Managing the process of change

FOUNDATION "THE OPEN NETWORK FOR COMMUNITY DEVELOPMENT"

HEALTH MASTER PLAN

2015-2024

- DRAFT June 2015 -
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Background

Romania faces serious health problems that the healthcare system does not seem to be able to cope with. Poor health indicators such as high morbidity and mortality through tuberculosis, hepatitis B and C, cervical cancer, infant mortality, dramatically dropping of
healthy life expectancy place Romania on the last places in Europe with regard to health showing the poor performance of its health system.

In addition, citizens from rural communities are even more disadvantaged than those living in towns with regard to healthcare. They have less access to basic health services, lower insurance coverage and worse health outcomes. Health and social assistance services at grass roots level are in general severely underdeveloped; this is even more obvious within rural communities in Romania whose citizens have poorer health indicators, in general (higher infant mortality, lower life expectancy, others) than the ones living in urban areas. Doing nothing represents an enormous threat to the health of citizens in rural communities in general and to the chronic patients living in rural areas in particular. This will automatically lead to more expenses as well for the patients as for the state budget.

The Foundation “The Open Network for Community Development” (TON) is a network organization that has been built bottom up. This foundation is the result of 25 years of cooperation between Flemish (Belgian) and Romanian communities. The Belgian NGO ‘ADR-Vlaanderen’ connects and represents approximately 100 twinning partnerships. Romanian partners have been organized within Romania in TON, as exchange and collaboration were deemed essential for future progress. At the moment, TON encompasses about 20 twinning partnerships, including partnerships that have evolved for more than 25 years. The Belgian-Romanian cooperation proved a big advantage for both partners, though having a Belgian partner is not requested as a condition for becoming part of the TON network.

TON is in a unique position to better articulate the needs of rural communities in Romania, to advocate for their fulfillment and to facilitate learning within the network. As access to healthcare does represent a basic need of any individual, family or community, defining a HEALTHCARE MASTER PLAN to express the vision of TON communities with regard to their health / access to health and to identify trigger actions that can better support the process of TON communities becoming Healthy Communities represents a key priority for the TON Foundation.

This Healthcare Master Plan will be part of a “General Master Plan 2015-2024” for the different TON departments to be developed in the upcoming years. In that perspective, the TON-network has a unique selling product as it covers different aspects of societal change (health and social services, citizen participation, environmental action, etc.) and stimulates interaction between these different departments.
SWOTAR (Strengths, Weaknesses, Opportunities, Threats, Aspirations, Results) Analysis

**Strengths**
- Strong partnerships between Romanian and Belgian communities with more than 25 years of existence;
- Civic groups initiated in target communities: women-/ men-/ youth-/ elderly organizations, Vizidom, etc.
- A number of Local Health Committees created, having implemented or having expressed willingness to promote innovative healthcare services within their communities (Slatina-Timis, Taut, Moldovita, Viscri, others).
- Some of the Health Committees, as in Slatina-Timis and Moldovita, have constituted formal organizational structures with juridical personality such as ADAM (Associația De Ajutor Mutual); ADAMs include important cultural shifts in approaching medical services within the community. They are voluntary mutualistic organizations, based on solidarity, where people can enroll by paying a yearly membership fee. Support is offered to individual members in various forms (subsidized access to medical equipment, drugs, etc.), provide primary and secondary prevention services to members, provide networking services with specialist doctors and hospitals, defending the rights of the patients, working on health promotion and prevention, etc. Voluntary work is promoted.
- More than that, the ADAM (community health center) in Slatina-Timis having more than 15 years of continuous activity started to be able to report better health of its citizens.

**Weaknesses**
- Low capacity in basic health services provision at community level in general (low level of specialized staff provided under public arrangements);
- Low overall funding of the healthcare services at community level;
- Lack of information at community level about basic health status of the population;
- Low institutional capacity/ weak governance structures of the Local Health Committees;
- Low financial and human resources;
- Lack of interest from local governments.

**External opportunities**
- Simple healthcare services that are not currently provided can enable high levels of health gain for the specific communities, hence, small investments can lead to high benefits in terms of health of the community members;
• Documentation and promotion of the successful case study in Slatina-Timis can represent an engine for an advocacy strategy developed by TON in favor of health policies better adjusted to the needs of rural communities;
• The 2014-2020 National Health Strategy of Romania (voted in November 2014) does emphasize the need to enable better access to basic services for most vulnerable populations; in this context, the progress accumulated through grass roots work has a good opportunity for being disseminated;
• Partnership arrangements catalyzed by TON do represent a real opportunity for each and every local community;
• Good potential of shared fundraising/advocacy; TON will develop knowhow to increase performance and coverage of health services at Romanian community level, ADR would support with the identification of Belgium partners; shared projects (fundraising) and shared learning would become beneficial for both TON and ADR; projects written and implemented in partnership will have better chances of success, higher chances for advocating for the solutions that prove to be of good benefit for the health of citizens in rural communities;
• We are broadening the cooperation also to Moldova and looking for other countries to set up joint activities in Romania and exchange on good and best practices;
• Talk with and explain things/changes to the population locally;
• Permanent exchange between B-Ro specialists in different matters.

