgeschichte aus Rumänien

Der erste und wohl bleibende Eindruck von Rumänien nach der Wende 1990 wurde bei vielen Menschen geprägt durch die entsetzlichen Bilder aus den Kinderheimen der Ceausescu-Zeit, welche über unsere Medien verbreitet wurden. Die westliche Welt stellte mit Entsetzten fest, dass ein kommunistisches Regime einen Teil seiner Kinder in Heimen versorgt und wie Tiere behandelt hatte. Die Gründe, warum diese Heime entstanden, waren erschreckend und vielseitig, sollen hier jedoch nicht thematisiert werden. Doch soviel sei bereits gesagt: Obwohl sich in den letzten 12 Jahren vieles positiv verändert hat, ist der Anblick vieler rumänischer Kinderheime und Sonderschulen für unsere Augen immer noch schwer zu ertragen.

*Von Anita Gerig**

Damals, nach der Wende, wurden vom Westen aus unzählige Hilfstransporte organisiert, Heime renoviert und auf diese Weise die Lebensbedingungen in vielen Kinderheimen und Schulen verbessert. So nötig diese Hilfe war und immer noch ist, der grösste Mangel in diesen Institutionen ist das Fehlen von heilpädagogischem, didaktischem und psychologischem Wissen. Während der Diktatur von Ceausescu waren Ausbildungen in dieser Richtung strikt verboten. Ein trauriger Nebeneffekt dieses Bildungsvakuums war auch, dass die schlecht bezahlten Angestellten sozialer Institutionen ihrer Arbeit oft völlig desinteressiert nachgingen.

Weiterbildung von Fachpersonen: Lohnende Investition in «Software»

HEKS hatte sich daher bereits 1993 entschieden, nicht in Hardware (Renovation von Heimen) sondern in Software (Ausbildung) zu investieren. HEKS ging schon damals vom Grundsatz einer nachhaltigen Entwicklung aus, in der Bildung eine entscheidend wichtige Rolle spielt. Das Heimpersonal und die LehrerInnen von Sonderschulen sollten eine Möglichkeit erhalten, die fehlenden heilpädagogischen Kenntnisse nachzuholen. Ziel war es, ein Netzwerk von Fachpersonen in Rumänien aufzubauen, um das neu erworbene Wissen weiterzugeben.

Um dieses Ziel zu verfolgen, gründete HEKS 1993 die zwei heilpädagogischen Vereine HELP und Pro Educatione. Die Vereine haben ihren Sitz in den Hauptstädten der siebenbürgischen Distrikte Covasna (St. Gheorghe) und Brasvo (Brasov). Es sind lokale Vereine, die selbstverantwortlich die Schwerpunkte ihrer Arbeit festlegen. HEKS übernahm die Rolle der Geburtshelferin und unterstützt seither die Arbeit der beiden Vereine finanziell und ideell.

Seit der Gründung wurden von beiden Vereinen rund 45 einwöchige Kurse durchgeführt. Während die Vereinspräsidentinnen für die Kursorganisation zuständig sind, werden für die fachliche Leitung vorwiegend ausländische Fachkräfte eingesetzt. Pro Kurs werden rund 15 bis 20 LehrerInnen, vorwiegend Frauen, aus Sonder- und Regelschulen und aus Heimen angesprochen. Sie können einen oder mehrere Kurse pro Jahr besuchen. Die Kurse werden durch Donationen des HEKS und zusätzlich durch einen bedeutenden Input der beteiligten ausländischen KursleiterInnen aus der Schweiz, Österreich und den USA getragen. Die rumänischen LehrerInnen können mit einem kleinen Beitrag Vereinsmitglieder werden; die Mitgliedschaft ist aber nicht Voraussetzung für die Teilnahme an Kursen. Die Mitgliederbeiträge sind sowieso nicht kostendeckend. Die sehr praxisorientierten Kurse sind oft als Fortsetzungskurse konzipiert und stossen auf grosses Echo. Sie bilden für die LehrerInnen oft die einzige Möglichkeit, sich didaktische und pädagogische Methoden anzueignen.

Photo: HEKS-Fotoarchiv

Heilpädagogische Aufbauhilfe im Kinderheim St. Gheorge.

Ein wichtiges Element in der Zusammenarbeit bilden Praktika im Kanton Bern, wo bisher für insgesamt 40 LehrerInnen ein drei- bis vierwöchiges Praktikum bei Schweizer Lehrkräften ermöglicht wurde. Neben der erworbenen fachlichen Ausbildung sind auch die persönlichen Kontakte für die rumänischen Partnerinnen von grosser Bedeutung.

Die Weiterbildung von Fachpersonen kommt einer grossen Zahl von leicht bis mittelschwer behinderten Kindern zugute. Diese Form der Unterstützung, die zu einer grossen Selbständigkeit der Partnerinnen und zu einer Weitergabe des Gelernten beiträgt, ist für das heutige Rumänien zukunftsträchtig; nicht zuletzt auch, weil als wichtige Voraussetzungen für einen EU-Beitritt Rumäniens die Verbesserung der Verhältnisse behinderter Kinder gefordert wird.

Vom Regen in die Traufe?

Auch wenn die 2. EU-Osterweiterung, bei der Rumänien möglicherweise aufgenommen wird, in weiter Ferne ist, unternimmt der rumänische Staat alle erdenklichen Anstrengungen, gewisse Bedingungen rund um behinderte Kinder und Heimkinder zu erfüllen. Es sind leider oft Ansätze, die von besser funktionierenden westeuropäischen Sozialsystemen übernommen werden und in Rumänien ohne Begleitmassnahmen umgesetzt werden. So sollen beispielsweise Kinderheime ganz aufgehoben werden; Waisenkinder sollen direkt in Pflege- oder Adoptivfamilien gebracht werden. Ob genügend Pflegeplätze vorhanden sind und was mit den Kindern geschieht, die in den Heimen leben, ist noch unklar. Trotzdem werden LehrerInnen bereits aus den Heimen zurückgezogen.

Überhaupt hat der beschwerliche Weg vom Kommunismus zur freien Marktwirtschaft dazu geführt, dass sich die Lebensqualität für die Mehrheit der Bevölkerung verschlechtert hat. Vielleicht am meisten betroffen sind Familien mit behinderten Kindern. Die Unterstützung, welche diesen Kindern von Seiten der staatlichen Institutionen zukommt, ist in allen Bereichen unzulänglich. In vielen Fällen verschlechtert sich der Zustand des Kindes, weil die Familie wegen Armut und Ignoranz keinen Zugang zu Informationen hat. Die Sozialisierung und Integration behinderter Kinder wird unter solchen Umständen immer schwieriger.

Vor diesem Hintergrund stehen auch die Partnerorganisationen des HEKS vor ganz neuen Herausforderungen. So muss aufgrund einer auf Schulbeginn 2002 wirksamen Gesetzesänderung ein Teil der Kinder mit Lernbehinderung in die Regelschulen integriert werden. Diese Form von Koedukation wird in EU-Ländern immer häufiger praktiziert und ist grundsätzlich auch richtig. Nur wurde in Rumänien dieses Gesetz ohne Begleitmassnahmen für Kinder, Eltern oder LehrerInnen rechtskräftig. Die LehrerInnen der Sonderschulen befürchten nun, dass behinderte Kinder, welche die Schule wechseln müssen, nach kurzer Zeit dem Unterricht fern bleiben, weil sie dem Stoff überhaupt nicht folgen können und von den restlichen Kindern nicht akzeptiert werden.

Photo: HEKS-Fotoarchiv

Kinder im Kinderheim St. Gheorghe.

Die frei gewordenen Plätze in den Sonderschulen werden durch schwer behinderte Kinder aus den Heimen besetzt. Das bedeutet, dass LehrerInnen der Sonderschulen plötzlich mehrfach behinderte Kinder unterrichten müssen. Auch dies ohne Begleitmassnahmen oder angepasstes Lehrprogramm.

Heilpädagogisches Ambulatorium in Brasov: Erfolgreich in die Lücke

Der Verein Pro Educatione in Brasov setzte sich schon seit längerer Zeit mit diesen Problemen auseinander und kam zum Schluss, dass ein heilpädagogisches Ambulatorium eine Möglichkeit bieten würde, diese schwierige Situation etwas abzufedern. Dank langjährigen Kontakten zu einem heilpädagogischen Ambulatorium in der Schweiz, wo zwei LehrerInnen des Vereins Pro Educatione ein Praktikum absolviert hatten, reifte die Idee langsam heran, selber in Brasov ein Ambulatorium zu eröffnen. Durch die erwähnte Änderung in den Sonder- und Regelschulen wurde die Idee konkret und die Umsetzung in die Hand genommen. So hat sich auch HEKS entschlossen, das Projekt des heilpädagogischen Ambulatoriums in Brasov mit einer Zusatzleistung von jährlich Fr. 40 000.– in der Pilotphase von vier Jahren zu unterstützen.

