Note. The country is part of the EU’s Stabilization and Association Process, started in 1999 – an individually tailored programme designed to pave the way for gradual integration into EU structures. This Process recognizes the countries of Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro and The former Yugoslav Republic of Macedonia as potential candidates for EU accession, a prerequisite for which is improved regional cooperation.
before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.

AREA (km²) 51 130
25% larger than Denmark
1.3% of the EU25 area
EU25: 3 970 000, EU15: 3 200 000, EU10: 738 000

POPULATION 3 810 000 (post-war estimate)
Equal to Ireland’s population
0.8% of the EU25 population
EU25: 455 532 896, EU15: 380 962 720, EU10: 74 570 192

THE PEOPLE
Bosnian 48%, Serbian 37%, Croatian 17%

LANGUAGES
Bosnian, Croatian, Serbian (in alphabetical order)

FORM OF GOVERNMENT
The state consists of the Federation of Bosnia and Herzegovina and Republika Srpska, as well as the Brčko District. At the state level, there is a bicameral parliamentary assembly (Skupshtina) with a House of Representatives and House of the People.

RELIGIONS
Muslim 40%, Orthodox 31%, Roman Catholic 15%, Jewish

INDEPENDENCE 1992
GDP PER CAPITA \( €1\,362 = 7\% \text{ of the EU25 average} \)

**EU25:** €20 400, **EU15:** €22 750, **EU10:** €5 530

In purchasing power parities: €5 970

\( = 24\% \text{ of the EU25 average (€24 480)} \)

**REGIONS**

2 first-order administrative divisions, 1 internationally supervised district

**CURRENCY**

convertible mark (BAM): 1 BAM = €0.51, €1 = 1.96 BAM

**HUMAN DEVELOPMENT INDEX** 0.78

**UNEMPLOYMENT RATE** 18–22%

**EU25:** 9\%, **EU15:** 8\%, **EU10:** 14\%

**MEMBER OF**

CoE, IMF, OSCE, WB, UN

**SOME MILESTONES IN THE RELATIONS BETWEEN THE EU AND BOSNIA AND HERZEGOVINA**

- In 1997, the EU Council of Ministers established a regional approach to setting political and economic conditions for the development of bilateral relations.
- In 1998, a Consultative Task Force was established as a joint vehicle of the country and the EU for technical and expert advice in the field of administration, regulatory framework and policies.
- In 1999, the Stabilization and Association Process was launched, offering a clear prospect of integration into EU structures.
- In 2000, the EU Road Map was published, which set out 18 essential steps to be taken by the country before work on a feasibility study for the opening of negotiations on a stabilization and association agreement could begin. The European Council stated that all the countries covered by the Process were potential candidates for EU membership.
● 2001 was the first year of the Community Assistance for Reconstruction, Development and Stabilization assistance programme specifically designed for the countries in the Stabilization and Association Process, and the Country Strategy Paper for 2002–2006 was adopted.

● In 2003, following substantial completion of the Road Map, work was underway on a feasibility study for the opening of negotiations on a stabilization and association agreement.

NOTE

In 1992 Bosnia and Herzegovina was recognized by the EU and the USA as a sovereign independent nation and became a member of the UN. The war that followed ended with the Dayton Peace Agreement of 1995, which recognized the existence of two entities – the Federation of Bosnia and Herzegovina and Republika Srpska – each with its own president and government. The executive branch of the central government is represented by a three-member presidency, with a rotation of the chairman and the cabinet (the Council of Ministers). The country is strengthening its democratic central government, which is in charge of foreign policy, foreign trade, human rights and refugees, civil affairs, security and the treasury. Governmental structures are also being strengthened at the entity level.

There are certain differences between entities. Republika Srpska has a unicameral national assembly (People's Assembly), and an elected president and vice-president chair the executive branch. Upon election, the president appoints a prime minister. The Federation of Bosnia and Herzegovina has a bicameral parliamentary assembly with a Federation House of Representatives and Federation House of the People. The president and vice-president of the Federation are nominated by the House of the People and elected by the House of Representatives. The Brčko District has a District Assembly and a District Government.

The Federation of Bosnia and Herzegovina is divided into 10 autonomous cantons, each with its own legislative and executive bodies. This model was chosen to prevent the dominance of one ethnic group by another. Republika Srpska has a north-western part with two regions and a an eastern part with five regions. Since 2000, the city of Brčko has been an autonomous district.

