| **HEALTH PROMOTION AND DISEASE PREVENTION**<br>**A Handbook for Teachers, Researchers, Health Professionals and Decision Makers** | |
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| **Title** | **Regional and Local Settings for Capacity Building in Public Health – Croatian experience** |
| **Module: 2.2** | **ECTS: 0,75** |
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| **Key words** | Public health, health policy development, decentralization, community health planning, Croatia |
| **Learning objectives** | After completing this module students and public health professionals should :<br>• recognise tools for community needs assessment<br>• recognise tools for educational capacity building<br>• understand capacity building process<br>• identified critical issues for public health management<br>• improve knowledge on the healthy policy development |
| **Abstract** | This paper describes how was incorporated a multi-disciplinary and inter-sectored approach into development of public health policy and plans at the local (county) level in Croatia by educational program. Method used was the public health capacity building program »Health – Plan for it«, which was developed with the aim to assist the counties to overcome recognized weaknesses and introduce more effective and efficient local public health practices. Two main instruments were used: Local Public Health Practice Performance Measures Instrument, and Basic Priority Rating System.<br>This program has helped counties to asses population health needs in a participatory manner, to plan for health and, ultimately, assure provision of the right kind and quality of services (better tailored to population health needs).<br>This program's benefits are going beyond and above the county level. It provides support for the Healthy Cities project locally, and facilitates changes in national policymaking body's mindset that a »one-size-fits-all« approach is sufficient. |

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| **Teaching methods** | *Lectures:*<br>Public health policy and community health; Management in public health and health promotion; Decentralization<br>*Exercise:*<br>How to recognize needs and organize capacity building for local public health?<br>*Small group discussions:* Croatian experiences and regional setting<br>*Individual work/Seminar:* Role of the public professionals (my role!) in the capacity building |
| **Specific recommendations for teachers** | If possible, use some real life local (community) setting to discuss, compare and analyse presented Croatian model. |
| **Assessment of students** | *Structured essay:* "Health promotion – Health policy – Capacity building"<br>*Case problem presentations:* Health promotion in selected (specific!) community |

# REGIONAL AND LOCAL SETTINGS FOR CAPACITY BUILDING IN PUBLIC HEALTH – CROATIAN EXPERIENCE*

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**Adapted text of:*
*Sogoric Sm Vukusic Rukavina T, Brborovic O, Vlahusic A, Zganec N, Oreskovic S. Counties Selecting Public Health Priorities – a »Bottom-up« Approach (Croatian Experience). Coll Antropol 2005; 29:111–9.*

**Theoretical background**

During the last fifteen years we have been witnessing tremendous changes in European societies, some of them been caused by globalization, economic transition, by demographic transition or by wars. Whatever the causes were their consequences were detrimental to health. Today's Europe is challenged with complex public health issues like poverty, terrorism and violence, social exclusion, pollution, depression, substandard housing, the unmet needs of elderly and young people, homeless people and migrants, unhealthy spatial planning, the lack of participatory practices, and unsustainable development. Due to the war and post-war transition, South-East Europe is faced with many others, like, for example, mental health, posttraumatic disorders, quality of life of disabled, family health, community regeneration and community capacity building, unemployment, especially among young and mid career workers, stress, alcohol, tobacco and substance misuse, etc.

Citizens in the Balkans and South East Europe (SEE) feel a lack of social well being and a sense of vulnerability as a result of the war and post-war experiences (1,2,3,4,5,6). The shift from a socialist government with centrally planned economies to democratic governments and more market-based economies has taken place rapidly in the SEE, but the transition has not been without economic problems. Variations in socio-economic factors have had strong impact on the health systems of the countries and the health of their citizens (7,8,9).

Public health can make a small, but significant contribution to the enhancement of social justice here and now in the SEE region (1). More than ever, public health is being viewed as a catalyst for peace (10,11,12,13,14,15) and an important factor in the socio-economic development equation (16). Of practical importance to the reversal of present negative trends is the strengthening of all public health structures, including policy-making support (17), human resources training (18), and population health research (19, 20).