Noch Ende letzten Jahres konnte eine geeignete Wohnung gefunden und renoviert werden, so dass die Arbeit im Ambulatorium losgehen konnte: Die ersten Klienten sind in die Regelschule integrierte ehemalige Sonderschüler, die im Ambulatorium gezielte Förderung erhalten. Mit einbezogen in die Arbeit werden auch die Eltern, da viele Kinder aus sehr armen Familien mit geringem Bildungsniveau kommen. Auf einer zweiten Ebenen wird heilpädagogische Beratung und Unterstützung für RegelschullehrerInnen angeboten, damit diese den Umgang mit behinderten Kindern in ihrer Klasse lernen können. Es wird auch entsprechendes Unterrichtsmaterial zur Verfügung gestellt.

In einem zweiten Schritt sollen auch Kinder aus dem Kindergarten im Ambulatorium betreut werden. Dadurch sollen Kinder mit Verhaltensauffälligkeiten, Lernschwierigkeiten oder anderen psychosozialen Problemen frühzeitig erkannt und deren Absonderung verhindert werden.

Für den Verein Pro Educatione – und in gewisser Weise auch für HEKS – ist die Geschichte des heilpädagogischen Ambulatoriums in Brasov eine Erfolgsgeschichte. Für den Zustand des rumänischen Sozial- und Gesundheitswesens sollte es ein Alarmzeichen sein, da diese eigentlich staatlichen Aufgaben nicht wahr genommen werden. Und so lange die Armut in Rumänien so gross ist, dass Eltern nicht einmal das Busbillet zum Ambulatorium selber bezahlen können, so lange wird es sozial behinderte Menschen geben, die auf die Unterstützung aus dem Ausland angewiesen sind.

** Anita Gerig ist Programmbeauftragte für Rumänien beim Hilfswerk der Evangelischen Kirchen Schweiz HEKS. Kontakt: gerig@hekseper.ch. HEKS war bereits vor der Wende 1990 in Rumänien aktiv. Diese Kontakte konnten nach dem Umbruch genutzt werden, um sofort mit der Aufbauhilfe zu beginnen. Heute arbeitet HEKS mit einem Länderprogramm in den Bereichen Soziales Engagement, Zwischenkirchliche Hilfe, Nothilfe, Ländliche Entwicklung und Empowerment (Stärkung der Zivilgesellschaft). Mehr Informationen zu den Projekten finden Sie unter www.heks.ch. HEKS PC 80-1115-1; Heilpädagogische Integrationshilfe Rumänien Projekt Nr. 942336*

Health Care Reform in Romania: Reorganisation of Neonatology Services

Under pressure…

Based on a request of the Romanian Government the Swiss Agency for Development and Cooperation (SDC) supports the Romanian Swiss Neonatology Project (RoNeonat) aiming at the reduction of neonatal mortality in Romania.

*By Manfred Zahorka**

Photo: STI/SCIH

Newborn room in an obstetrics department in a level 1 institution. Resources are limited at that level in Romania.

Romania had a well organized health system based on the Bismarckian sickness fund model during the first half of the 20th century. Due to its limited coverage the system was changed since 1949 to a state run health system with universal coverage resembling the system used in the Soviet Union characterised by government financing, central planning, rigid management and a state monopoly over health services. As the private system was abolished all professionals in the health system had the status of salaried civil servants. The absence of competition or individual initiative lead to a highly regulated, standardized and centralized system operated through the Ministry of Health. The typical problems of such systems, such as the poor quality of first level services, inadequate referral and the overemphasis on hospital-based curative services with lack of good equipment and drugs and centralized and inequitable allocation of resources can be felt up to today.

Since the revolution of 1989, Romania has gone through a period of rapid and major change in every sector. The Romanian political system was changed, moving the country from a soviet style system in the direction of liberal-democracy. Economic reform has been rather gradual and many business have been left under state control. Health care reform started in the early 1990s with major organisational changes taking place since 1995. Social and Health Insurance was re-instated and a restructuring of hospital organisation transferring the state owned, tax based system into a more decentralized and pluralistic social health insurance system, with contractual relationships between health insurance funds as purchasers and health care providers.

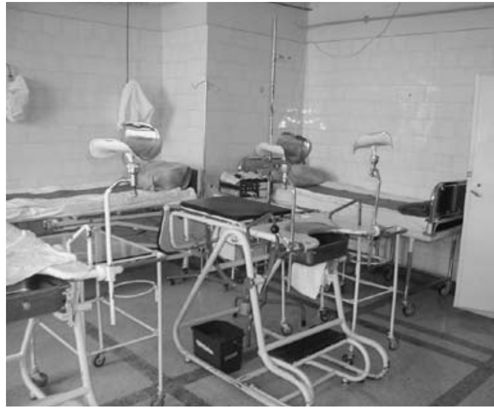
The health status of the Romanian population has steadily declined since the 1960s relative to the rest of Western European countries. Life expectancy at birth is five years lower than in Western Europe with a huge variation between Bucharest (1.5 years above national average) and the eastern part of the country (2.5 years below national average). The part of the population living in absolute poverty is among the highest in the European Union. Infant mortality (20.5 per 1000 live births in 1998) is almost three times higher than in Western Europe. Maternal mortality (40.5 per 100,000 live births) is six times the EU average despite a huge decline since 1990. Tuberculosis is on the rise and HIV/AIDS particularly in children is a huge problem. However, the number of new HIV cases has declined in recent years due to the end of a number of unsafe medical practices in children's foster homes.

Focus on the newborn: The Romanian Swiss Neonatology Project

The health situation of the newborn depends on a variety of factors. These include not only health systems related and clinical issues but also socio-economic, knowledge based and attitudinal factors. Preventive measures including health education for couples and a thorough follow up of pregnant women are insufficient leading to a high percentage of premature births requiring specialised intensive care. Perinatal services in Romania are under particular pressure suffering from a lack of specialised equipment and training at all levels of service delivery, insufficient collaboration between obstetricians and neonatologists, a weak organisational framework in terms of referral systems and a non-existent emergency transport system for neonates in many areas outside of the capital. The quality of neonatal services in Romania varies largely between the three levels of health care delivery: level I as the entry level, level II as the intermediate level and level III as the referral centre of a region. Whereas all levels suffer from a lack of qualified staff and equipment, the situation is much worse at the lowest level of care. Often there is no staff trained in neonatology at all and immediate care for the neonate at risk is provided by obstetricians. Management of at risk pregnancies with a threat for premature delivery is weak so that a referral of mothers with children in utero is often not possible. Transport facilities for neonates under intensive care conditions are hardly available. Where the necessary equipment is available, often needed consumables are in shortage or missing totally. Financial resources provided through national and regional insurance houses are frequently insufficient or released late so that procurement costs cannot be met in time.

The Romanian Swiss Neonatology Project supported by the Swiss Agency for Development and Cooperation (SDC) aims at the reduction of neonatal mortality in Romania. Following a needs assessment and a thorough analysis of Romanian health indicators the modernisation of the Romanian neonatology system was identified as the key objective the project would have to achieve. Two Romanian regions were selected for project implementation: Iasi will host the referral centre for the Moldavia region including the departments of Iasi, Neamt and Vaslui. The three departments combine a population of 2 Million inhabitants with more than 17,000 neonates in 2001. Tirgu Mures will host the referral centre for the Transylvania region including Mures and Harghita. The two departments have a combined population of 1 Million inhabitants with nearly 10,000 neonates in 2001. The two regions serve as model areas with the option to implement successful strategies in the rest of the country through other independent projects. In every region all levels of neonatology service provision (levels I to III are included in the project) will be addressed. The following elements will lead to a modern system of neonatology curative and preventive care:

Training of neonatology staff will be done in a step down manner beginning with a training of trainers in Swiss university clinics. Physician and nurse teams are trained to share the acquired knowledge in a step down process with their colleagues. Local training will be facilitated through the establishment of regional training centres. Training will improve the neonatology care at all levels. Selected equipment items to complement existing equipment and to operationalise neona-



Delivery room at a level 1 obstetrics department in East Romania.

tology care centres will be procured together with a basic set of spare parts. The selection of equipment will be done through a participatory process and based on needs assessment, sustainability criteria and adaptedness to the local environment and to match the skills acquired through training. The development and application of clinical guidelines and procedures based on the acquired skills and the procured equipment will complete a comprehensive improvement of quality of care package. The ability to evaluate quality is an essential part of quality assurance. For neonatology services long term effects of neonatal and intensive care are important aspects of quality. The project will implement a long term follow up system to capture not only physical but as well cognitive and psychological development of children who underwent intensive care treatment.