All population-based data in Bosnia and Herzegovina are estimates, since no official census has been made since the end of the war.

Sources: 2–6, 16, 17.
What are the demographic essentials on the people?

**POPULATION PROFILE**
- Gender ratio: 1.02 females per male
- Urban: 44%  \(\text{EU25}: 77\%, \text{EU15}: 79\%, \text{EU10}: 65\%\)
- Age structure: 0–14 years 24%
  \(\text{EU25}: 17\%, \text{EU15}: 17\%, \text{EU10}: 17\%\)
  \(\geq 65\) years 6%
  \(\text{EU25}: 16\%, \text{EU15}: 17\%, \text{EU10}: 14\%\)
- Dependency ratio: 39
  \(\text{EU25}: 49, \text{EU15}: 50, \text{EU10}: 47\)

**POPULATION DYNAMICS**
- Annual growth rate (%)
- Fertility rate (children born per woman)
- Birth rate (live births per 1000 population)

**PROBABILITY OF DYING (per 1000 population)**

- EU25: current members of the EU
- EU15: members of the EU
LIFE EXPECTANCY AT BIRTH (years)

Total population: 73  
EU25: 78, EU15: 79, EU10: 74
Males: 69  
EU25: 75, EU15: 76, EU10: 70
Females: 76  
EU25: 81, EU15: 82, EU10: 78

HEALTHY LIFE EXPECTANCY (HALE)

<table>
<thead>
<tr>
<th></th>
<th>HALE (years)</th>
<th>Total life expectancy lost (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At birth</td>
<td>At age 60</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Males</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>EU15</td>
<td>72</td>
<td>68</td>
</tr>
<tr>
<td>EU10</td>
<td>66</td>
<td>61</td>
</tr>
</tbody>
</table>

Points to remember

demographic trends

Over the past decade, there has been a decreasing fertility rate, but still a positive population growth rate. The socioeconomic and demographic trends still show the impact of the war. The return of refugees and internally displaced people continues. The last seven years of reconstruction and growth have brought some improvement. Overall, the processes of reconciliation, political stabilization and democratization are continuing, with the decisive support of the international community. Along with ensuring equity and tackling corruption, they are the major sociopolitical issues facing the country.

Sources: 2, 5, 8, 9.

What do the people suffer from?

CARDIOVASCULAR DISEASES

- They are the leading cause of death. Within this group, the two major killers are:

before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.
– ischaemic heart disease (8% of disease burden)
– cerebrovascular disease (10% of disease burden).
- High blood pressure causes 29% of the total disease burden.

CANCER/MALIGNANT NEOPLASMS
- Cancer is responsible for 11% of the disease burden.

DIABETES
- Diabetes affects 1.2% of the population

MENTAL HEALTH
- Neuropsychiatric disorders accounts for 20% of the total disease burden.
- Mental disorder prevalence is 2%. EU15: 2.5%, EU10: 3%

UNINTENTIONAL AND INTENTIONAL INJURIES
- Road traffic accidents injure 574 people per 100 000.

INFECTIOUS AND PARASITIC DISEASES
- These diseases cause 2% of the total disease burden.
- There are 46 new cases of tuberculosis per 100 000.
- There are 0.3 new cases of HIV infection per 100 000.
- The rates of sexually transmitted infections (per 100 000 per year) are low compared to EU figures:
  – under 1 new case of syphilis EU25: 3, EU10: 5
  – under 1 new case of gonoccal infection EU25: 9, EU10: 6

EU25: current members of the EU. EU15: members of the EU
CHILD AND ADOLESCENT HEALTH

- Infant mortality: 15 deaths per 1000 live births.
- WHO, UNICEF and UNFPA estimate that the maternal mortality rate is 32 per 100 000 live births.
- Immunization coverage is 87%.

**EU25: 95%, EU15: 95%, EU10: 96%**

TOP 10 CAUSES OF DEATH IN BOSNIA AND HERZEGOVINA

<table>
<thead>
<tr>
<th>Cause</th>
<th>Total deaths (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cerebrovascular disease</td>
<td>19</td>
</tr>
<tr>
<td>2. Ischaemic heart disease</td>
<td>16</td>
</tr>
<tr>
<td>3. Inflammatory heart disease</td>
<td>10</td>
</tr>
<tr>
<td>4. Tracheal, bronchial, lung cancer</td>
<td>5</td>
</tr>
<tr>
<td>5. Diabetes</td>
<td>2</td>
</tr>
<tr>
<td>6. Colon and rectal cancer</td>
<td>2</td>
</tr>
<tr>
<td>7. Self-inflicted injury</td>
<td>2</td>
</tr>
<tr>
<td>8. Liver cancer</td>
<td>2</td>
</tr>
<tr>
<td>9. Nephritis and nephrosis</td>
<td>2</td>
</tr>
<tr>
<td>10. Cirrhosis of the liver</td>
<td>2</td>
</tr>
</tbody>
</table>

