MANAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**QUALITATIVE NATURALISTIC APPROACH - TRANSITION OF PARADIGMS AND PUBLIC HEALTH PRACTICES**
Module: 3.9	**ECTS (suggested): 0.2**
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Keywords	research, qualitative methods, public health,
Learning objectives	After completing this module students and public health professionals should: • understand qualitative naturalistic approach in public health • differentiate use and results of quantitative and qualitative approaches • identified main use and importance of naturalistic approach • recognize possibilities for naturalistic approach use in public health practice
Abstract	The use of qualitative and consensus building techniques enables better understanding and improved collaboration among "policy stakeholders" (politicians, administration, public health professionals and community) involved in needs assessment and health policy formulation. War, migration, and transition in South East Europe hardened most of public health activities but especially made the process of health needs assessment and formulation of health policy very difficult. Qualitative analytical methods have been introduced in Croatia over the last 10 years. Nine Croatian cities and 15 Croatian counties created City/County Health Profiles and City/County Health Plans by using qualitative methods. The greatest gain from introducing the qualitative analytical approach is wider participation in planning and managing of the resources for health at all levels, from community and regional to national level. Qualitative analytical approach was conducted through an intense and prolonged contact with a field, and real community life, enabling gaining of a 'holistic' overview of the local community.
Teaching methods	Lecture (2 hours); Seminar (2 hours) – student presentations and discussion Individual/small group work (2 hours) – exercise
Specific recommendations for teachers	Total of 6 teaching hours consist of: 4 contacts hours: 2 lectures + 2 seminars (presentations + discussions based on the exercise findings) 2 individual/small group hours work (Naturalistic approach and policy analysis)
Assessment of Students	Case problem presentation (exercise findings and conclusions) + structured essay.

QUALITATIVE NATURALISTIC APPROACH - TRANSITION OF PARADIGMS AND PUBLIC HEALTH PRACTICES

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THEORETICAL BACKGROUND

Importance of introducing new paradigms – qualitative-naturalistic approach

Ideological similarity between the philosophy and practice of health promotion and the assumptions and procedures of naturalistic approach has facilitated the introduction of qualitative methods into the public health practice. Health promotion believes in the ability of individuals (non-professionals) to generate useful knowledge and insights, whereas qualitative methods grant a research value (scientific legitimacy) to individual, subjective experience. Both tend to be inductive (as opposed to classical, deductive approach) and derive general principles from particular facts. Health promotion holds that a solution to a problem can come from the bottom-up (community) rather than the top-down (national level and professional experts). The same is believed in qualitative research, which starts from the idea that concepts and explanations are best generated from the bottom-up, from particular empirical data, rather than the top-down, i.e., from a general theory (1,2,3).

As a result of the transition, war and post-war experiences citizens in South East Europe (SEE) are faced with a lack of social security and limited possibilities to influence changes in the society. Most of these problems were caused by rapid changes from socialist government with centrally planned economies to democratic governments and more market-based economies. Variations in socio-economic factors have had strong impact on the health systems of the countries and the health of their citizens (4,5).

Appropriate public health approaches and methods can make significant contribution to the enhancement of social justice. More than ever, public health is being viewed as a catalyst for peace and an important factor in the socio-economic development equation. During the last fifteen years, public health became insufficient due to wars, economic and political changes. There is a recognized lack of competence in public health, particularly in health management and strategy development, but also in health surveillance, policy analysis and prevention. Apart from rapid changes and changed context, public health is faced and with many limits and shortcomings of "official", institutionalized practice (6,7,8,9,10,11).

War, migration and transition in the region hardened most of public health activities, but especially made the process of health needs assessment and formulation of health policy very difficult. All health indicators obtained at that time were based on estimates of a key factor – population. Yet today, 15 years after the transition has began and 10 years after the war has finished, Croatia still has two crucial public health problems: poor accessibility of health indicators at a local level and non-inclusion of the community opinion. These reasons led to an initiative to implement a different, corrective mechanism in public health practice – qualitative analytic approach, enabling formulation of health policy from non-standard sources.

Three detailed examples will show how results of qualitative analytic approach can be grounds for needs assessment, priority rating and health policy creation.

CASE STUDY

Croatian experience in utilization of qualitative-naturalistic methods

The establishment of the idea of health promotion in the late 1980s, and especially the practical experience in its implementation through the "Healthy cities" project during the 1990s has changed public health approach and research practice in Croatia.