Although in principle the best and safest way of transporting neonates at risk is to transfer them to specialised centres, when they are still in their mother's womb, the organisation of a transport system for neonates remains an important factor in the referral system. A reorganisation of the transport facilities including the procurement of some transport equipment for neonates under intensive care conditions will be undertaken.

Preventive measures and information campaigns will be undertaken to reduce the number of pregnancies at risk including premature birth and to motivate women to participate in prenatal visits. The collaboration between family practitioners, obstetricians and neonatologists will be strengthened to create a continuum of care for mothers and newborns.

Through its first steps the project initialised the regionalisation of neonatology facilities in the implementation area defining clearly the referral structures including the type of services to be delivered at each level and thereby targeting sparse funds in an effective way. Currently the training of trainers has started in Switzerland to prepare the necessary subjects for step down training and to develop the necessary curriculum. The rehabilitation of neonatal facilities involved in the project has started as well.

The RoNeonat project is met with high expectations from the Romanian side as it is highly innovative for the Romanian context and it re-establishes a focus on decentralised high quality care and a public health focus on infant morbidity and mortality.

**Manfred Zahorka is a family practitioner, public health expert and epidemiologist by training. He has been working for more than 15 years in public health and health systems development in developing and transitional countries in Eastern Europe, Central Asia and Africa. Currently, he is working with the Swiss Centre of International Health within the Swiss Tropical Institute in Basel. Contact: Manfred.Zahorka@unibas.ch*

Resources

- *Health Care Systems in Transition, Romania Country Report, European Observatory on Health Care Systems Series, 2000, www.euro.who.int/observatory*
- *Kreditantrag Nummer 77/2002-08-14, Rumänien, Direktion für Entwicklung und Zusammenarbeit, Eidgenössisches Departement für auswärtige Angelegenheiten*

Die Bedeutung von HIV/Aids in Bosnien-Herzegowina

Was ich nicht weiss…

In Bosnien-Herzegowina, einem Staat mitten in Europa, ist die Infektionskrankheit HIV/Aids heute noch ein Tabu wie ehemals in manchen Ländern der Dritten Welt. Die zugänglichen Daten weisen zwar noch auf eine äusserst niedrige Ansteckungsrate hin, die Erfahrungen in anderen Regionen der Welt zeigen aber, dass die Bedeutung von HIV/Aids ohne präventive Massnahmen im Gefolge der allgemeinen sozialen und wirtschaftlichen Krise rasch zunehmen wird.

*Von Manuela Gregori**

Bosnien-Herzegowina steckt in einer tiefen ökonomischen Krise, und so werden auch im Gesundheitsbereich noch wenig sichtbare Probleme vernachlässigt, gibt es doch genügend dringende Aufgaben zu meistern. Das Gesundheitssystem in Bosnien-Herzegowina hat sehr unter dem Krieg gelitten, und es müssen neue, der aktuellen Situation angepasste Konzepte entwickelt werden. Das Personal im Gesundheitswesen hat um 40% und die Betten der Krankenhäuser um 35% abgenommen. Zwei Drittel des medizinischen Materials sind unbenutzbar geworden. Dass angemessene medizinische Versorgung oft nicht möglich ist, hat noch weitere Gründe: Kompliziertheit der Versicherungssysteme, Fehlen der nötigen Einrichtungen und Medikamente, Knappheit grundlegender Ressourcen. Hinzu kommen Transportprobleme und der Umstand, dass der Krieg grosse Teile der Bevölkerung gesundheitlich beeinträchtigt hat, was zu einem enormen Anstieg des Bedarfs an Gesundheitsversorgung geführt hat.

Menschen in Bewegung

Nach Angaben des Amts des UNO-Flüchtlingshochkommissariats sind seit Kriegsende rund 900 000 BosnierInnen heimgekehrt. Darüber hinaus beherbergt Bosnien-Herzegowina ungefähr 50 000 Flüchtlinge aus anderen Ländern Ex-Jugoslawiens. Mindestens 200 000 Personen sind zu intern Vertriebenen geworden. Leute in Bewegung sind Risikogruppen für HIV/Aids.

Der steigende intravenöse Drogengebrauch wird ebenfalls seine Auswirkungen auf die Ansteckungsrate haben, wie auch die alarmierende Zunahme des Menschenhandels: Schätzungsweise 5000 Frauen aus Osteuropa wurden in den vergangenen Jahren für Sexdienste nach Bosnien-Herzegowina «importiert», verteilt auf landesweit 300 bis 600 Bordelle. Das Durchschnittsalter der Betroffenen beträgt 22 Jahre. Nicht zu vernachlässigen sind die Ansteckungsgefahren während des vergangenen Krieges: Bluttransfusionen, medizinische Versorgung ohne entsprechende Schutzkleidung des Personals, Prostitu-

tion von Frauen und Mädchen, die sich so das Nötigste zum Leben beschafften, Vergewaltigungen und vieles mehr: In Krisenzeiten ist Prävention kein Thema.

Aids – noch keine Priorität

Angesichts dieser Tatsachen ist eine Ausbreitung der Aidsepidemie in Bosnien in den nächsten Jahren durchaus vorstellbar. Doch aktuelle Zahlen über HIV-Infizierte oder gar Aidstote gibt es nicht. Und die letzte UNAIDS-Statistik von Ende 1999 ist nicht besonders alarmierend: 750 Personen im Alter von 15 bis 49 Jahren trugen nach Schätzungen das HI-Virus in sich, und weniger als 100 Aidstote waren zu verzeichnen.

Das Thema Aids stellt somit für Menschen und Gesundheitsstrukturen in Bosnien noch keine Priorität dar. Dr. Vesna Ferkovic, stellvertretende Direktorin am öffentlichen Gesundheitsdepartement in Tuzla, bringt es auf den Punkt: «Bei uns funktioniert das sehr einfach: Wir untersuchen, an welchen Krankheiten die meisten Menschen sterben, und in diesen Bereichen wird investiert.» Im Moment werden die wenigen Gelder, die im Departement zur Verfügung stehen, in eine Präventions- und Informationskampagne für Herzkrankheiten gesteckt.

Laut der Expertin für soziale Medizin wird an den Schulen zwar Aufklärungsarbeit geleistet, «aber nicht sehr systematisch», wie sie zugibt. Mit Fragebögen, die an Schüler und Studenten verteilt werden, wird deren Wissensstand über Aids getestet. Auch sind immer wieder Strassenaktionen geplant, an denen Ärzte und Studenten mit Plakaten auf die Krankheit aufmerksam machen.

Soviel Dr. Ferkovic bekannt ist, starb im letzten Jahr in Tuzla eine Person an Aids. Aber auch hier gibt es keine zuverlässigen Zahlen, denn Statistiken zu erstellen kostet Geld, und wer hat das schon? Der Kanton Tuzla ist einer der ärmsten Kantone von Bosnien und Herzegowina, zudem leben dort nach wie vor über 80 000 intern Vertriebene.

Foto: IAMANEH Schweiz

«Wir sind uns der Aidsproblematik bewusst, können aber aus finanziellen Gründen nichts machen», sagt Dr. Vesna Ferkovic, stellvertretende Direktorin am Gesundheitsdepartement von Tuzla.

Foto: IAMANEH Schweiz

Allein im Kanton Tuzla leben noch 80 000 intern Vertriebene. Sie gehören laut WHO zu den Risikogruppen für eine HIV-Infektion.

Und in zwei, drei Jahren?

Sehr ähnlich äussert sich Dr. Kasim Brigic, Psychiater an der Universitätsklinik in Tuzla und Mitglied der Kommission für Drogenbekämpfung: «Unter allen sogenannten Risikogruppen werden Aidstests gemacht, aber wir haben keine konkreten Zahlen.» – In den letzten vier Jahren wurden in Tuzla etwa 1000 Drogenabhängige registriert; wie viele von ihnen HIV-positiv waren, ist Dr. Brigic nicht bekannt. Zu den Risikogruppen zählt er auch die Prostituierten sowie die Jugendlichen, die während des Krieges im Ausland waren. Die Kommission versucht, an Schulen und Universitäten Aufklärungsarbeit durchzuführen. Bis heute wurde diese freiwillig geleistet. Dr. Brigic hofft aber, demnächst für die Arbeit der Kommission Geld von der Regierung zu erhalten.