*Note. These figures are based on WHO estimates, not on official mortality statistics.*

before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.
## DISEASE BURDEN IN BOSNIA AND HERZEGOVINA AND THE EU

<table>
<thead>
<tr>
<th>Cause</th>
<th>Share of disease burden (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bosnia and Herzegovina</td>
</tr>
<tr>
<td>Cardiovascular diseases</td>
<td>30</td>
</tr>
<tr>
<td>Neuropsychiatric disorders</td>
<td>20</td>
</tr>
<tr>
<td>Cancer/Malignant neoplasms</td>
<td>11</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>7</td>
</tr>
<tr>
<td>Non-infectious respiratory diseases</td>
<td>4</td>
</tr>
<tr>
<td>Infectious and parasitic diseases</td>
<td>2</td>
</tr>
<tr>
<td>Respiratory infections</td>
<td>1</td>
</tr>
<tr>
<td>Perinatal conditions</td>
<td>3</td>
</tr>
<tr>
<td>Intentional injuries</td>
<td>3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2</td>
</tr>
<tr>
<td>Sense organ disorders</td>
<td>5</td>
</tr>
<tr>
<td>Total communicable diseases</td>
<td>7</td>
</tr>
<tr>
<td>Total noncommunicable diseases</td>
<td>83</td>
</tr>
</tbody>
</table>

**Points to remember**

- Noncommunicable diseases dominate the epidemiological profile of the country.
- Communicable diseases remain high on the agenda.
- Mental health problems are predominantly a consequence of the war.

**Sources:** 5, 10.

EU25: current members of the EU. EU15: members of the EU
Where do the risks lie?

SMOKING
- Adult smoking prevalence is 38%.
- Tobacco use causes 21% of the disease burden.

ALCOHOL CONSUMPTION
- Total reported alcohol consumption is 10 litres per person per year. **EU25: 9.4, EU15: 9.4, EU10: 8.9**
- Alcohol consumption causes 4% of the disease burden.

ILLEGAL DRUG USE
- Illicit drug use causes 0.5% of the total disease burden.

OBESITY
- 14% of men and 21% of women are obese.
- Obesity (BMI ≥ 30) affects 12% of males and 7% of females aged 25–34 years and 21% of males and 40% of females aged 55–64 years.
- Obesity causes 10% of the disease burden and physical inactivity, 5%.

FOODBORNE INFECTIONS
- The reported *Salmonella* infection rate is 14 per 100 000.

**Sources:** 2, 10, 11, 13.

*before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.*

Points to remember
- Lifestyle risk factors, especially smoking, obesity and sedentariness, are traditionally widespread. Risk behaviours are on the rise.
- Unexploded mines and other explosive devices, estimated at about 1 million, are a health threat for the country; children are particularly vulnerable.
Who’s who in the public health sector of Bosnia and Herzegovina?

PUBLIC ADMINISTRATION

According to the Dayton Peace Agreement, the country’s health system is divided into separate systems. Organizing, financing and delivery of health care are the sole responsibility of each entity. Overall, the country has three health care systems for its 4 million people, administered by 13 health ministries.

The Brčko District directly provides primary and secondary care through its Department of Health, Public Safety and Community Services. The health care system of the Federation of Bosnia and Herzegovina is highly decentralized, with a Federal Ministry of Health, Federal Health Insurance and Reinsurance Fund and Public Health Institute and branches of these in each of the 10 cantons. Republika Srpska has a Ministry of Health and Social Welfare, which supervises the Health Insurance Fund, the health care network and the public health institutes.

At the state level, the Ministry of Civil Affairs is responsible for defining the underlying principles, coordinating activities and defining strategy in the fields of health and social care, pensions, labour and employment.

PROFESSIONAL ASSOCIATIONS

The Federation of Bosnia and Herzegovina and Republika Srpska each have medical chambers, professional associations and health professionals’ unions.
How are services provided?

The fragmentation of the country severely affects people’s access to services. In 2000, the entities’ two health ministries carried out a survey, according to which at least 48% of the population was unemployed and had serious problems with access to health care. A 1999 WB study found that only 28% of the people in rural areas had access to basic health services.