External Threats
• The low employment rates and low coverage with health insurance;
• The underdeveloped health services at community level; the low level of prevention services that practically condemn the population to become unhealthy very early during life course;
• Low overall budget for the healthcare system; with an overall budget of around 3.6-4.0% of the GDP allocated to the healthcare system. Romania places itself near Bulgaria on the last place in Europe;
• The financing and implementing national policy decisions remains a challenge as remains the articulation of decentralized EU funds (i.e. making operational programs respect the strategic directions of the National Health Strategy 2014-2020);
• The upcoming private health insurance that will introduce fees established according to the level of the risk of each individual shall put individual in rural isolated communities at much more health risk than other citizens of Romania. This would increase the existing gap between the access to services in rural versus urban areas, leading to an increasingly polarized health system (system at two speeds); in this context, identification of solutions for better services in rural areas and advocating for these to be included in the
basic health packages represents the key challenge to which TON / ADR partnership dedicate its efforts;

- Doing nothing represents an enormous threat to the health of citizens in rural communities in general and to the chronic patients living in rural areas in particular. This will automatically lead to more expenses as well for the patients as for the state budget;

**Aspirations**

- To develop TON as a reference organization concerning local healthcare, improved access and equity to healthcare for rural population;
- To improve the health status of citizens in at least 20 TON communities;
- To identify and to contribute to innovative solutions for better services in rural areas;
- To increase TON institutional capacity for health at national level;
- To increase TON institutional capacity for health at local community level;
- To implement and monitor new services in TON communities;
- To develop TON will contribute to better health of the population by becoming a strong advocate for better healthcare services.

**Results**

- TON Master Plan healthcare is Implemented by 2025;
- 20 local health action plans are developed and implemented by 2025;
- 10 community healthcare centers (ADAM’s) are functioning by 2025;
- 10 local health committees (LHC) are functioning by 2025;
- Monitoring reports are issued quarterly by each of the 20 communities implementing action plans;
- 10 monitoring reports / socio-medical maps have been developed;
- At least 3 community health projects have been implemented in each of the 20 TON local communities;
- At least 40 training and educational programs have been provided for health professionals working in the new projects;
- At least 10 trainings have been provided to TON facilitators;
- Guidelines for setting up local health projects have been defined.

**Mission**

The “raison d’être” of TON is one of an enabler, of creating and sustaining a learning environment amongst TON communities where communities start to better understand and articulate their health needs, their rights for health, to identify effective and cost efficient
ways of intervention, to acquire the knowledge and skills to monitor their access to health services, their outcomes in terms of health status.

**Vision**
In the medium / long term future, TON communities should be free of avoidable deaths (such as the ones due to infant / maternal mortality, tuberculosis) and should be successful in decreasing the burden of chronic diseases to increase the quality of life of their citizens by developing their basic health services environment: prevention, monitoring, basic treatment of main chronic diseases, access to basic drugs, dentistry, etc..

In 10 years’ time, citizens of TON communities shall become healthier than today; they will become agents of change for training other Romanians on how to become healthier.

**General Objective**
To improve the health status of citizens in 20 TON communities during the next 10 years (better trends of major health indicators as compared to the national trends).

**Specific Objectives (SO)**
SO1. To increase TON institutional capacity for health at national level.
SO2. To increase institutional capacity at local community level and create 10 ADAMs/or grass root organizations with juridical personality and 10 Local Health Committees (LHC) in 20 of the TON communities.
SO3. To effectively implement and monitor at least 60 new services within the 20 TON communities (at least 3 new services per community).

**SO1. To increase TON institutional capacity for health at national level**
Activities to be undertaken should focus on:
- a) Network / develop partnership with key professional bodies / leaders of innovative services / projects of change (Caritas, Hospice Casa Sperantei, Center for Studies in Family Medicine, Association of Social Psychiatry in Campulung Moldovenesc, World Vision Romania, others;
- b) Document casestudy Slatina-Timis;
- c) Look for beset practices in Romania and facilitate their cooperation;
d) Identification of sources of funding (Grants / funding from companies CRS / communities contribution, local public funds / in kind contributions, etc.), project proposal writing, develop Fund raising and fund raising capacity;

e) Technical assistance for local communities / identification and dissemination of learning points / TON website for health to collects all experiences/ lessons learned in communities implementing health projects. Creation of a ‘TON Inspiration brochure’ and ‘TON Bank of materials’;

f) Creating opportunities for increasing visibility and awareness, networking, interacting amongst the actors, creating coalitions, task forces for the promotion of the agenda of health of vulnerable remote communities: UNICEF, World Vision, Save the Children, Belgium Embassy, Norway Embassy, Swiss Embassy, IMF, World Bank, AIM, UN, WHO, Coalitia Health Task Force (Ro), other;

g) Identify, interconnect and follow-up on interface between the different layers in Romanian healthcare;

h) Increase effectiveness and sustainability of fundraising activities.