Für Dr. Brigic steht ausser Frage, dass in den nächsten zwei, drei Jahren ganz andere Zahlen zu erwarten sind und dass das Aidsproblem auf Bosnien zukommen wird. Es fehlt aber eine brauchbare Strategie für das ganze Land, es fehlen finanzielle Mittel, um die nötige Präventionsarbeit zu leisten, und es fehlt an höchster Stelle die Bereitschaft, Aids als Problem anzuerkennen.

**Manuela Gregori ist Kommunikationsverantwortliche bei IAMANEH Schweiz. Kontakt und weitere Informationen zur Tätigkeit von IAMANEH Schweiz in Bosnien-Herzegowina: info@iamaneh.ch.* *Siehe auch den weiteren Artikel in dieser Bulletinausgabe. Ihre Spende mit dem Vermerk «Bosnien» wird gerne entgegengenommen auf Postkonto 40-637178-8*

Once upon a war…

In post-war Bosnia and Herzegovina, it has become clear that teamwork between the public and the NGO sector is important for the development of the health system.

*By the Vive žene professional team**

Reaching people outside the Centre:
A car, a driver... and a skilled field team.

Before the war, health care in Bosnia and Herzegowina was very much intervention oriented and hospital based. There was a strong bias towards high-tech medical approaches and solutions. Primary health care did not receive much attention and preventive measures and health promotion were neglected. Rising costs were outstripping the available resources. The government reduced funds for the health care system, but extended at the same time free access to all forms of health care. The health system was centralized and private practice was extremely rare. However, on the positive side, health protection was available across the country.
A psychotherapeutic approach did not exist in spite of the high level of neuropsychiatry in the country, because the attention was directed to the psychopathology and the treatment of psychiatric disorders, while the so called healthy population did not have easy access to counselling – and did not even seek this type of assistance. Counselling services were only available within the structure of the social protection system, but for obvious reasons no-one in Ex-Yugoslavia wanted to be a “social case”.
Already two years before the war started, it became more difficult to obtain drugs and people had to contribute to their health care expenditure. The beginning of the war led then to a total breakdown of the system. In the aftermath of the war, humanitarian organizations arrived in Bosnia and Herzegovina and drugs became available again so that medication continued to be the common approach.

Establishing of the Vive žene Therapeutic Centre

Based on the initiative of a group of local women and with the support of the international community, the NGO Vive žene was established in 1994. For Bosnia Herzegovina the emergence of civil society organizations was a new phenomenon and it took quite some discussion for the Tuzla municipality to approve the centre’s working program. At that time Tuzla had been overcrowded by hundreds of thousands of refugees from various areas who were accommodated in facilities like dormitories, kindergartens, schools etc.

New hope? Women in the in-patent section of the Centre.

The structure of our organization and of our centre relied on professional staff that consisted of psychotherapists, pedagogues, social workers, a physiotherapist, a general practitioner and a nurse. Work focused initially on in-patient psychotherapy giving help in form of group and individual therapies, groups with social workers and medical help. The centre’s capacity was a maximum of 40 patients. Compared to the general difficulties, working conditions were exceptionally good: we had water, electricity and a sufficient working space. This facilitated the development of a new approach in a community which at that time was only familiar with medical treatment of psychosocial problems.
For example in the beginning traumatized women thought that entering the centre would bring them the stigma of being a “crazy person” and it was therefore not easy for them to seek help in our centre. The staff of Vive žene did its best to consider each traumatized person as an individual and give him or her the feeling to be understood and respected. Patients got a feeling of safety and that someone cared for their chance of regaining their lost identity and their self-esteem. As Vive žene did not only concentrate on in-patient care, but also provided psychosocial and medical support to refugee settlements in the canton, the refugee population started to know about the existence of the Therapeutic Center and its approach.

Consequence of war

Poverty and war had significant negative consequences for public health in Bosnia and Herzegovina. Migration, disability and new environmental factors have led to worsening social and economic conditions and unhealthy life styles and finally resulted in more chronic illnesses.

The Vive žene Director and two social workers showing some of the patients' paintings.

The devastation of health care facilities, the emigration of trained health care professionals have made it difficult for the health sector to cope with these problems. In addition, an increasing number of private clinics attract with their higher salaries the well skilled staff of the state institutions, but are not willing to offer affordable services for the people.
As a direct consequence of the war, the incidence of mental illness increased considerably, especially among displaced, refugees, orphans, elderly and demobilized soldiers. 15% of the population are estimated to have suffered psychological trauma, in particular post-traumatic stress disorder. The most common diseases are neurotic disorders associated with stress (61%) and affective mood disorders (14%). There are certain indications that there has been an increase of violence as a result of mental problems.
In the immediate post-war period Vive žene's work focus remained on the refugee population in the refugee settlements. Seriously traumatized women were offered in-patient treatment. As a result of the treatment successes the confidence in the therapeutic treatment has grown considerably. In 2001 the offer for psychotherapy and counselling was extended to victims of domestic violence, and an increasing number of local people of the Tuzla canton are now using the centre. Almost 400 clients per year in our out-patient clinic highlight the big need for this unique type of service.

Building partnerships

As the only organization in the Tuzla canton offering in-patient psychotherapeutic treatment, Vive žene has become an important referral point for other NGOs working in the area. Clients in need of in-patient therapy are frequently referred to the centre. The cooperation with other NGOs provides ample synergistic opportunities, for example in the field of continuous education. To strengthen the collaboration and synergies 49 NGOs formed in 1996 a network, which is called "Reference Group". All organizations of the Reference Group are recognised by the governmental institutions as important service providers and actors in and for the community.
In the last years, cooperation between Vive žene and the public institutions has improved in terms of quantity and quality. Referrals of clients from the public psychiatric clinic to the centre of Vive žene or vice versa have become common. Influenced by the new approaches used by Vive žene, also the public psychiatric clinic introduced some changes in its working concept and started also to provide psychotherapeutic and out-patient psychiatric care. This cooperation and the sensitization work of Vive žene and the Reference Group led to positive changes in the health system and it is now widely accepted that a good collaboration between the public and the NGO sector is vital for the development of the health system.
The Reference Group has a very important role in the future of Vive žene, as a part of the NGO sector being established in Bosnian society. Through the activities of the Reference Group we can influence the governmental institutions and the government itself. We are invited to work on the family law, the law for the NGO sector and we jointly organize public campaigns about human rights, democracy, domestic violence etc.
The general situation in the country – very low and slow economic development, high unemployment – is causing young people to leave the country. In order to make it attractive for them to stay, investments in infrastructure to induce development, a prerequisite for modernization, are crucial. However, as we can see in our work at the Therapeutic Centre, it is also important to invest in the training of professional staff.

Patients and staff sitting and laughing together in front of the Centre.

Smiling again. Clients of the Vive žene Center.

Photos: IAMANEH Schweiz

Vive žene uses a multidisciplinary approach in working with clients at the community, out- and in-patient level. The development of the out-patient therapy and the counselling service is receiving particular attention.
Because of a lack of personal capacities in the public sector the centre was also requested to provide psychosocial services for the general population. However, the centre is still lacking the official recognition of the government. It is therefore the aim of Vive žene to become one of the officially approved mental health centres of the canton. This process is on good track and will open the possibility to obtain in the future public funding.
The work of Vive žene is now widely recognized, and fruitful working relationships and cooperation projects have been established – not only with the psychiatric clinic, but also with the Police, the Center for social work, the Federal Ministry for health and the Federal Ministry for Work and Social Politics. The sustainability of Vive žene is closely linked to building partnership relations with governmental organisations and to fit into the system of psychosocial care of Bosnia and Herzegowina.

**Since 1997, Vive žene has been supported by IAMANEH Switzerland and co-financed by DDC/AZO, Glückskette, the Canton Aargau, the Communities of Jona and Meilen. Contact and information: info@iamaneh.ch. For your kind donations: IAMANEH Switzerland, PC 40-637178-8*

10 Jahre «hospital-twinning.ch»

Seit nunmehr zehn Jahren engagieren sich Schweizer Spitäler im Bereich der Spitalpartnerschaften in Osteuropa. Seit dem 1. Juli 1992 unterstützt die Direktion für Entwicklung und Zusammenarbeit (DEZA) dieses Programm in finanzieller wie auch beratender Hinsicht. Die Partnerschaften sind auf einen längeren Zeitraum ausgelegt und zielen auf den kontinuierlichen Aufbau der Personaldienste (z.B. Teamwork, dezentrale Entscheidfindung) und der Patientenversorgung ab. Weiterbildung vor Ort und in der Schweiz sowie gut vorbereitete Materiallieferungen sind die Mittel dazu.