The design of the health care system makes it difficult to achieve efficiency and quality. In the Federation of Bosnia and Herzegovina, health care is organized at the canton level and coordinated at the federal level. The cantons have had major operational difficulties in providing health services. Republika Srpska manages health institutions at both the entity level and the municipal level; it currently has two parallel systems of primary health care delivery – the former (pre-war) system and the new and reformed system based on family medicine.

**PRIMARY CARE**

Both health ministries have committed themselves to adopting the family medicine approach and reforming primary health care. Reform, however, needs to be balanced against the expected changes in the hospital sector. Developing a health information system will be decisive for the ability of primary care to perform the gatekeeping function, offer scheduled appointments, etc.

Primary care is provided by health centres (dom zdravlijas – “houses of health”). In principle, each has a team of GPs, office nurses and visiting nurses. Primary health care in these centres is, on average, divided into seven distinct functions: general practice, occupational medicine, schoolchildren, preschool...
children, women’s protection, tuberculosis protection and epidemiological surveillance. Under the same roof and with the same administrative structure, specialized care units for specific population groups often coexist. Within the sphere of each health centre there are several subsidiary health stations (ambulantas) for local communities. These are small, staffed by a GP and a few nurses, and provide basic first-line care and refer people to other health care facilities.

In the reformed system, all patients are supposed to enter through the family medicine team at the community health station level. The family medicine team provides basic health care to all patient groups, including health promotion and disease prevention activities, basic diagnostic and therapeutic services, and follow-up or rehabilitation activities at home after treatment at higher levels of care. The family doctor is responsible for referring patients for additional testing or treatment. The family medicine model was tested and the country aims at 100% coverage with in the next 5–7 years.

SECONDARY AND TERTIARY CARE

Inpatient services are provided in a general/cantonal hospital with a catchment population of about 70 000–150 000 and at least four departments: internal medicine, surgery, paediatrics and gynaecology/obstetrics. Complex medical specialities are exclusively confined to clinical centres (there are four in the country), with a catchment population of over 500 000.

There are four types of hospitals: clinical centres, general acute hospitals, specialized hospitals and small district hospitals.

Given the low level of hospital occupancy, one may conclude that there is no lack of hospital beds. The problem seems to be more with the composition and quality of services, which are generally deemed to be unsatisfactory.
PUBLIC/PRIVATE MIX

Private practice and private ownership of health care facilities have been enacted in both entities, but proper stewardship of the public/private mix remains a challenge. Privately delivered care is increasing and health professionals often practise in both public and private settings.

Points to remember service provision

- The planned reforms in primary health care continue to be implemented.
- Public health services are underfunded and need to be supported.
- Existing inequities in access to care need to be recognized.
- Carrying out a systematic, in-depth assessment remains high on the agenda to measure the effectiveness of current services.
- Hospital directors should demonstrate proper competence in health management.

What resources are available?

HUMAN RESOURCES FOR HEALTH

The war, migration and cultural preferences have influenced the availability and distribution of health professionals. Overspecialization is traditionally a key feature that affects the desired introduction of primary care. The existence of five medical schools contrasts with the considerable shortages of health funding. Salaries are in general low. In the Federation of Bosnia and Herzegovina, most physicians are specialists and the proportion of nurses with higher education is low.

before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.
HEALTH PROFESSIONALS (per 100 000)

- Physicians: 146  EU25: 343,  EU15: 356,  EU10: 278
- Pharmacists: 10  EU25: 78,  EU15: 81,  EU10: 60
- GPs: 21

HOSPITALS

- Hospitals per 100 000: 0.9  EU25: 3.2,  EU15: 3.3,  EU10: 2.8
- Hospital beds per 100 000: 314  EU25: 611,  EU15: 600,  EU10: 661
- Annual inpatient admissions per 100: 7.9  EU25: 18.5,  EU15: 18.4,  EU10: 19.5

PHARMACEUTICALS

During and immediately after the war, the supply of drugs was mostly channelled through humanitarian aid. At present, the country does not manufacture sufficient drugs to cover its needs. While the availability of medicines and medical devices in the country seems to be satisfactory, accessibility of drugs varies significantly among cantons and between entities. In many cases patients have to pay for medicines from their own pockets.

In 2005, a draft national drug policy was developed, through an EU-funded project and with the assistance of WHO, which has also assisted both entities to develop and update their essential drugs lists since 1995.