Inputs
- TON Board;
- TON Health policy expert;
- 2 researchers to analyze / document / write report of Case study Slatina-Timis;
- One server and software development for management of community health information system;
- Network of support, to support the idea of healthy Romanians;
- Sponsorship agreements signed.

Outputs
- Case Study Slatina-Timis defined; health indicators and monitoring strategy to highlight needs of rural communities are defined;
- Strategy for the dissemination of the case study defined, implemented, monitored and evaluated;
- Health Master Plan defined;
- Project proposals / project applications defined;
- Network with Romanian / Belgian organizations and institutions; partnership agreements / definition of clear tasks for the following 10 years to fulfill objectives of Health Master Plan;
- Round tables with interactions between actors on health and healthcare;
- Basic funding for implementing community health projects ensured in a sustainable way.
SO2. To increase institutional capacity at local community level and create 10 ADAMS and 10 Local Health Committees (LHC) in 20 TON communities by 2024.

ADAM and LHC will be strong organizations that would have clear operational procedures, good knowhow on defining community health action plans (starting from needs assessment, to implementation, monitoring and evaluation), extended partnerships with a wide range of stakeholders in their communities, and would have implemented, monitored and reported on a routine basis at least 3 types of community based health projects each.

In addition to the 10 LHC which use appropriate operational procedures, but are not yet constituted as formal organizations, in 10 of the communities this process is to be finalized in the form of an ADAM. In the meanwhile we also will look for existing examples that are in the same range as our models (f.e. group practice of family doctors in Bucharest).

Activities to be undertaken should focus on:

a) Selection and hiring of community health facilitators that would contribute to the institutional development of LHC and ADAM;

b) Design intervention methodology / train / coach community health facilitators;

c) Selection of TON communities to start up process highlighting the opportunity to start investing in health programs (organize visits with facilitators in each of the “willing” communities / assess their “preparedness” to invest efforts in developing the local health agenda;

d) Provision of effective process facilitation services that would start from identification of community health leaders, support community leadership for generating participatory needs assessment, participatory monitoring of services provided, definition of roles and responsibilities for the Local Health Committees, support the formalization of the institutional structure and creation of ADAMs, support to LHCs or ADAMs in defining local health community plans;

e) Organization of quarterly trainings / workshops with selected persons (ensuring the secretariat for LHCs) to address issues such as health needs assessment of the community /models of services / access to services and services quality / seek support of local councils (administration) / partnership building / fundraising / legal matters / monitoring and reporting; these workshops shall represent the venue / place where the problems appearing during implementation / learning from specific projects shall be discussed (from menu of possible projects in SO3); developing ADAM Slatina-Timis as Training Center;

f) Development of a model to attract local committees to cooperate; this model would imply on one side the involvement of the community population / civic groups in a participatory planning of the local (community) health plans / seek support of local
councils (administration); the benchmarking of community health indicators with the health indicators of other communities, the provision of evidence based information on the most appropriate and effective services to be developed at grass roots, at community level, the participatory monitoring of the services provided, etc.;
g) The ‘TON Social Map’, based on statistical figures but also including the qualitative interviews as already done in Viscri and Slatina Timis, can be a start to analyze the local situation. If quantitative data will help position local communities according to their health indicators, resources dedicated to health, the qualitative assessments will start building ownership of the community members over their diagnosis on the community health needs, their participation within the processes of defining community health plans as well as monitoring and evaluation plans for the healthcare services provided;
h) Develop and advocate for the development of the role of the community nurse / community health assistant, a key member of the community health team. Development of partnerships between Romanian and Belgium Universities, University Colleges, partnerships with Belgium Nurses Association, Nursing Schools such as Thomas More Belgium, Belgium nursing provider organizations such as White Yellow Cross Belgium organizations involved in the provision of nurses training and continuous education, organizing joint training programs, organization of job shadowing / internship experiences, contributing to the definition of comprehensive training curricula and job description for nurses at community level on applied fields such as home care, palliative care, mental health, revalidation, advocating for increased budgets for community care services would be some of the activities that would contribute to develop the role of the community nurse in Romanian communities;
i) The specific situation of an ADAM, being a “mutualistic organization” in solidarity. Meaning with members, membership, general assembly and board. This accentuates the input of members (patients and non-patients) locally and make guarantees a democratic organization. They are steering the organization / center.