*Von Nils Undritz und Marlies Kurt**

Die von uns vorgestellten vier verschiedenartigen Projekte zeigen die Kreativität im Bereich der Partnerschaften, die sich nach den Möglichkeiten und Neigungen der ProjektleiterInnen und dem aktuellen Bedarf ausrichten.

Aufbau einer Schule für medizintechnische Radiologie-AssistentInnen (MTRA) in Varna, Bulgarien

Die Abteilung Nuklearmedizin des Kantonsspitals Aarau, unter der Projektleitung von Herrn Prof. J. Locher, hatte es sich zum Ziel gesetzt, in Varna eine MTRA-Schule aufzubauen. Bevor das Projekt richtig starten konnte, wurde der Bedürfnisnachweis durch eine Umfrage ermittelt. Das rechtliche Umfeld wurde sorgfältig abgeklärt (Studienpläne, Akkreditierung, Kooperation mit Uni/College und den Spitälern etc.). Der Bedarf der Räumlichkeiten wurde ermittelt und angepasst, Unterrichtsmittel und Ausrüstung wurden beschafft, die Schulleitung und der Lehrkörper bestimmt; es mussten Praktikumstellen gefunden und die Kaderaus- und Fortbildung sichergestellt werden.

Die Finanzierung wurde von Anfang an klar definiert. So musste die Besoldung des Lehrkörpers, die Bereitstellung der Infrastruktur und die Organisation des Lehrbetriebes von Varna sichergestellt sein. Das Kantonsspital Aarau verpflichtete sich unter anderem zur Finanzierung von ausbildungsbezogenen Ausrüstung, Einrichtungen und Unterrichtshilfen, von Reisekosten und Aufenthaltskosten von Stagiaires in der Schweiz, von Lehrmittelbeschaffung, Übersetzungen etc.

Inzwischen haben zehn StudentInnen das erste Ausbildungsjahr mit guten Prüfungsresultaten bestanden. Alle haben eine Praktikumstelle angetreten. Für den zweiten Kurs wurden von Sofia 13 Studienplätze bewilligt, die nach den Aufnahmeprüfungen von zehn Bulgaren und drei voll zahlenden Ausländerinnen besetzt wurden. Es besteht eine riesige Nachfrage. Bei der Inspektion durch die staatliche Akkreditierungskommission wurde der Schule ein sehr hohes Rating verliehen (41.38 Punkte von max. 50 Punkten), was die Durchführung weiterer Kurse sichert. Trotz der Anerkennung steckt das Projekt noch in der Anfangsphase, und Erfahrungen werden kritisch analysiert und im Projekt integriert.

Das Projekt belegt die Notwendigkeit der Integration in das staatliche Rahmengefüge, sonst bestehen keine Überlebenschancen, und die Diplome sind für die AbsolventInnen wertlos. Dieses Projekt schafft Nachhaltigkeit, denn die einmal gegründete Schule wird auch nach einem Erlöschen der Partnerschaft weiter funktionieren und Wissen vermitteln.

Landwirtschaftliches Projekt der Psychiatrischen Klinik Sonnenhalde in Veliko Tarnovo, Bulgarien

Die Klinik Sonnenhalde in Riehen führt als erste Privatklinik der Schweiz seit Sommer 2002 eine Spitalpartnerschaft mit der Psychiatrischen Klinik in Veliko Tarnovo. Nebst Projektaktivitäten wie der Weiterbildung von Ärzten und Pflegenden oder der Einrichtung einer Aktivierungstherapie will sie die Wiedereinrichtung der Schweinehaltung sowie den Gemüse- und Kleeanbau auf dem reichlich vorhandenen, aber ungenutzten Land aufbauen.

Welches war der Hintergrund für dieses Projekt? Bei einem ersten Abklärungsbesuch der Riehener Delegation hat sich rasch gezeigt, wo die Probleme liegen: Die Patienten werden zuwenig beschäftigt, und sie haben zu wenig zu essen. Mit dem Aufbau der Schweinehaltung werden die Patienten aktiviert, bei der Unterhaltung der Landwirtschaft kann eine Arbeitstherapie etabliert werden, und als sichtbares Ergebnis der Schweinezucht wird der Speisezettel mit Fleisch bereichert. Unterstützt werden die Therapeuten der Partnerklinik von einem Arbeits- und Ergotherapeuten sowie einem Landwirt aus Riehen. Mit dem Kleeanbau wird nebst der Arbeitstherapie für die Patienten die Selbstversorgung der Schweinezucht mit Klee angestrebt. Die Klinik Riehen wird im Anfangsstadium noch finanzielle Unterstützung bei der Kultivierung von Klee (Saatgut, Pflege, Ernte) und beim Kauf von Tieren und Futtermittel geben, ansonsten werden die Projekte vor allem durch Vermittlung von Know-How unterstützt.

Dieses Projekt nimmt Anleihen aus der früheren und leider verloren gegangen Kultur psychiatrischer Kliniken auf. Sie integriert die Landwirtschaft in die Therapie und verbessert gleichzeitig die Ernährungssituation. Der Mittelbedarf seitens der Schweiz ist vergleichsweise bescheiden. Die baslerische Unterstützung hat der Klinikleitung von Veliko Tornovo Flügel verliehen: Mit eigenen Mittel wurden Baukörper neu gestrichen, die sanitären Anlagen völlig erneuert und eine Privatabteilung mit geschmackvoll möblierten Zweierzimmern eingerichtet. Deren Erträge sollen allen Patienten zugute kommen.

Informatikprojekt der Fribourger Spitäler im Spital Constanta in Rumänien

Während verschiedenen Besuchen einer Fribourger Delegation im Spital Constanta (1400 Betten, 4000 Angestellte) hat sich gezeigt, dass das Personal in allen Abteilungen zu viel Zeit darauf verwendet, Informationen und Daten über die Patienten von Hand zu notieren. Dieselben Arbeiten wurden mehrfach gemacht, zudem sind handgemachte Statistiken nicht sehr zuverlässig. Das Pflegepersonal braucht zu viel Zeit für administrative Tätigkeiten, die damit den Patienten vorenthalten wird.

Um diesen Mangel zu beheben, wurde die Projektidee geboren, die Abteilungen des Spitals mit weiteren PC auszustatten und sie miteinander zu vernetzen. Die Patienten werden so nur noch einmal erfasst. Durch die Netzwerkverbindung in der Informatik für alle Abteilungen dient die Kostenerfassung aller Leistungen gleichzeitig als Instrument für die Tarifverhandlungen mit der Krankenversicherung.

Das Projekt wurde vom Kooperationsbüro der DEZA in Bukarest unter Einbezug eines externen Informatikers evaluiert und als mutig, aber rea-

Gesprächsbereite Patienten in der Klinik Veliko Tarnovo zeugen von freundlicher Betreuung

lisierbar befunden. Daraufhin wurde ein Pflichtenheft erstellt und Offerten eingeholt. Die ersten Bestellungen wurden erst aufgegeben, nachdem ein detaillierter Vertrag zwischen den Fribourger Spitälern und dem Spital Constanta unterschrieben worden war
Das Projekt steht jetzt in der Startphase und wird auch für andere Spitäler von grossem Interesse sein. Die Kultur der Erfassung objektiver Daten als Verhandlungsgrundlage zwischen Partnern war in den ehemaligen Sowjetrepubliken inexistent.

Pilotprojekt des Kantonsspitals Aarau im Vereinigten Oblastspital Dshalal-Abad (VOSD) in Kirgisien

Das Pilotprojekt «Patientenkarte für die chirurgischen und medizinischen Stationen» im VOSD bezweckt die Rationalisierung der Arbeitszeit der Ärzte und des Pflegepersonals in den Spitälern und die effizientere Nutzung der Zeit für die Dokumentationsführung. Dazu wurde im Frühling 1999 ein Seminar vor Ort durchgeführt. Durch Schulung vor Ort und von Moderatorenausbildung von vier Krankenschwestern im Kantonsspital Aarau wurde eine sorgfältige und umfassende Ausbildung des Personals gewährleistet. Mit der Teilnahme an einem Internationalen Pflegekongress in Nürnberg wurde die Ausbildung abgerundet.
Überzeugt vom Nutzen der Patientenkarte, die administrative Abläufe vereinfacht und die medizinische Information standardisiert und verbessert, hat das kirgisische Gesundheitsministerium ein ministerielles Dekret zur Einführung der «Patientenkarte» erlassen. Die Patientenkarte wird nun im ganzen Land verwendet. Die Analyse der Projektergebnisse hat gezeigt, dass noch einiges verbessert werden kann. Man hat sich für die Einführung des Pflegeblattes insbesondere auch in den Intensivstationen entschieden. Zu diesem Zweck wurden drei Krankenschwestern während einem Praktikum von drei Monaten im November 2002 im KS Aarau weitergebildet. Im Gang ist auch der Auf- und Ausbau eines Informationszentrums für alle medizinischen Institutionen des Südens von Kirgistan.
Die geographische Abgeschiedenheit Kirgistans von der Schweiz lässt im Rahmen einer mit wenig Mitteln funktionierenden Spitalpartnerschaft keine Materialtransporte auf dem Landweg zu. Trotzdem kann dem Land geholfen werden. Die in Aarau weitergebildeten Pflegepersonen haben 16 Projekte für die Verbesserung der Kommunikationskultur aufgegriffen, um die Motivation des medizinischen Personals in Kirgistan zu fördern.