Participatory methods of community health needs assessment needs have been implemented in the mid-1990s, but a practice of establishing local databases (such as the development of Local Area Indicators in the UK) is yet to be developed. We believe that conventional and positivist approach, as used so far, does not reach local communities. Over the last ten years, qualitative analytical methodology has been introduced in the different areas of public health activities (needs assessment, priority setting, planning, decision making and strategy development) in Croatia. Methodology was used on three different levels:

1. *City level* - assessment of community health needs and, based on these findings, production of the City Health Profile and the Plan for Health;
2. *County level* - assessment of community health needs and, based on this findings, production of the County Health Profile and the Plan for Health, studies of complex human health-related behaviour in their natural environment -Healthy Counties program;
3. *Regional level* - strategy development for inter-county regional level.

City Level: Rapid Appraisal to Assess Community Health Needs

The most popular and most used method in the Croatian cities is the method of Rapid Appraisal to Assess Community Health Needs. It was used in 9 cities between 1996 and 2004 (Pula, Metković, Rijeka, Karlovac, Varaždin, Zagreb, Split, Dubrovnik, Crikvenica). The advantages of this method in comparison with classical approaches to health assessment are as follows: it can be done quickly (in two months from the start), it does not take too much expert time and financial resources (approximately 6.500 EUR per city), it is participatory (representatives of different groups of citizens participate in the process, from needs identification to solution finding; includes representatives of city authorities, institutions and organizations as well as those from non-governmental and non-for-profit sector), sensitive (ability to reflect local particularities), valid (scientifically sound), action-oriented (as a product it gives short-term and long-term activity plan), and its achievements are sustainable (it establishes and facilitates co-operation among key stake-holders in the project via priority thematic groups).

Academic credibility of this method is strengthened by the establishment of strict selection rules of participants and panellists and by the process of triangulation of both information sources (essays, observations and collected objective indicators from the system) and researchers (experts of three different backgrounds: public health, epidemiology and medical information science). By use of this qualitative method (combined with available quantitative indicators), health needs assessment was carried out

in 1996 in Rijeka, which was used to devise a city health profile and a city health plan The outcomes of 'Rijeka – Healthy City' project were evaluated in 2003.

Rijeka – Healthy City

Healthy City has been active in Rijeka since 1990. Till 1995, its activities were mostly determined by the aftermaths of war and economic slump Croatia was suffering, and focused on caring for the refugees and the displaced people, as well as helping the socially disadvantaged. In 1995, the City Department for Health and Social Welfare of Rijeka started devising the city health profile and the city health plan.

Rapid assessment of the population health needs was used to devise these documents. Following the suggestion of the project team, about seventy panellists were selected, comprising representatives of the city administration, important city institutions and the citizens, who were all asked to write an essay on health in Rijeka. In the working meeting, held at the end of June 1996, the participants were presented the most interesting and the most common answers from their essays, as well as statistical health indicators in the city, and the photographs taken based on their reply to the question what it was that diminished and added to the beauty of living in Rijeka.

The participants then chose three most important problems, first individually and then in small groups. Taking into consideration the choice made by the groups, a joint list of five priority areas was made, to be used in future 'Rijeka – Healthy City' project:

- sustainable development;
- advances in environment protection;
- support for disabled people;
- quality of elderly life;
- improvements in children and youth's health.

In 2003, due to the need to evaluate the outcomes of the 'Rijeka – Healthy City' project, an analysis of the changes was carried out for the period between 1996 and 2003. Three sources of information were used for the evaluation:

(a) 14 quantitative health indicators defined by RAP
(b) observations made by the project participants (both "veterans" and "fresh forces" from 2003), gathered through work in focus groups
(c) analysis of program documents and resolutions passed by the city administration.

The evaluation results showed the following:

- quantitative indicators of health and quality of life in Rijeka more reflect demographic, economic and epidemiological transition that other urban areas in Croatia are undergoing as well, than they speak about outcomes of the healthy city project
- analysis of participants' observations pinned down the key areas in which change is evident:
  - community participation in decision-making, inter-sector co-operation

  "The project has met all its basic goals: its direct users in the local community created and participated in it, RAP stressed the specific needs of this local

community; the actions were taken in logical order, according to set priority list – and were complementary; resources were mobilised in the local community, joint planning and activities facilitated co-operation between interest groups, whose activities are complementary…"

- upgrading people's awareness

"The project's value lies in giving individuals responsibility, and realising that everything they do have some kind of effect they as individuals are responsible for... People become aware that what we do today is good for their children… Healthy city project helps us do the most we can, given the circumstances we live in… Work on the project results in the awareness of the pride that it is our city and that I am responsible for my city… The people's awareness has been upgraded in a satisfactory manner (relation toward the disabled and the elderly), we succeeded in fostering inter-generation socialising in local community, i.e. in connecting our oldest and youngest citizens, the people became aware of the need to preserve the environment (water, air, dangerous waste management)…The outcomes of the theme groups' work, and the project itself, show resistance to the sign of our times, to do only what pays, no matter what happens.