Inputs
- Process facilitation / Community health facilitation: a minimum number of 2 or 3 facilitators could work on a regional basis / regional area with 2 or 3 communities at a time;
- Trainings in community organization, setting priorities, defining and monitoring projects to community members;
- TON Social map.
Outputs

- Community Health Facilitation Guide defined; this is to include the description of processes from health needs assessment to monitoring and evaluation of intervention and definition of monitoring / reporting templates;
- 10 communities were a TON social map is performed;
- 10 ADAMs / other organizational set ups with juridical personality and 10 LHCs in 20 TON communities are created;
- 10 ADAMs and 10 LHCs define **20 local health action plans**, aiming to implement and monitor at least 3 health projects in each community.

SO3. To effectively support the implementation of at least 3 community health projects in each of the 20 TON communities during the next 10 years

A menu of projects / innovative services that are responding to most of the health needs in the community is broadly defined below; the principles underneath these possible services are the following:

- a) Use evidence based services that with minimum of resources will maximize health gain;
- b) Are the expression of communities will and commitment / represent a need of the community and are owned by the communities / LHC;
- c) Start from implementing simple services, coach / provide feed-back to community teams during their implementation and only when a lesson is well learned go to a more complex type of services;
- d) Simple services (i.e. prevention campaigns) can be implemented on a broader geographical area from the beginning whereas more complex services would need to be focused / documented and only after that disseminated;
- e) Use as role models people that had already performed those services / enhance adult learning skills / learning by doing;
- f) Allow sufficient focus on monitoring and evaluation / reflection of the new practice / new learning;
- g) Experts from Belgium: exchange of knowledge.

TON will ensure the network and partnership with appropriate / lead organizations, implementation of the training programs that will precede all start up implementation of a new service in a community; community health teams may participate in clusters of 3 communities to a training that would be commissioned by TON. Readiness and commitment for the implementation of community health projects shall be criteria for selection for participation in the training program. **Community Health Facilitators** shall also participate in each thematic training program to be further capable to support / coach the community.
teams in the implementation / reporting on effective services delivery / assessment of community members’ opinion on the new services provided, etc.

Possible Menu of Projects

A. First response services at rural community level

This type of project would include activities as:

a) The definition of a partnership between ADAM or LHC / local Government / county and local (cooperation professional (ISU) and voluntary fire brigades (SVSU) in a region) fire brigade / family doctor / community nurses / schools / Flemish partners / local civic organizations;

b) The selection of team of first responders at community level;

c) The training of trainers at community level- team of first responders in: first aid, firefighting, use of existing protocols. Especially for firefighting, a common training by ISU of SVSU and action plan will be developed;

d) The definition of a first response community plan i.e. first responders team further provide trainings to school children, implementation of preparedness exercises, definition of role of volunteer fire fighters, definition of communication protocols with fire brigades / healthcare units, training, cooperation, evacuation plans for schools and other public places and evacuation trainings, installation of smoke detectors and CO-detectors in public spaces and promote for private houses, etc.);

e) Dissemination of good practices / hands on training models: see existing models from Belgium and Switzerland;

f) Advocacy for defining the role of volunteer fire fighter / including skills based development curricula and possible compensations (remuneration);

g) Actively look for twinning between Ro and B firefighting teams.

Inputs

- TON creates partnership with leader organizations providing services in the area- SMURD / Flemish partners;

- TOT program for professionals / volunteers from TON communities, including guidelines / manual for good practice- provided by SMURD / Flemish experts;

- Existing materials Be / Switzerland and new approach ministry of Internal affairs on safety (Master Plan for 10 years – communication with Mr. Arafat / Mr. Zoicas);

- BIG (Brandweer Informatiecentrum Gevaarlijke stoffen, Belgium) Firefighters Information Centre Dangerous Goods.
Outputs

- 15 TON professionals / volunteers per each TON community are trained under a TOT program by SMURD/ Flemish partners;
- 100 youth (from Youth groups) / children are trained in each TON community;
- Preparedness exercises in case of emergency are tested yearly in participating TON communities;
- Dissemination / advocacy strategy defined for recognition of the volunteer firefighter / the integration of his/her intervention within the intervention protocols;
- Communication and warning systems for volunteer firefighters / Personal insurance for volunteer firefighters / yearly medical check-up by ADAM for free.

Initial startups may be possible in a pilot number of communities (3-5) and a minimum investment with scaling up to all TON communities.

Regions (cooperation within a Romanian region) and Belgium partners: f.e. Caras Severin and Geel, R.M. Valcea and Balen; additionally, cross-border cooperation may also be looked for (f.e. N-E: Iasi-Moldova and S-W: CS/Timis/ARAD-Serbia/Hungary).

Cost estimate

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B. Mother and child health community projects

This type of project would include activities such as:

a) The definition of a partnership between the ADAM or LHC / local government / social worker / family doctor / community nurse (where available) in each of the communities / specialists / hospitals;

b) Creation of the task force on Mother and Child Health at community level;

c) Selection and training of professional teams at community level;

d) Identification of mother and children at risk within the community;

e) Systematic provision of services - to be targeted especially on families at risk;
f) Monitoring and evaluation; the evaluation shall look at the health indicator obtained after each year of intervention against the baseline indicators existent at the beginning of the intervention;
g) Monthly electronic report of the activities.