The current Law on Medicines and Medical Devices was adopted in 2001. In the Federation of Bosnia and Herzegovina, the Federal Ministry has established a Pharmaceutical Department; implementation of the regulations is mostly left at cantonal level. Republika Srpska has established a Drug Agency.
WHO and the EU assisted national authorities in drafting the Law on Medicines and Medical Devices and the Law on the Federal Drug Agency.

Points to remember

- With externally funded projects being planned and launched, new human resources are needed to carry out reforms, with a wider range of experts, not solely those working on the projects.
- Decisions about medical training need to reflect the country’s population, the need for high-quality training and the financial constraints.
- Country-wide benefits can be achieved by strategic human resources planning.

Sources: 2, 14.

Who pays for what?

By law, most citizens should be entitled to health care and have compulsory health insurance coverage. In reality, many are not. Health care financing is seriously complicated by the administrative structure of the country.

In the Federation of Bosnia and Herzegovina:
- the cantonal health insurance funds finance health services, and the Federal Health Insurance and Reinsurance Fund, founded in January 2002, addresses the problems of the highly decentralized system;
- the collection of funds is low and the movement of funds and patients is obstructed;
- the scope for redistribution of resources to those in need is greatly limited;
- the current average contribution rate of 18% of salary is split between the employee (13%) and the employer (5%).

before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.
In Republika Srpska:
- the system is relatively centralized;
- around 70% of the population contributes to the Health Insurance Fund (with rates for different groups) in the compulsory social health insurance system;
- there is no option for voluntary insurance but supplementary (extended) insurance is allowed for some extra benefits.

Both health ministries are developing a basic benefit package to be provided through compulsory social health insurance. The fragmentation between the entities and within the Federation, however, is an obstacle to risk pooling. This is one of the reasons why the entitlements promised by publicly financed health care exceed the resources of the various funds.

In both entities, the main sources of health care financing are the health insurance funds, which derive 75–80% of their resources from wage taxes. Compliance rates are relatively low, however, leaving the public sector as the main source of funds for health insurance. This creates inequities, hampers competitiveness between health enterprises, encourages the proliferation of the informal sector and undermines the sustainability of the social insurance system.

In both entities, health insurance fund revenues fall significantly short of covering all legislated entitlements, and as a result the funds have little control over budget-item spending or its impact on the quality and scope of services. The main shortcomings of the health financing system are:
- the low tax base and high tax burden, particularly in the Federation;
- ineffective inclusion of the self-employed and farmers as contributors to the funds;
- the large number of beneficiaries excluded from making personal contributions, and the widespread failure of intended contributors (extrabudgetary funds and government budget) to do so;
- the increasingly large share of people who are not covered;
- low tax collection rates;
- highly skewed ability to generate revenues across cantons;
- small risk pools and inability to exploit economies of scale.

**Points to remember**

- The economic impact of the war on the whole country is estimated at US$ 50–60 billion.
- The health sector is supported by the international donor community. While this is commendable, it may also have an unintended effect: diminishing the incentive to take up health reforms at the national level.
- The main challenge for the country as a whole is solidarity.
- A national, non-fragmented mandate for health care financing is still lacking. As a result, citizens of one entity are left without protection when they need health care in the other. Under-the-table payments are not officially reported, but both health ministries recognize this practice as a big challenge.
- Overall EU assistance to the country is €2.164 billion.

**Out-of-pocket expenditure on health** 100

(\% of total private health spending)

**Population below the national poverty line** 20\%; an additional 30\% live just above the poverty line and 16\% on less than US$ 2 per day

**Sources:** 2, 8, 15, 18, 19.

Before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.
How has the country reformed its health care system?

The country is still seeking a way out of the political crisis, reconciliation and stabilization, and establishing a sustainable economy and a functioning state administration. The international community has supported national policy development. The EU carried out a functional review of the health sector administration in 2004.

There have been some country-wide efforts for health reform; in 1997:

- the two health ministries signed an agreement to implement primary health care reform, with a family medicine approach;
- both entities developed strategic plans for reform and reconstruction of the health sector.

With the assistance of WHO, a primary health care strategy is being developed. In 2005, a project was launched to scale up family medicine throughout the country.

In the post-war period, a number of new laws and policies have been adopted. Accrediting agencies were created in both entities to improve the quality of care. Developing new, modern health information systems has attracted a lot of external funding and support.