Wie weiter?

Unser Abriss von vier verschiedenen Projekten in verschiedenen Ländern zeigt, wie sich die Partnerschaften Schritt um Schritt entwickeln und worauf es in der Osthilfe ankommt: das Verhalten des medizinischen Personals mit den Anforderungen einer leistungsfähigen, auf dem Dialog basierenden Gesundheitsversorgung in Einklang zu bringen.
Mit dem voraussichtlichen Beitritt von Bulgarien und Rumänien zur EU voraussichtlich im Jahre 2007 wird sich die offizielle Schweiz langsam aus diesen Ländern zurückziehen. Die aus langjähriger Zusammenarbeit entstandenen Freundschaften werden aber anhalten. Ausserdem gibt es Arbeit genug in anderen Ländern wie zum Beispiel Moldawien und Mazedonien, wo allenfalls neue Partnerschaften entstehen werden. Eine weitere Herausforderung ist es, die in der Schweiz und vor Ort gewonnenen Kompetenzen in der Gesundheitsentwicklung Dritten zur Verfügung zu stellen.

Nils Undritz leitete von 1978 bis 1995 das Generalsekretariat der Veska, heute H+ Die Spitäler der Schweiz. Seither ist er unabhängiger Berater und führt die Netzwerke hospitaltwinning.ch und healthhospitals.ch. Marlies Kurt ist für die Logistik zuständig. Kontakt: contact@hospitaltwinning.ch.

Die an Spitalpartnerschaften beteiligten Schweizer Spitäler sind in einem Netzwerk organisiert, welches die DEZA-Mittel auf der Grundlage von Verträgen zuteilt, Erfahrungstreffen organisiert, die Qualität mittels einem standardisierten Reportingverfahren evaluiert, falls nötig Seminare durchführt und logistische Unterstützung liefert. Weiterführende Informationen: www.hospitaltwinning.ch. Eine ausführlichere Version des Artikels findet sich in der Internetausgabe des Bulletins: www.medicusmundi.ch/bulletin.htm.

«Wir haben unser Versprechen eingelöst»

Seit zwölf Jahren unterhält die Kantonale Psychiatrische Klinik Liestal eine Partnerschaft mit der Psychiatrischen Universitätsklinik der Stadt Varna an der bulgarischen Schwarzmeerküste. Eine Bilanz.

*Von Theodor Cahn**

Die Psychiatrische Universitätsklinik der Stadt Varna ist für die gesamte psychiatrische Versorgung, inklusive Tagesklinik, Ambulanz und Kinderpsychiatrie, einer Region von 600 000 Einwohnern zuständig. Das ganze Angebot ist am Klinikstandort zentral zusammengefasst.

Das Partnerschaftsprojekt wird im Rahmen der Spitalpartnerschaften mit Osteuropa vom Bund unterstützt und von H+ überwacht. Es ist breit und interdisziplinär angelegt und hat in erster Linie die fachliche und institutionelle Förderung zum Ziel, mit den Hauptthemen: klinische Psychotherapie, psychiatrische Pflege und therapeutisches Klinikmilieu, Klinikorganisation sowie die ambulante Versorgung der Stadt. Materielle Hilfen sind hinzugekommen, denn sie erwiesen sich in der Not des Landes als unerlässlich – zum Beispiel subventionieren wir die Mahlzeiten der Patienten, allerdings unter der Bedingung, dass sie, zu ihrer Aktivierung, von ihnen selber zubereitet werden.

Der intensive Austausch geschieht vier bis sechs Mal im Jahr in gegenseitigen Besuchen von kleinen, gemischten Equipen mit ÄrztInnen, PsychologInnen, Pflegenden, SozialarbeiterInnen: In Varna beteiligen wir uns am Alltag der Klinik, halten Kurse ab, bieten Supervisionen und Beratungen an. Umgekehrt können die Gäste aus Varna bei uns in Liestal unsere therapeutische Haltung und Vorgehensweise direkt kennen lernen. Es haben sich daraus herzliche, freundschaftliche Beziehungen entwickelt, welche das Projekt tragen und sehr bereichernd sind.

Von Solidarität und schnellen Tricks

Als wir 1991 den Kontakt aufnahmen, war uns Bulgarien, wie den meisten Westeuropäern, völlig unbekannt. Es gab in der Psychiatrie keine vergleichbare Partnerschaft. So mussten wir uns voran tasten. Wir wollten solidarische Hilfe bringen, waren neugierig, hatten aber noch keine definierten Vorstellungen oder konkreteren Ziele.

Bulgarien erlitt nach der Wende einen tiefgreifenden geistigen Orientierungsverlust. Der Blick auf die westlichen Welt übte eine unwiderstehliche Anziehung aus und erzeugte die Illusion, den westlichen Lebensstil und Wohlstand rasch erreichen zu können. Unser Erscheinen war daher sehr willkommen und mit idealisierenden Erwartung behaftet. Die bulgarischen Partner erkannten nicht zuletzt den eigenen enormen Rückstand auf dem Gebiet der Psychotherapie – das war unser Einstieg. Sie wünschten, dass wir ihnen auf die Schnelle ein paar Tricks beibrächten, dann wäre ihr Problem erledigt. Unsere Abgrenzung dagegen brachte erst Frustration, war aber unerlässlich um eine langfristige Entwicklungsarbeit zu eröffnen.

Die Lernbereitschaft und das Interesse unserer Partner an unseren Beiträgen haben uns stets motiviert. Die Ausgestaltung des Projektes ist hingegen weitgehend unsere Initiative geblieben. Auch die Patienten erscheinen passiver und duldsamer als in der Schweiz. Die Zurückhaltung unserer Partner entspricht einer kulturellen Schwierigkeit: Die Bulgaren stützen sich traditionell auf Familien- und Klientelsysteme, aber für ein Engagement in Institutionen, das auch konstruktive Kritik beinhaltet, scheinen die mentalen Voraussetzungen eher zu fehlen. Institutionen gegenüber bleibt man passiv – es sei denn, man könne sie ausbeuten. Währenddessen bieten wir aus dem Westen gerade institutionelle Aufbau und Projektarbeit an.

Der Widerspruch verweist auf eine typische – unser Verständnis herausfordernde – Entwicklungshilfesituation. Sie entspringt dem Gefälle zwischen dem «Westen» und dem «ex-sozialistischen Balkan». Bulgarien geriet zudem statt in die Prosperität in eine Dauerkrise. Hilfsbedürftigkeit und -abhängigkeit waren die Folge, was das Gefälle akzentuierte. Nach dem Zusammenbruch des totalitären Staates zerfiel die Gesellschaft und konnte weder minimales Auskommen noch Sicherheit garantieren. Misswirtschaft, Korruption und Mafia machten sich breit, während die wirtschaftliche Produktion absackte, grosse Teile des Volkes verelendeten und die öffentlichen Betriebe nicht mehr zureichend unterhalten wurden. Heute können sich viele Menschen zum Beispiel im Winter keine durchgehende Heizung leisten. Auch in der Klinik fehlt dafür oft das Geld ebenso wie für eine qualitativ ausreichende Ernährung der Patienten.