**Inputs**
- TON creates partnership with leader organizations providing services in the area - World Vision Romania / National Center for Studies in Family Medicine;
- Professionals from TON communities follow a minimum training program (training to be provided by experts of the National Center for Studies in Family Medicine);
- Belgian partners: TBC.

**Outputs**
- At least 10 persons are trained at the level of each TON community (Task force members/ professional team / social worker / volunteers) in mother and child health;
- Selected / specific indicators are identified;
- Monthly monitoring electronic reports are issued / overall TON communities map of indicators.

**Outcomes**
- Decrease of maternal and infant mortality in TON communities.

Initial start-ups may be possible in a pilot number of communities (3-5) and a minimum investment with scaling up to all TON communities.

**Cost estimate**

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**C. Fighting communicable diseases**

From all communicable diseases, tuberculosis and hepatitis C remain a challenge for the Romanian healthcare system, the morbidity and mortality generated by these diseases being
on the first places in Europe. Despite the alarming indicators, there is no clear articulation of policy measures to enable more appropriate health outcomes.

C.1. Tuberculosis
The healthcare system fragmentation, the diminished role of the community nurse as a proactive follow up agent in the community, the changing role of a family doctor from serving a catchment population to serving a number of persons on its private list of patients, the counterproductive financial incentives provided to specialized medical staff for number of patients “in treatment” and not the number of patients cured, all are factors that contributed to the poor coordination of services provided to TBC patients.

**Inputs**
- Mapping of TBC patients in the community;
- Training for community nurses, family doctors for the proactive monitoring of TBC patients, TBC contacts and suspects;
- Vertical integration with specialized services.

**Outputs**
- Number of patients correctly taking the treatment;
- Number of contacts that are adequately investigated.

**Outcomes**
- Decreasing trends of TBC infection.

**Cost estimate**

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C.2. Hepatitis C

Increased levels of Hepatitis C (highest in Europe) seem to be associated in Romania with poor sterilization conditions (not only in health and dentistry units, but also in manicure / tattoos / piercing, etc.).
Inputs

- Health education trainings for health professionals (community nurses, family doctors) and community members over hepatitis C transmission;
- Basic screening for liver malfunction;
- Training on diseases care planning, treatment guidelines, vertical integration between PHC and specialized services.

Outputs

- Number of new cases with Hepatitis C identified;
- Number of patients with hepatitis C appropriately treated.

Outcomes

- Decreased mortality due to Hepatitis C.

Cost estimate

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D. Primary prevention for non-communicable diseases

This type of project would include activities such as:

a) The definition of a partnership between the ADAM or LHC / local government / social worker / family doctor / community nurse (where available) in each of the communities / civic organizations;

b) Creation of the task force on NCD Prevention at community level;

c) Recruiting teachers / health-social workers / youth;

d) Training recruited teachers/health-social workers / youth from TON youth organizations / women from TON OLF;

e) Implementation of day to day activities in schools and kindergartens;

f) Provision of monthly reports of activities in schools and kindergartens;

g) Monitoring and evaluation of the implemented activities;

h) Dissemination of the learning to other NGOs / communities.
Inputs

- TON creates partnership with Norwegian Embassy / MoH / District Health Authorities / National Institute of Public Health for the use of the tools developed by the project funded through Norwegian Government- Ensuring access of children and adolescents to high quality prevention services for non-communicable diseases - healthy nutrition and physical exercise;
- Trainings to task forces and professionals in TON communities;
- Small grants for schools and kindergartens (standard packages with balls / ropes / Frisbees / bikes, etc.);
- Cooperation with DSP; evidence based activities such as food triangle and actions in schools together with parents in order to get healthy food to be incorporated in lessons;
- Cooperation with AGLT / play days / Youth Organizations Flanders (Somepro);
- Monitoring and evaluation of activities and reporting to local councils, DSP.

Outputs

- At least 80% of the schools and kindergartens in the 20 TON communities enroll to the program and foresee these activities within their Rule for Internal Organization;
- At least 75% of children 03-18 year old have access to prevention of NCDs in TON communities;
- At least 50% of parents of children 03-18 years old have access to prevention of NCDs activities in TON communities;
- Activation and cooperation with parent organizations in schools.

Outcomes

- Increased prevalence of healthy behaviors in children and adolescents in TON communities;
- Decreased rates of NCDs in TON communities: Evidence Based Measurement.