The World Health Organization (WHO) and the Council of Europe have called attention to growing health status disparities and population vulnerability in SEE (21). The regional Health Development Action Plan for SEE undertaken by the Council of Europe and WHO European Office within the scope of the Stability Pact, led to the Dubrovnik Pledge in 2001 (22) – a political instrument to improve social well-being and promote human development in SEE.

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 and prevention. There was a need for sustainable collaboration, and support in advanced training and continuous education of qualified professionals to reach required conditions

(23). Thus the Open Society Institute, New York, and the Association of Schools of Public Health in the European Region (ASPHER) became actively involved in public health developments in the region (24). In the spirit of the new public health, there was a strong initiative to assess the need for human resources in the health sector and to provide much of the needed interdisciplinary training. Such training is described in this paper.

The central challenge for public-health practitioners is to articulate and act upon a broad definition of public health, a definition that incorporates a multidisciplinary and inter-sectoral approach to the underlying causes of premature death and disability (25). Public health education for much of the world (not only SEE countries) is welcome, and public health leadership programs are under development (26). These programs will encourage empowerment of local communities, a necessary step in rejuvenation of public health (27). Nevertheless, questions arise as to whether public health practitioners should be concerned with fundamentals such as employment, housing, transport, food and nutrition, and global trade imperatives, as opposed to just individual risk factors for diseases. A broad focus inevitably leads to involvement in the political process (28), an arena that is as well emphasized in the program described in this paper.

Within the European public health community there is a widespread recognition of the importance of inter-sectoral collaboration. An extensive research from WHO's Healthy Cities (29) and Regions for Health movements showed what can be achieved by building effective cross-sectoral alliances (30,31,32).

**From Healthy Cities to Healthy Counties – chronological order of events**

*Healthy Cities Project – gaining experience in bottom-up policy building*

The Healthy Cities (HC) Project, initiated by the WHO European Office in 1986, is a long-term international development project that seeks to put health on the agenda of decision-makers in cities and to build a strong lobby for public health at the local level.

The crucial notion that stimulates HC project development was the recognition of importance of the political will. The Healthy Cities Project challenges cities to take seriously the process of developing health–enhancing public policies that create physical and social environments that support health and strengthen community action for health. Initiating the Healthy Cities Project process requires explicit political commitment and consensus across party political lines, leading to sound project infrastructure, clear strategy, participation mechanisms and broadly-based ownership (33,34). Healthy Cities is about change, openness to participation, innovation and formal system reorientation. It is changing the ways in which individuals, communities, private and voluntary organizations and local governments think about, understand and make decisions about health.

European cities in general are challenged with complex public health issues like poverty, violence, social exclusion, pollution, substandard housing, the unmet needs of elderly and young people, homeless people and migrants, unhealthy spatial planning, the lack of participatory practices, and unsustainable development (35).

The Healthy Cities Project framework provided the testing ground for applying new strategies and methods for addressing these issues in Croatia. Especially helpful was the second phase of the European Healthy Cities Project (1993–1997), which encouraged the process of development and implementation of the strategic city health documents: the City Health Profile and City Action Plan for Health (36,37). It was a breaking point that renewed dignity and a sense of mission to the public health profession, and emphasized

issues of health, participation and community development. While working on those key documents, public health physicians, who act as the process facilitators, had legitimacy and access to all main players – city politicians and administration, professionals and institutions, citizen representatives and NGOs. It gave them a chance to conduct community based needs assessment, and to open dialogue between different interest groups, i.e. future main »health stakeholders« (38,39).

Unfortunately, the Healthy Cities experience has remained quite localized and undervalued by the formal health policy system at the higher County and national levels since the end of the 90s. The process of decentralization and health and social welfare system reform has imposed a great pressure for change on the local governments and health sector at the end of 90s. It encouraged them to consider new (public health) approaches, techniques and methods. Public health professional involved in the Healthy Cities project decided that future engagements at the higher County level would likely yield more positive results.