The reform processes have been largely supported by the international community. WB has completed its support for rehabilitation of war victims, development of essential hospital services and the Basic Health Project. Currently, it focuses on investment support for health insurance to be able to respond to post-war decentralization. UNICEF and UNFPA are also
delivering health programmes. Bilateral donors, such as the governments of Canada, Italy, Japan and Switzerland are also present in health sector reform. For instance, CIDA is preparing a major investment in the health sector focusing on primary health care, youth and health and strengthening civil society’s voice for public health. GAVI is providing a five-year supply of hepatitis B vaccine and support for injection safety and training activities. The Global Drug Facility is providing a three-year supply of tuberculosis drugs.

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### Points to remember

- Health system reforms continue. Both health ministries, together with the Ministry of Civil Affairs, support this effort, but they need to strengthen their own abilities to enforce the laws and carry out policies.
- Implementation of the laws and regulations is the key challenge for the country.
- Among the most important developments are the efforts to develop the family medicine system at the community level, throughout the country.
- Health information remains to be used as a tool for a culture of transparent and goal-oriented decision-making.

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### What is one of the things learned by doing?

**HEALTHY MINDS, HEALTHY COMMUNITIES**

Bosnia and Herzegovina is leading the mental health project of the South-eastern European Health Network, which was established in 2001 by the WHO Regional Office for Europe and the CoE as part of the Stability Pact initiative for south-

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*about the new EU neighbours* 59

before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.
eastern Europe. Funded by the governments of Belgium, Greece, Hungary, Italy, Slovenia and Sweden, the project aims to support countries in working in partnership to develop their mental health services.

Bosnia and Herzegovina has taken a ground-breaking approach, with the vision that no success is possible if the countries themselves do not have ownership and responsibility for the project. According to the project leaders, this is the only way to ensure that outcomes will be sustained even after the project’s international assistance expires. To make this happen, Bosnia and Herzegovina has supported countries in exchanging information and working together to develop solutions. Ten technical workshops have been held in less than three years (2002–2005), gradually building up a unique regional alliance. The project evolved step by step:

• making a situation analysis and mapping the problems;
• drafting standards for mental health services at the community level;
• introducing international and EU standards;
• drafting and reviewing national mental health policies;
• introducing international mental health legislation and human rights;
• making a joint statement about the south-eastern European dimension of the problem with recommendations to governments:
  • piloting mental health centres at the community level in each country;
  • adopting a south-eastern European model of community mental health services;
  • building the capacity for managing mental health services;
  • developing the information systems in the area of mental health.
What has the Regional Office been doing in Bosnia and Herzegovina?

A WHO humanitarian assistance office was established in the country in 1992. During the war, WHO’s main activities were assistance and relief. A liaison office started to function in 1993, and in 1998 it was integrated into the WHO Country Office, Bosnia and Herzegovina, in Sarajevo.

WHO’s involvement in the country focuses on supporting the development of the health system. WHO seeks to provide a forum for international exchange and learning that will enhance the abilities of senior staff in the health ministries. Other areas of interest are developing a health financing policy and confronting the existing inequities of access to health care. Currently, WHO is implementing a major EU-funded project with a budget of €2 million. For 2004–2005, the priorities were:

- mental health;
- health policy with focus on management, primary health care and nursing;
- development of the pharmaceutical sector;
- accreditation and quality assurance;
- public health management and planning, with focus on communicable diseases;
- immunization and vaccine-preventable diseases;
- noncommunicable diseases;
- food safety;
- tuberculosis.
For the period 2006–2007, some priorities for collaboration are:

- strengthening the capacity of the health ministries to assess the performance of health systems and to regulate the pharmaceutical sector;
- scaling up the prevention and control of communicable diseases;
- mental health and drug abuse.

OTHER SOURCES OF INFORMATION ON BOSNIA AND HERZEGOVINA

Bosnia and Herzegovina Council of Ministers (http://www.vijeceministara.gov.ba/)
Government of Federation of Bosnia and Herzegovina (http://www.fbihvlada.gov.ba/)
Government of Republika Srpska (http://www.vladars.net)

World Bank’s Mission in Bosnia and Herzegovina (http://www.worldbank.ba)
Office of the High Representative (http://www.ohr.int)
OSCE Mission to Bosnia and Herzegovina (http://www.oscebih.org/)
European Union in Bosnia and Herzegovina (http://www.eubih.org/)
before 1 May 2004. EU10: countries that joined the EU on 1 May 2004.

about the new EU neighbours