Cost estimate
E. Management of risks for chronic diseases (i.e. diabetes and hypertension)

Assessing and managing risks for most prevalent non communicable diseases – diabetes type II and blood hypertension:

a) The definition of a partnership between the ADAM or LHC / local government / social worker / family doctor / community nurse (where available) in each of the communities;

b) Creation of the task force at community level on Diabetes and HTA Risk management (ideally headed by the family doctor / community nurse, but with one representative of HTA/ diabetes patients or family member of patient with diabetes / HTA);

c) Training health workers / community leaders / volunteers in using the risk assessment tool / dissemination of the information for risk management / support provided to the family doctor to organize health classes (not yet in contract with the National Health Insurance House);

d) Monitoring and evaluation of the implemented activities / of the risks for diabetes / hypertension existent at community level;

e) Cooperation and partnerships with diabetes organizations and specialists.

Inputs

- TON creates partnerships with the Center for Studies in Family Medicine for provision of the needed training / coaching of health workers teams in diagnosing / managing risks for diabetes / hypertension;
- TON will develop a ‘diabetes passport’ and a ‘diabetes daily registration notebook’;
- TON will look for a project installing a ‘Green Diabetes Phone line’ where all kind of information regarding diabetes can be asked. Dial in for free;
- Common purchase of products: i.e. lancets for glucose meters, glucose meters, etc. will be examined.

Outputs

- 75% of the community members at risk of diabetes and HTA are trained to become aware of their risks, to acquire knowledge, skills and attitudes to be able to control their risks;
- Cooperation with the Romanian diabetes organizations and federations as well with the Flemish diabetes league and the international diabetes federation IDF will be set up.
Outcomes

- Decreased morbidity with diabetes and HTA in TON communities.

Cost estimate

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F. Implementing chronic diseases management plans (i.e. for diabetes and hypertension)

Within 10 years, 30% of the populations can develop diabetes. In communities that have chosen the project above, further work in enabling diabetes and hypertension care plans between the family doctor and the specialist doctor at the level of the nearest town/county town.

a) The definition of a partnership between the ADAM or LHC / specialist doctor / social worker / family doctor / community nurse (where available) in each of the communities;

b) Creation of the task force at community level on Diabetes and HTA management (ideally headed by the family doctor / community nurse, but with one representative of HTA / diabetes patients or family member of patient with diabetes HTA);

c) Ensure communication with dedicated specialist doctors / dietician, definition of individual treatment plans, including healthy nutrition and daily physical activity, homecare monitoring and treatment;

d) Ensure programming of patients according to the severity of their case;

e) Develop tools / pattern of intervention that can support smooth implementation;

f) identification of cases with more relapses / identify and address causes;

g) Monitoring and evaluation of the activities.

Inputs

- Partnerships with medical doctors associations of diabetologists and cardiologists (Romanian Society of Hypertension) to enable dissemination loops starting from the actual examples in communities;
- Training of professionals / task force members;
- Access to ECG in each community medical center;
- Blood pressure meters in community medical centers that can be lend to patients for a week for monitoring the blood pressure; mediate for common purchase to reduce prices for good quality;
- Preventive checkup for diabetes; definition of specific plans for the different risk groups;
- Partnership with “Vlaamse Diabetes Liga”, the Romanian diabetes organizations and “The International Diabetes Federation”.

**Outputs**

- Health staff is trained to apply evidence based guideline for DZ/HTA treatment, implement correctly disease management plan;
- More than 75% of patients of DZ type II / HTA are trained to understand importance of treatment / life style;

**Outcomes**

- Decreased severity of chronic diseases (people do not advance towards stages 3 and 4 of diseases); decreased number of complications / mortality through diabetes and HTA.

**Cost estimate**

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**G. Community mental health projects**

As this is a project of higher complexity, it should be first initiated in a limited geographical area (i.e. Suceava county area / Campulung Moldovenesc surroundings together with a number of TON communities around the town: Moldovita, Vatra, Frasin).

Buying in of professionals working within the selected communities (family doctors / nurses / social workers / other community leaders / relatives of persons with severe mental health problems / users of mental health services) represent an important step; a “promotion / selling workshop” to promote such a service in the area sustained with the support of the psychiatric physicians leaders of the community mental health in Campulung Moldovenesc.
would be needed in order to explain the possibility of such a service, its conditions, but also to see what members of the staff at community level can take over the tasks to be performed. This type of project would include activities such as:

a) The definition of a partnership between the ADAM or LHC / local government / social worker / family doctor / community nurse (where available) in each of the communities;
b) Creation of the task force on Community Mental Health;
c) Social services locally (local councils);
d) Organization of workshop / training with leadership from the Association of Social Psychiatry / Estuar Foundation;
e) Shadowing professionals in Campulung Moldovenesc / Estuar Foundation project sites;
f) Effective provision of services;
g) Monitoring and evaluation of services provided;
h) Report writing.

Inputs

- Partnership with the Association of Social Psychiatry/ Psychiatric hospital in Campulung Moldovenesc / Estuar Foundation;
- Training provided to health workers/ social workers in TON communities around Campulung Moldovenesc;
- Cooperation with OPZ (Public Psychiatric Hospital Geel, Belgium), Emmaus group Belgium, and Mutualities;
- Define a good practice for Foster Families.