**Case study - healthy counties – public health capacity building in Croatia**

Due to the war and post-war transition, Croatian cities are faced with many others, like, for example, mental health, posttraumatic disorders, quality of life of disabled, family health, community regeneration and community capacity building, unemployment, especially among young and mid career workers, stress, alcohol, tobacco and substance misuse, etc.

**Developing the paradigm – situation analysis**

Key players able to bring changes in public health policy development and implementation at the county level were identified: as those who can (have political power), as those who know (have knowledge and skills) and those who care (have direct interest in bringing change). Political power at the County level in Croatia is within County Councils* and their executive bodies County Departments for Health, Labor and Social Welfare. Technical expertise is within County Institute of Public Health and Centers for Social Welfare. Citizens groups and associations were seen as the most direct representatives of citizen's interest. The assumption was that only active participation of all mentioned key players from the political, executive, technical, and community arenas could improve process of creation and implementation of the county's health policy and guarantee better health outcomes.

But due to the centralized state policy and vertical process of decision-making used in the previous years, collaboration among the various players mentioned above has not been established. Non-existence of an articulated County health policy was a logical consequence of the lack of collaboration. County officials had insufficient knowledge of new population health needs resulting from the war, post-war transition and economic and social difficulties, and these needs have not been addressed properly. Consequently, the population is receiving traditional services, hardly those that respond to real needs. Throughout 90s County Councils did not have real political power and County Governors acted more as Central Government than County Government servants. With the exemption of the few old and well-equipped Institutes of Public Health majority of them was established within the last eight years. Through the collection of data, monitoring and reporting they provided primary, information to national Institute of Public Health and did not see themselves as the players at the county level.

The first step in development of public health policy and plans at the local level in Croatia was assessment of present state and conditions. In the summer of 1999, directors of the Motovun Summer School of Health Promotion convened a panel of 25 Croatian public health experts to review existing public health policy and practice at the county level. The group used an assessment tool called the Local Public Health Practice Performance Measures Instrument, which was developed by the U.S. Centers for Disease Control and Prevention Public Health Practice Program Office (40,41,42). This instrument recognizes three core functions of public health: assessment, policy development and assurance, and 10 practices associated with them. Three of the 10 practices emphasize important components of the assessment function: assessing community health needs, performing epidemiological investigations, and analyzing the determinants of health needs. Another three practices address the policy development function: building constituencies, setting priorities, and developing comprehensive plans and policies. Finally, four practices relate to major aspects of the assurance function: managing resources, implementing or assuring programs to address priority health needs, providing evaluation and quality assurance, and educating or informing the public. The 10 practices mentioned can be used as performance standards, supported by the 29 associated indicators to measure the effectiveness of local public health practices.

The original Local Public Health Practice Performance Measures Instrument was translated into Croatian, with appropriate revisions. The finished instrument allows situation analysis for each of 10 practices and measurement of associated indicators, i.e., whether or not they exist, whether they are satisfactory or unsatisfactory, and who is or should be in charge of this activity. The panel of 25 Croatian public health experts discussed all topics and identified the following as the weakest points in existing public health policy and practice at the county level: formulating public health policy, especially in selecting priorities among health needs; strategy formulation and comprehensive planning for solving priority issues; coalition building and gaining support from the community and relevant organizations; public health policy assurance, an issue stemming from the lack of objectives and therefore an inability to determine whether they are achieved; and, finally, lack of analysis of the adequacy of existing health resources. From the results, it was obvious that counties require professional public health guidance and assistance to develop more effective and efficient local public health practices, i.e., to assess population health needs in a participatory manner, plan for the health of the population, and assure the provision of the right kind and quality of services based on the population's needs.

**Healthy Counties project development**

Given this scenario in mid-2001, the process of change caused by decentralization was seen as an excellent opportunity for improving Public Health practices in Croatia at the County level. A »learning-by-doing« training approach appeared to be the best tool for public health capacity building and strengthening of collaboration between health policy stakeholders at the county level in order to both build knowledge and skills. Based on Healthy Plan-it™ program (43) (developed by Centers for Disease Control and Prevention, USA) for identifying and prioritizing healthcare needs and developing plans for addressing them, and other materials, the faculty members tailored a public health capacity building »Health – Plan for it« program proposal for Croatia. The program's aim is to provide guidance and assistance to counties, while introducing more effective and efficient public

health policies and practice. By the end of 2001, the program was discussed with several panels: public health physicians from County and National Institute of Public Health, county officials, health managers, Ministry of Health and Ministry of Labor and Social Welfare officials. Finally, it was revised and sent for comments to the pilot group of counties.