- undertaken activities (exceed the expectations)

Undertaken activities range from removing architectural barriers, labelling parking places for disabled people, lowering public telephones… the biggest achievement was done in the area of help provided to elderly and disabled people, The Healthy City Youth Council was founded, the youth became more interested in active participation in the project as well as in civil society, making use of the space the project has opened for them…the media coverage was very good, many social programs in Rijeka were encompassed in the project, new associations were founded and started work, attracting many volunteers, environment situation was improved – gas, sewerage, water, waste management…The presentation of every bigger project is a chance to discuss modes of avoiding possible pollution and taking measures for protection… Additional value of the project lies in the continuing 'Generation Bridge' activity, which was exceptionally well accepted, and has the greatest value in connecting, socialising and decreasing isolation of elderly people, through activities with primary students and children from various associations… The prominence of Rijeka was proved by its advanced solutions in health promotion of various segments of the population.

- analysis of the program documents showed the following:

- Evident positive approach to health by the city administration (Guidelines of Rijeka City Council).The 2004 Guidelines of Rijeka City Council in its introductory part pay much attention to the analysis and evaluation of economic and social environment, and the city's social profile. According the resolution by the City of Rijeka (therefore not as provided by the legislation, but as their own, additional obligation), resource allocation provides for "minimum 5% of total revenues for the social program";

- Broad grounds of the 'Rijeka – Healthy City' project - over 80

organizations have been involved (departments of the city administration, institutions, public associations, companies), through programs for priority areas, 310 associations are financially supported;

- A large number of 'Rijeka – Healthy City' project "products": 24 publications (two books), 26 action groups that have continually been carried out, 28 program projects in accordance with selected priorities, and 22 researches.

Qualitative methods used in evaluation process were more precise (than quantitative methods) in detecting changes, their outcome and importance for Rijeka. Gathered change indicators were presented to the public at the Consensus Conference, held on 18 June 2003, at the premises of Rijeka City Council. Around fifty conference participants, politicians, professionals and members of citizen's initiative, came to a conclusion that "the first phase of the project – focusing – has been completed." Priorities were identified and remain the same. "And the main challenge of the project is to continue bringing efficiently together all parties interested in solving the identified problems, and developing mutual trust and co-operation." It is necessary "to maintain the existing achievements, and to further upgrade them, providing vision for future in urban planning, economic and human development of the city." Outcomes of 'Rijeka – Healthy City' project have been highly rated on both national and international levels. These recognised outcomes were the grounds for accepting Rijeka as a designated project city in the fourth phase of the 'Healthy City' project of the European WHO office.

County level: County public health capacity building: "Healthy Counties" program

It is the "County public health capacity building: Healthy Counties" program that has used primarily naturalistic and participatory approach in the counties health needs assessment. Program started in March 2003. By the September 2004, 15 Croatian counties successfully finished education. It has resulted in County Health Profiles and Plans for Health in 15 out of 20 Croatian counties, with 5 clearly defined public health problems as priorities in each county. All the three key elements of the participants in the project were included in the health needs assessment at priority setting: the politics, the profession, and the community, with emphasis on inter-sector co-operation. Each Plan for Health, confirmed by the top political bodies in each county (Councils), represents the starting point for introducing a change in public health practice at local level. At the same time, it also allows for formulation of a complete national health policy that would include the community (Cities and Counties) opinion.

One of the most frequently recognized priorities among counties was high alcohol consumption among adolescents. It was selected as a priority in 15 counties.

Studies of complex, health-related behaviour, such as drinking patterns in young people in Virovitičko-Podravska county linked to the "County public health capacity building: Healthy Counties" program, represents a more novel way of using qualitative analytical methodology in Croatia. They are still in the initial phase of research. It is in this area that the phenomenological approach, used to understand human behaviour through experience of the participants, has been shown most efficacious. By using qualitative methods (interviews) and by observing, listening and investigating the participants of the process at every level (waiters, school psychologist, ER physicians and teenagers), local researchers

from Virovitičko-Podravska County have gradually started to understand the investigated phenomenon in the context of their own social environment. The aim of this study is to recognise particular behavioural patterns associated with excessive drinking, and to develop effective interventions specific in the given social context.