Outputs

- Community health / social workers/ community nurses / volunteers team (at least 10 members) trained / working procedures for approaching patients with mental health problems agreed amongst professionals for most frequent conditions.

Outcomes

- Patients with mental health issues are attended through a network of services in the community; they live a happier and healthier life in their communities;
- Hospitalization rates of patient with mental health problems is decreased;
- The concept and practice of foster families for persons with mental health problems introduced as an innovative practice within the community based mental health services in Romania.
H. Home care projects (Medical – Social)

This type of project would include activities such as:

a) The definition of a partnership between the ADAM / local government / social worker/ family doctor / community nurse (where available) in each of the communities / specialists / hospitals;

b) Creation of the task force on Home Care at community level;

c) Rescue commitment from Adam Slatina-Timis to support with knowhow the process of accreditation of the new home care providers;

d) Identify training providers / conclude training - shadowing / joint advocacy arrangements;

e) Organization of trainings of the home care teams;

f) Network with local hospital and family doctors / community home care team for early discharge of the patients;

g) Selection of beneficiaries and effective provision of services;

h) Monitoring and evaluation;

i) Reporting;

j) Participation in lobby and advocacy efforts for public funding of the dependent cases that need home care on a chronic basis (today only discharged patients can get a limited recommendation for entitlement to home care provision).

Inputs

- Training providers/ training of community home care teams;
- Identified sources of funding for initial salaries of the home care teams;
- Cooperation with White-Yellow Cross Belgium;
- Develop renting services for revalidation materials in TON communities;
- Develop a system of providing hearing aids to TON members in cooperation with specialists;
- Develop a system of providing reading glasses to TON members in cooperation with specialists;
- Test adding the “Meals on wheels” services together with home care services;
Advocate for less paperwork and more effective take-in for homecare;
Develop the system of ‘TON social fund’ locally.

Outputs
- At least 10 of the 20 TON communities that have achieved juridical personality (ADAM) will also achieve accreditation status allowing for the provision of home care services;
- At least 7-10 persons trained in each community for home care services provision;
- At least 50% of the persons in need for home care in the community do benefit from services;
- Network / advocacy with other home care providers for appropriate funding of home care services (i.e. funding for chronic home care and not merely home care for discharged patients).

Outcomes
- Decreased hospitalization rates of elderly (avoidable hospitalization) / decreased costs of care;
- Elderly appropriately attended in the community / chronic diseases appropriately monitored.

Cost estimate

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<tr>
<th>I. Community palliative care projects</th>
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<tr>
<td>Palliative services are of relatively high complexity / need to be integrated within overall networks of such services / rely on more specialized medical staff (oncologists trained in palliative care / family doctor / community nurse trained in palliative care).</td>
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<td>Given the good development of this network in Brasov County, one issue to be explored would be the openness of TON communities in Brasov to participate in this network. Another option for development would be to facilitate the adding up of palliative services to the home care services that would be developed.</td>
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<td>This type of project would include activities such as:</td>
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a) The definition of a partnership between the ADAM / local government / family doctor/ community nurse / social worker;
b) Creation of the task force on Home Care and Palliative care / or Palliative Care at community level;
c) Identify training providers / conclude training - shadowing / joint advocacy arrangements;
d) Organization of trainings of the palliative professionals / network with professionals in a cluster of communities around local hospital/ network with specific hospitals for enabling continuity of care;
e) Selection of beneficiaries and effective provision of services;
f) Monitoring and evaluation;
g) Reporting.

**Inputs**
- Partnership with expert organization- Hospice Casa Speranteii;
- Pre-existence of networks of professionals in the area/ other types of services such as home care;
- Funding secured for initial training;
- System of Vizidom within TON network;
- Belgium partners.

**Outputs**
- 100% coverage of cancer patient with palliative services in TON communities.

**Outcomes**
- Cancer patients in TON communities live in dignity throughout the end of their lives;
- Social-medical support;
- Special needs: renting materials (hospital beds, wheel chairs, toilet chairs, crutches, etc.), selling diapers, rebuilding houses, etc.

**Cost estimate**

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J. Enabling community access to cancer screening programs

Ensure access of the population within the 20 TON communities to the three types of screening agreed in Europe: cervical screening, breast screening and colorectal screening by using the simplest recognized – evidence based- methods available (pap smears, mammography, detection of blood in feces).

The setup of the services will include:

a) the definition of a partnership program with the District Health Authority;

b) a training of professionals at community level on increasing population awareness;

c) network / define partnership with laboratories providers that perform tests of good quality (respect EU criteria i.e. for reading the BP smears).

The role of TON would be to take action through first line – awareness population – collecting samples need promotional actions and involvement of GP’s, community nurses etc. – specialists and lab’s needed + CJAS and DSP cooperation.