Topics included were:

- Public health management (from identification to better satisfaction of public health needs, i.e. provision of the right kind and quality of services)
- Organizational and human resources management (improvement of personal managerial abilities, routine use and application of modern management techniques),
- Collaboration and community participation (emphasizing the necessity of continuous consultation with the community in all stages of health policy development, and reorienting the health care and social welfare system to make them more responsive towards county specific public health needs).

After two months of consultation the main program stakeholders reached consensus about the aims and content of the program. County teams will first complete four months of intensive training, which will be followed by biannual monitoring and evaluation meetings. Since mutual learning and exchange of experience is an important part of the process, three counties from different parts of Croatia with different levels of local-governance experience will be in training at a time. Each County team should be composed of 9 to 10 representatives: three from the political and executive component (County Council and Department for Health, Labor and Social Welfare), three from the technical component (County Institute of Public Health departments, Center for Social Welfare); and three from the community (NGO's, voluntary organizations and media). The Ministries will support the direct cost of training (training packet development, teaching and staff expenses) and the counties will cover lodging and travel expenses.

**"The counties training program" – strengths and weaknesses**

From March 2002 till June 2007, six training cohorts (18 county teams or about 180 participants) had completed the Healthy Counties program and produced County Health Profiles and County Health Plans with prioritized health needs and specific recommendations for addressing them. Since the City of Zagreb, as the largest city in Croatia, has County authority it completed a slightly modified program alone, as a seventh cohort (with 24 participants). Each cohort of three counties went through the following training scheme (44):

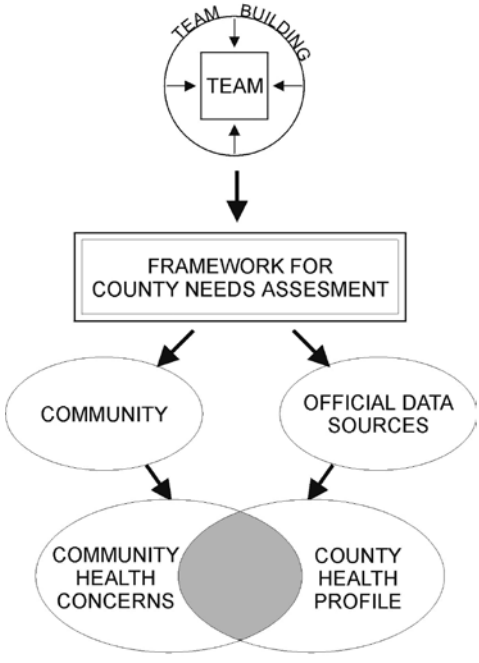
*Module 1 – Assessment functions*
*(4 days intensive training)*

During the first module, county team members reviewed the core public health functions and practices and become familiar with the participatory needs assessment approach, methods and tools. Each team developed a framework for its county health needs assessment and decided on methods to involve citizens. Considerable attention was devoted to self-management and group management techniques, especially time management and team development. Analysis of information gained through the Local Public Health Practice Performance Measures Instrument that all county teams completed before the training

brought a new insight on how to improve process of creation and implementation of the county's health policy.

Estimation of the assessment function given by most of the training teams was similar, it doest exist but is unsatisfactory. The biggest differences among counties were noticed in assessment of health policy development and formulation function. In estimation of assurance function counties, again, very strongly agreed that this is the weakest one of all three, since it hardly exists in any of the counties. Homework assigned to the county teams for completion prior to the next module involved creating a draft version of a County Health Profile. To accomplish this, the teams had to apply one or more methods of participatory needs assessment, identify sources of information inside and outside the health sector, formulate county health status indicators, and collect appropriate data (Figure 1).