Regional Level: Change of public health practices using qualitative naturalistic approach

It was the 'Healthy Counties' project that showed that some priorities, such as care for the elderly, are the problem shared by all parts of Croatia. The information that the elderly have been selected a priority in eleven, out of the fifteen counties included in the 'Healthy Counties' program (based on the health needs assessment by use of quantitative and qualitative methods), provides the grounds for designing inter-county action plan In order to design action plans for the elderly, further use of qualitative research methods is needed.

Elderly care

Due to the demographic transition in Croatia, the elderly (people older then 65) are the fastest growing subgroup in the general population. Due to the Census data (2001) there is 15,6% of elderly in the Croatian general population. Comparing 1991 and 2001 census data in some counties we registered increase in elderly population of more than 20%. Unequal, in-county distribution of elderly, i.e. much higher percentage of the elderly in rural, low-density populated areas and islands (up to 33.3%) makes situation even more alarming. Despite the problems, evident from the statistical data, local authorities failed to respond to them, and offer intervention. Such a state was due to lack of adequate methods for evaluation of specific needs and analysis of details of the problem, required for the intervention.

The first step toward the solution was taken through the 'Healthy Counties 2002-2004' program, which used qualitative and quantitative methods (interviews, focus groups, semi-structured questionnaires) to design county health profiles and priority setting. Analyzing the problems of the elderly, research was carried out in several elderly groups and their family members, including the professionals engaged in the work with the elderly. As a result, 10 counties and the City of Zagreb, described the problems of the elderly even through local specific needs, and included them in their action plans. (www.zdravi-gradovi.com.hr).

In the second step, representatives of all participating counties and the City of Zagreb were brought together for a special conference of all project teams, to discuss the problem of the elderly. The conference was aimed at deepening the problem analysis, and comparing and analyzing joint and specific difficulties the counties are facing. The conference goal was to devise joint guidelines that would serve as basis for design and implementation of the inter-county (regional) elderly care plan. Participants worked in small groups and plenary sessions, which led them to the conclusion that the system lacked:

- sufficient knowledge of elderly peoples' needs (what we usually have are more providers' estimates than users' concerns);
- a good overview of existing resources (institutional, non-institutional) that provide for the elderly (since everybody is providing for the elderly, no one is really responsible);
- mechanisms in place to support collaboration between users, providers and county

policy making bodies; and
- Comprehensive ELDERLY CARE policy and a plan for action at the county level.

The following separate problems were identified:
- lack of political interest among county officials;
- lack of interest in collaboration between providers, between providers and county policy making bodies, and between users and providers;
- lack of funding for enlarging existing or introducing new services;
- misunderstanding and confusion about "who is doing what" because of the absence of comprehensive ELDERLY CARE policy and a plan for action at all levels (municipality, county, country);
- lack of knowledge of "what should be done", and by whom.

The obtained results will form the grounds for designing action plan on the problems of the elderly in Croatia. Activities related to more detailed needs analysis will start in April 2005, with emphasis on identification of specific groups.

Without findings of qualitative analyses, it is not possible to focus activities on problem causes, on identifying specific subgroups and their needs, or adjusting the intervention programs to specific needs of the social environment. Participation of political structures in the planning process will ensure political framework necessary for long-term "healthy" policy.

Conclusion

The job of public health professionals, including those in academic setting, is not only to investigate and understand the world; it is also to change it. This is why in post-war, transitional Croatia the emphasis has been put on the development of applied (action) research by which the academic knowledge may be used for intensifying activities and development of local communities.

The basic principle of qualitative analysis – to explain the causes and build the theory on the basis of fieldwork – describes the best the difference between the empirical and naturalistic approach in research. Qualitative data provide a rich and detailed description, emphasizing the context in which the experience occurs and allowing us to gain insight into and deep understanding of a process, which is not possible by use of other methods.

Post-war situation, migrations, and the process of transition were the reasons why it was not possible to generate credible demographic analyses, statistical studies and quantitative health indicators. Therefore, use qualitative analysis was chosen as a corrective mechanism in the formulation of health policy. The system was so weakened by aforementioned objective reasons that the application of these very methods, which could empower and strengthen the community, was an imperative.

In all described cases, qualitative and quantitative methods were combined. Inter-sectoral and inter-disciplinary collaboration was used in all stages of the processes, emphasizing crucial role of the involvement of all three key parties (politicians, administration, public health professionals and community). By this triangulation of different approaches to the same problem, we increased the validity of our findings.

The introduction of qualitative and consensus building techniques in the policy formulation process in Croatia has brought much better understanding and improved collaboration among "policy stakeholders" (politicians, administration, public health professionals and community).

At the moment, the greatest gain from the introduction of qualitative analytical approach and participatory methods into the practice of Croatian public health is the achievement of a higher degree of participation in planning and managing of the resources for health at all levels, from community and county to national level.

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