Inputs

- Training programs for community health staff, information sessions, and sessions of practice analysis / scheduling of lab tests, etc.
- Screening tools f.e. BIOCARTIS (Biocartis aims to provide direct access to personalized medicine for patients worldwide by developing fully integrated and broadly applicable molecular diagnostics. Our platforms can be used in a wide variety of healthcare settings to enable rapid and high-quality care close to patients.);
- Provision of correct and adequate Information to people.

Outputs

- Systematic referral of eligible population to organized cancer screening programs- at least 75% of eligible population.

Outcomes

- Decreased trends of morbidity and mortality due to cervical, breast and colon cancers in TON communities.

Cost estimate
K. Enabling community access to basic dentistry services
Access to dentistry services became poorer and poorer during the last decades in Romania due to gradual decrease of the financial coverage, to the massive move of dentists from rural areas towards towns. This meant that the rural areas remained almost fully deprived of dentistry prevention, treatment or rehabilitation services.

Inputs
- Refurbished dentists cabinets with needed equipment;
- Contracts with medical dentists for services provision at rural community level;
- Training in modern techniques / prevention techniques of the staff of the dentistry cabinet;
- Belgian partners with know how in evidence based preventive practices in dentistry;
- Trainings in oral hygiene / prevention / access to prevention techniques for children / youth / and their parents;
- Special measurement in order to have dental care for free for children.

Outputs
- Number of children / youth having had access to dentistry prevention services;
- Number of dental care patients treated at community level.

Outcomes
- Lower ratio of decays especially in the younger generation (children and youth);
- High satisfaction of community members that have access to dentistry services in their own community.

Cost estimate

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their products, recommending primarily expensive drugs of last generations and bypassing steps of recommended guidelines is clearly not appropriate for maintaining health. In this context, pharmacy services that correctly inform the patient and support the patient in having access to the best affordable drugs are of clear benefit.

**Inputs**
- Training of pharmacists / nurses working in community pharmacies in provision of information to patients;
- Access to subsidized essential drugs is ensured.

**Outputs**
- Increased number of patients with appropriate treatment.

**Outcomes**
- Improved health indicators;
- Improved patients’ satisfaction with the pharmacy services.

**Cost estimate**

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**M. In the 10 ADAM structures, pilot the principle of mutual funding**

In times when economic crisis lead to more and more liberal and commercially driven healthcare systems, the access to basic healthcare services is difficult to be “granted”. Communities need to explicitly recognize their needs for health, understand the need to be proactive as well as the benefit of mutual support towards this endeavor. Community health center ADAM as a multidisciplinary center (different services with advantages for patients) developing this social, mutual approach is a good example for the positive result that mutual support has brought to the health of the community members.

**Inputs**
- Case study ADAM Slatina-Timis;
- Cooperation with Belgian Mutualities;
- Trainings, examples of bylaws, coaching during general assembly meetings; coaching on how to manage the budget within an ADAM;
PR campaign to “sell” the benefits of mutualities to be developed within the pilot communities.

**Outputs**
- ADAM mutual structures defined in at least 10 more TON communities;
- Populations in pilot communities start paying contributions.

**Outcomes**
- The 10 ADAM institutional structures are institutionally strong and able to oversee the access to health services of the population within their communities;
- Health outcomes of the population are gradually improving.

**Cost estimate**

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**N. Several other types of services**
a) Homecare shops / health promotion shops.

b) LOGO (prevention – health promotion in Flanders) and DSP in Romania. Working on a ‘Healthy Commune Charter’ for TON communities (kind of label).

c) Internships (social students, nurses, etc.). Erasmus contracts: VGU Arad / University Resita: look here also for trainings centers for TON.

d) European e-health training portal. Image toolkit.

The menu list is open / flexible; their initiation will depend on their complexity / simplicity and level of funding needed as a startup. More complex projects will need more financial support and are pending upon funds needed for implementation.

**Relevant extra information (on website ADR and TON)**
- ADR-Vlaanderen: [www.adrvaanderen.be](http://www.adrvaanderen.be)
- The Open Network for community development: [www.theopennetwork.ro](http://www.theopennetwork.ro)
- LHC (CLS): leaflet.
- ADAM: leaflet and presentation.
- AGLT (youth movement within TON): leaflet.
- OLF (women organization within TON): leaflet.
- OLB (men organization within TON): leaflet.
- GLD (local development groups within TON): leaflet.
- TON Social Map.
- Annual report The Open Network (TON) 2014: http://issuu.com/adrlvlaanderen/docs/ton_annual_report_-_2014_for_online/1
- Memorandum Romanian Health Care TON 2012.
- Asociatia de Ajutor Mutual Slatina-Timis (ADAMSlatina-Timis) with support of Actie Dorpen Roemenië-Vlaanderen (ADR-Vlaanderen) and The Open Network for Community Development: BENISI Scaling Social Innovation www.benisi.eu
- Forum on Decentralized cooperation Belgium-Romania www.fobero.eu

Responsibility for the project at TON

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