**Figure 1.** County needs assessment

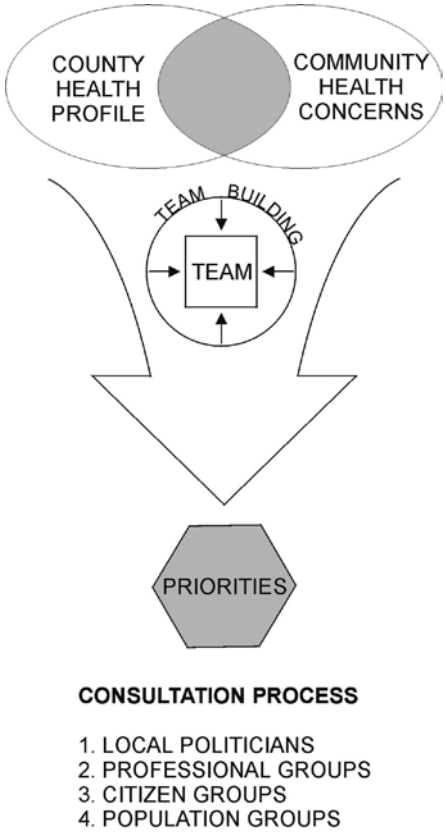



*Module 2 – Healthy Plan-it™*
*(4 days intensive training)*

At the beginning of the second module, the county teams presented the results of the health needs assessment exercise they performed. Although still in draft form, the County health Profiles reflected community health concerns and served as a basis for selecting priorities. Through application of »Healthy plan-it™«, an educational program developed by the CDC's Sustainable Management Development Program, county teams. Prior to the next module, the teams were to identify county »health stakeholders« and conduct consultation with them about selected priorities. Following these meetings, each county

team could revise priorities, add or select new ones and begin drafting their County Health Plans (Figure 2).

**Figure 2.** County Health Plans development

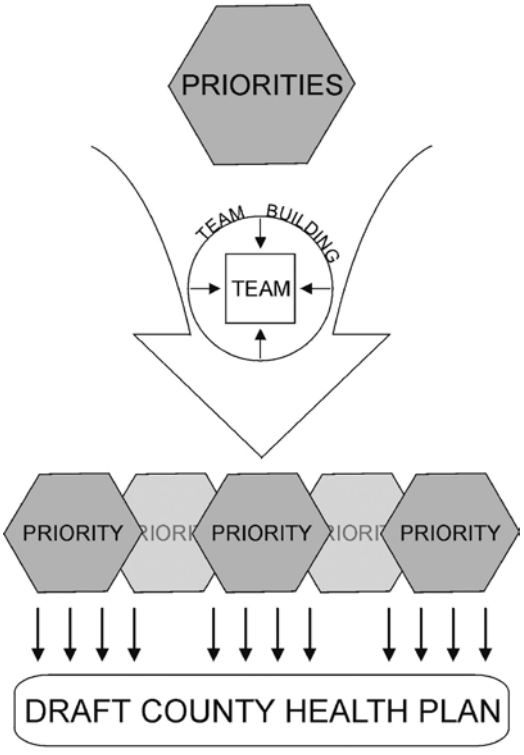



*Module 3 – Policy development function*
*(4 days intensive training)*

This module began with team presentations of the results gained through the consultation process. Majority of the county teams found that the parties they consulted shared most of their views, so only minor revisions to the priorities they had developed were required. The consultations were a good introduction to the process of building constituencies, a key topic in the third Module. Participants learned interpersonal communication, collaboration, advocacy and negotiation skills. Collaboration with the media, public relations and social marketing were addressed, as well. The remaining time was devoted to developing a plan and determining how best to intervene (Figure 3).

Homework assigned to the county teams required them to convene local expert panels in their respective counties to secure their advice on appropriate policies and interventions to address their priority health issues.