Reformen: Für Risiken und Nebenwirkungen…

Viel Zeit brauchten hingegen die Reformen. Das überkommene staatlich-zentralistische Gesundheitswesen blieb trotz immer weniger Ressourcen noch über Jahre bestehen. Immerhin wurde so eine gewisse institutionelle Sicherheit und Konstanz gewährleistet. Die Reform erfolgte in chaotischer Weise und auf westlichen Druck erst in den Jahren 2000 und 2001. Unsere Partnerklinik, zuvor unter einheitlicher Leitung des Lehrstuhlinhabers, wurde dabei in drei Chefarztbereiche aufgeteilt, ohne fachliche Rücksichten und Sor-

Patienten der Männer-Akutabteilung

ge für einen ausreichenden Zusammenhalt der Psychiatrie. Auch konnte nicht ausbleiben, dass sich Elemente von Korruption auch bei unseren Partnern zeigten. Ein typisches Beispiel sind die Medikamentenerprobungen für westliche Pharmafirmen, die für bulgarische Verhältnisse sehr lukrativ sind. Einzelne Klinikärzte erhalten Versuchsleitungen unter intransparenten Bedingungen als Begünstigung zugesprochen. Das hat das Interesse an unserem Projekt beeinträchtigt. Wir mussten unsere Partner mit einigem Druck dazu bringen, einen Teil des eingenommenen Geldes für das Mahlzeiten-Projekt einzusetzen.
In dieser Entwicklung, in welcher sich keine nachhaltige Besserung einstellen will und die Leute einem ständigen Wechsel von Hoffnung und Resignation ausgesetzt sind, hat sich unser Projekt bewähren müssen. Dabei machten wir emotionale Wechselbäder durch, welche die äusserst instabile, oft prekäre Situation unserer Partner und ihrer Patienten spiegelte, die sich fast alle in prekären Lebensverhältnissen durchschlagen müssen. Wir mussten von unserem gewohnten Standards der Projektarbeit trennen und lernten zu improvisieren und mitzuschwimmen, ohne den konzeptionellen Faden zu verlieren; sonst hätten wir wohl rasch resigniert oder den Kontakt verloren. Um uns aufzufangen und zu orientieren, brauchen wir in unserem Team regelmässig Zeit für Austausch, Reflexion und Planung. Den Rahmen dazu bildet die Liestaler Aktivgruppe unter dem Namen «Pro Varna».

Weiterhin in die Hoffnung investieren

Welche Bilanz ist zu ziehen? – Das Versprechen der Solidarität konnten wir einlösen. Unser zuverlässiges, engagiertes und zugleich kritisches Interesse wurde von unseren Partnern wahrgenommen. Sie mussten sich nicht in einem abgelegenen Winkel Europas vergessen fühlen. Das legte den Boden für eine beachtliche Entwicklungsleistung, die allerdings je nach Bereich unterschiedlich weit geführt hat.
Die grössten Fortschritte zeigen sich in der Pflege, die zuvor sehr geringe Geltung hatte. Mit unserem Projekt wurden breites fachliches Interesse und eine praktisch umgesetzte Initiative zur Aktivierung der Patienten geweckt. Die Pflegenden haben Selbstachtung gewonnen und eigenständiges Arbeitsprofil entwickelt. Bei den Ärzten und Psychologen ist das Resultat zwiespältiger. Unsere interdiziplinäre Arbeitsweise löste teilweise Angst um ihren privilegierten Status aus. Doch hat sich eine Gruppe engagierter Ärzte und Psychologen herausgebildet, welche viel psychotherapeutisches Know-how gewonnen haben und jetzt mit ihren Patienten einen psychotherapeutischen Prozess führen können.
Am schwierigsten hat sich der Versuch herausgestellt, die Entwicklung der Klinikstrukturen und der ambulanten psychiatrischen Versorgung zu fördern, die sehr nötig wäre. Unsere Partner haben hier, trotz gemeinsam erarbeiteter Problemsicht, insgesamt wenig übernommen. Diese Arbeit wäre auf der Leitungsebene zu leisten gewesen, jedoch manifestierte sich Widerstand, wo zwangsläufig Führungsaufgaben berührt wurden. Dieser mischte sich mit der erwähnten kulturellen Schwierigkeit einer konsistenten institutionellen Projektarbeit.
Nach der langen Zeit haben wir uns für eine Zäsur entschlossen: In einem Jahr wird das Projekt in der gegenwärtige Form beendet. Allerdings ist das Erreichte noch so gefährdet, dass wir ein Anschlussprojekt in anderer, begrenzter Form planen, um uns auf die Unterstützung derjenigen Bereiche zu konzentrieren, die bereits eine Chance der Nachhaltigkeit erarbeitet haben.

**Dr. med. Theodor Cahn ist Chefarzt an der Kantonalen Psychiatrischen Klinik, Liestal. Kontakt: theodor.cahn@kpd.ch. Informationen zum Verein Pro Varna: p.A. Kantonale Psychiatrische Klinik 4410 Liestal; Homepage der Spitalpartnerschaften: www.hospitaltwinning – siehe den weiteren Beitrag in dieser Bulletinausgabe.*

Bulgaria: Experience with the transition process in the health sector

"Technology is not enough"

The progress of the Bulgarian health care system transition has been impressive. However, there are numerous problems remaining. The transition process has shown that there is not only need for new technology, but also for know-how transfer. A Bulgarian-Swiss Project is a good illustration of this combination.

*By Assen Pacheijeff and Christine Rutschmann**

Due to dramatic changes after the collapse of the communist system, Bulgaria has got into a deep social and economic crisis which has left more than 70% of the population to live on the edge of poverty. Health services were one of the most affected components of the social security system. The morbidity and mortality rates have risen up to levels of the first half of the last century. The average life expectancy shrunk for both men and women. Calculated against GDP, the overall health expenditure has decreased to 3.2% and is lower than in other East European countries (average: 5.1%) and substantially lower than in Western European countries, where health care expenditure is approx. 8.4% of GDP on average. Since 1999, the Bulgarian health care system has engaged in a major reform process. After the establishment of a national health insurance system, the reform process focused first on transforming former out-patient polyclinics into general practices and diagnostic centres. Today some 8 000 family doctors are providing primary medical care. They are paid on a per capita basis. There is a reimbursement scheme for drugs, and some vulnerable patient groups are fully exempted.
The reform process was not smooth, although it has been so far quite successful. However, there are still a lot of shortcomings and open questions. Many of the new general practitioners do not have an adequate training and experience. For example they are not always familiar with immunization schedules for children and adolescents. The former well organized network of school physicians was demolished in the recent years for financial reasons.

Reforming the hospital sector

However, the situation of the hospitals has deteriorated dramatically in the past five years and is now threatening the success of the whole health sector reform. Accordingly the National Health Strategy 2001-2007 addresses now problems at the hospital level. The most burning issues in Bulgarian hospitals are:
a. Insufficient budget allocation: Frequently patients have to pay by themselves for drugs and for basic consumables, such as wound dressings and disinfectants, because the hospital has no money.
b. Squandering and financial mismanagement of the hospital administrations.
c. Corruption in the hospitals: Staff is trying to compensate their low salaries by requesting 'under the table' payments from the patients.
d. Exodus of highly skilled specialists and nurses: staff leaves public facilities either for the local primary care sector or for other countries.
e. Last but not least, poor quality of the services provided in the hospitals and in particular inadequate hygienic conditions which cause a high risk of hospital acquired (nosocomial) infections (NI). A large part of the problems associated with NI arise from the lack of information, lack of adequate basic and continuous training of medical and paramedical staff in the field of nursing and hygiene standards and a lack of treatment guidelines. There are also loopholes in the quality assurance and control system.

Patients room at the Alexandrowski University hospital, Sofia.

The practical implementation of the new Strategy for Restructuring of the Hospital Sector has major challenges. The restructuring of the 300 hospitals in the country is underway and coincides with the introduction of an obligatory 5-year accreditation scheme. The credit points assigned to a particular hospital provides a basis for the funding allocation of the health insurance. In addition treatment costs in the hospitals are covered according to specified clinical pathways. New medical standards in all basic and interdisciplinary therapeutic areas have been introduced, including quality assurance measures at all levels in the health care system. Basic training for all healthcare workers has been harmonized with the training requirements in other European countries and a credit-points-based system for continuous medical education has been established.

International cooperation and reform

The Bulgarian health care reform provides a lot of opportunities for development and cooperation projects. Such opportunities have already been seized by a number of international institutions and organizations, like the World Bank (WB), the World Health Organization (WHO), the US Agency for International Development (USAID), the Swiss Agency for Development and Cooperation (SDC). One of the WB-sponsored projects provided equipment for the new general practitioner clinics. The World Health Organization (WHO) supported several projects for epidemic control and prevention.

In addition and more recently several projects have been supported by various national and foreign non-governmental organizations (NGOs), like the Swiss Red Cross, Médecins Sans Frontières, and others.

The Bulgarian-Swiss Program for Hospital Hygiene

The Bulgarian-Swiss Hospital Hygiene Program (BSHHP) is financed by the Swiss Agency for Development and Cooperation, and the Bulgarian Ministry of Health. It is implemented by the Swiss Red Cross and the Hygia-BSHHP Association, a local NGO. The program comprises three components: hospital hygiene, clinical microbiology and central sterile goods supply in the hospital. The overall goal of all three components is to harmonize the standards for prevention and control of nosocomial infections in Bulgaria with the standards that are in use in other European countries. In the long term, the program will contribute not only to a substantial decrease in hospital-acquired infection rates, but also to a qualitative improvement of the services provided in the hospitals. Thus the programme intends to establish basic surveillance standards. It will also provide information on the prevalence of nosocomial infections existing in the hospitals. The nosocomial infection rates are today varying from 0.01% up to 30% (average in Switzerland: 5–8%). The program has started in April 2002 and will cover six hospitals until the end of 2004. The results of this pilot project shall be assessed and the potential for replication at a countrywide level will be explored.

The tactics of the program with respect to the particular projects is based on following activities:

Clinical Microbiology Component: Training courses will be carried out to promote modern methods for microbiologic identification and diagnosis. An Internet-based network for reporting, exchange and analysis of data from the microbiological laboratories will be set up and measures for standardization and external quality control will be instituted.

The Hospital Hygiene/Prevention and Control of NI Component: The development of a contemporary professional standard for hospital hygiene will be supported. Theoretical and practical training courses for hospital epidemiologists, infection control nurses and clinicians will be carried out and a new position within the infection control team in the hospital will be introduced, that is an "infection control nurse".

The Central Sterile Supply Department (CSSD) Component: Training courses for CSSD staff will be carried out and based on the pilot project, the concept for a "closed circle" for quality assurance in the field of aseptics and antiseptics will be demonstrated.

One other important aspect of BSHHP is the building up of Bulgarian clinical mentors providing practical guidance and support to all trainees in their respective working place. Currently there are no mentors available in Bulgaria, neither nurses nor medical doctors who could fulfill this role. The purpose of the clinical mentor is to instruct and to teach students on the job while in hospitals, clinics, community and other clinical settings, to facilitate with staff in the clinical site to enable the best learning experience for the students. There might be some opposition from the medical staff as far as the nurses receiving additional continuous training is concerned. The mentors can be instrumental in defusing these tensions.

Poor hygiene is common place in Bulgarian hospitals.

It is obvious that the program design is emphasizing the educational factor, i.e. the transfer of modern know-how. It is also a logical continuation of a former technology-transfer oriented program, which had been sponsored by the Swiss State Secretariat for Economic Affairs (seco). Thirteen regional hospitals in Bulgaria have received modern central sterile supply departments. In the final evaluation of the project in 1999, hospitals realized that their main problem was not only the absence of equipment but also the lack of adequate hygiene measures in disinfection, decontamination and lack of know-how and quality assurance. In 2000, the Swiss Development Cooperation developed with the Bulgarian partners a new project which has built on the achievements of the former seco project. The continuity of the two programs represents a good example of sustained cooperation, based on a mixture of technological and of know-how transfer and highlights the need to combine the two.

It is also representing the continuous support which Switzerland, has been providing to the Bulgarian healthcare system over the past ten years.

** Assen Pacheijeff is the coordinator of the local Project Implementation Unit of the Association Hygia for the Bulgarian Swiss Hospital Hygiene Programme. Christine Rutschmann is the responsible programme coordinator at the Swiss Red Cross, International Cooperation, for Bulgaria as well as Central-Eastern Europe and the CIS and the programme director of the BSHHP. Contact: christine.rutschmann@redcross.ch or assen.pach@hygia.orbitel.bg*

Some Key Resources and Basic Reading

The European Observatory on Health Care Systems
The observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe. The Observatory is a partnership between WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, Open Society Institute, World Bank, London School of Economics and London School of Hygiene & Tropical Medicine.
www.who.dk/eprise/main/who/progs/obs/toppage

European Health Report 2002
"Although overall levels of health in the European Region are among the highest in the world, the report points to major inequalities between and within countries. Most striking is the widening gap in life expectancy and healthy life expectancy between western and eastern European countries, with a particularly marked decline in the NIS due largely to premature mortality among adult males. Important inequalities in health status result from the dramatic increase in the incidence of communicable diseases such as HIV/AIDS and tuberculosis in eastern European countries, largely related to the deterioration in the socioeconomic situation, and the persistence of malaria in some areas in the south-eastern part of the Region."
www.who.dk/eprise/main/WHO/Progs/EHR/Home;

The World Health Report 2000 Health Systems: Improving Performance
"The World Health Report 2000 is an expert analysis of the increasingly important influence of health systems in the daily lives of people worldwide. Health systems provide the critical interface between life-saving, life-enhancing interventions and the people who need them. If health systems are weak, the power of these interventions is likewise weakened, or even lost. Health systems thus deserve the highest priority in any efforts to improve health or ensure that resources are wisely used."
www.who.int/whr

Health Care Systems in Transition profiles (HiTs)
"HiTs are country profiles that provide an analytical description of each health care system and of reform initiatives in progress or under development. HiT's aim to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to learn in detail about different approaches to the financing, organization and delivery of health care services; to describe accurately the process, content and implementation of health care reform programmes; to highlight common challenges and areas that require more in-depth analysis; and to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region."
www.who.dk/observatory/Hits/TopPage

Ten years of health sector reform in CEE and NIS
"The decade since the break up of the Soviet bloc has brought enormous political and socio-economic change. The health sector has not been spared the effects of transition and the countries emerging from the process have each engaged in varying degrees of health system reform. It is at last possible to reach some judgement about how this process has unfolded, and to identify successes and failures, and to understand better the scale and nature of the remaining challenges. It is now timely to take stock of these experiences and to draw lessons for the future development of health systems in this complex and dynamic region."
Josep Figueras, Martin McKee, Suszy Lessof, Ten years of health sector reform in CEE and NIS: An Overview. A background paper prepared for USAID Conference, Washington, DC, 29–31 July 2002 (draft). First of a series of six commissioned papers discussing the key issues for health systems in transistion. Download: www.eurasiahealthtransitionconference.org/Overwiew.pdf, Conference website: www.eurasiahealthtransitionconference.org. Conference reader available in early 2003.

Health as Citizenship
"Hannah Arendt developed three dimensions of being fully human: family life, work life and public life, the vita activa. Within these arenas, what connects us as human beings is trust, reciprocity and mutuality, dimensions of what increasingly is being called the social capital of societies. Discussing these issues in terms of health presents several difficulties in former closed socialist societies that are now open to the free market and to increasing individualization. It highlights crucial policy conflicts between what is considered a public and collective good and what is considered a private responsibility. As a principle, the mobilization of citizens and communities for better health embodies both the dimensions of democratization (including joint decision-making and accountability) and of individualization. In the countries of central and eastern Europe, it was (and is being) experienced in all its ambivalence and ambiguity as many countries moved from a collective to an individualistic understanding of health. This is reinforced by moves (and strong pressures from major donors) to reshape the health system and shift responsibilities from the state to other levels of governance, to the private sector and to individuals and families.
Any analysis of this process must take into account the political and social contexts within which participatory and collaborative strategies for health are proposed. For citizens, it includes the ambiguity of gaining a concept of individual human rights or patients' rights yet perhaps losing the collective right to health as a public good and, in the context of the transition, losing access to services. For health professionals, the changes could be seen as a major loss of authority, both towards the general population and towards other sectors with whom they were now called on to cooperate. Nothing had prepared them to work in this new manner. For politicians, it meant accepting voices outside the formal political system, a more open democratic process than that represented by political parties."
Ilona Kickbusch, Mobilizing citizens and communities for better health: The civil society context in central and eastern Europe. A background paper prepared for USAID Conference, Washington, DC, 29-31 July 2002 (draft). Download: www.eurasiahealthtransitionconference.org/Mobilizing.pdf, Conference reader available in early 2003.

Health care in central Asia
"Central Asia remains one of the least known parts of the former Soviet Union. The five central Asian countries have faced enormous challenges over the last decade in reforming their health care systems, including adverse macro-economic conditions and political instability. Common strategies have involved devolving the ownership of health services, seeking sources of revenue additional to shrinking state taxes, "down-sizing" their excessive hospital systems, introducing general practitioners into primary care services, and enhancing the training of health professionals. This book draws on a decade of experience of what has worked and what has not."
Martin Mckee, Jane Falkingham and Judith Healy (ed.), Health care in central Asia, Buckingham 2002 (Open University Press). Download (pdf) from: www.who.dk/observatory/Publications/20020524_15

Deepening democracy in a fragmented world. Human Development Report 2002
"Politics matter for human development. Reducing poverty depends as much on whether poor people have political power as on their opportunities for economic progress. Democracy has proven to be the system of governance most capable of mediating and preventing conflict and of securing and sustaining well-being. By expanding people's choices about how and by whom they are governed, democracy brings principles of participation and accountability to the process of human development."
http://hdr.undp.org/reports/global/2002/en

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