**Figure 3**. Intervention Plan development



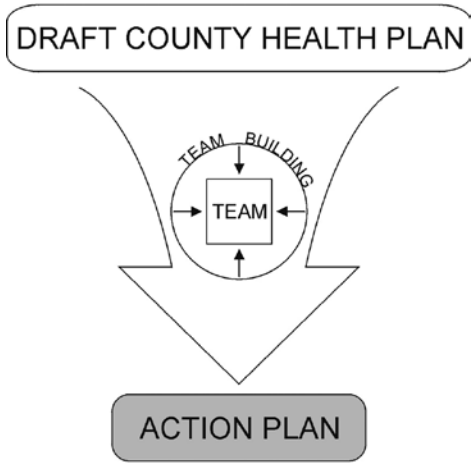

*Module 4 – Assurance function*
*(4 days intensive training)*

At the beginning of the fourth module, the county teams presented draft versions of their County Health Plans, including priorities and intended activities. Skills developed in this module include planning change, building institutional capacity for change, and conflict recognition and resolution. Another training objective was to familiarize participants with methods for analyzing the wider environment. Presentations given by representatives of the Ministry of Health, Ministry of Labor and Social Welfare and by the leader of the national health system reform project helped participants to view their county project from a larger, national perspective, anticipate changes and foresee potential obstacles. Skills like resource planning and management (both human and financial), implementation, quality assurance, monitoring and evaluation were also part of this module. Homework for this module was to finalize the County Health Profile and the County Health Plan for public presentation six months later. The assignment required the teams to present the results as well as describe the processes used to obtain them, including the participative assessment of health status and needs, selection of priority areas, policies and programs to address priority health needs, implementation plans, monitoring and quality assurance mechanisms, and evaluation plans (Figure 4).

Teams had to present their County Health Profiles and Plans locally to their own County Councils, and then nationally to other (not jet involved) Counties, and Ministries.

After the fourth workshop, for each cohort of Counties, a tutorial system of guidance and monitoring was introduced to ensure that team members not lose their commitment and enthusiasm. County team coordinators met mentors monthly and expert help and support to the counties was provided by the faculty on request throughout the process of development of the County Health Plans, till the "final exam". At the beginning of 2003 "Health – Plan for it" training program was officially recognized as postgraduate (continuing education, i.e. re-licensing) training course by Medical School, University of Zagreb and by Croatian Medical (and Dental) Chamber. So for every County the modular training was successfully accomplished when the County Health Profile and Plan were orally presented (i.e. publicly defended) in front of the members of public health academia.

**Figure 4.** Action Plan development




In mid 2003, after three cohorts of Counties completed their modular training we decided that the best way to proceed (actually, open the second "implementation" stage of the project) is to work simultaneously with all nine counties reduced training teams, so called troikas. "Troikas" are groups of 3 people in county leadership positions: one elected official, one professional civil servant from the county administration, and one professional from the county public health institute. Their members liaise own county team with other counties and trainers from Stampar School. So, as soon as County completed its' modular training her troika joined the second phase, assuring program continuity. During 2003 till 2007 troikas were regularly gathered to report on progress and get additional training that will enable them to steer the process of change locally (Mljet - October 2003, Samobor - March 2004, Uvala Scott – May 2004, Motovun – July 2004, Split – October 2004, Terme Tuhelj – February 2005, Vinkovci – April 2005, Motovun – July 2005, Labin – November 2005, Topusko – February 2006, Motovun – July 2006, Dubrovnik – September 2006, Motovun – July 2007).

Another second phase innovation was the introduction of the thematic gatherings. In order to assure the quality, in selection and implementation of public health interventions, we invited County troikas to "extend" their core teams with the local experts in field for each occasion. Thematic gatherings were covering Counties' most frequently chosen priorities

– breast cancer, cardiovascular diseases, quality of life of elderly, quality of health care, water supply and sanitation, early drinking among youngsters, mental health, etc.

**Conclusions**

There are several changes in counties' health policy and practice that could be, even without thorough evaluation (will be published by December 2007), attributed to the "Healthy Counties" project.

1. The pure existence of eighteen Counties (and the City of Zagreb) Health Profiles and Plans is the evidence that this program had built counties capacity to assess public health needs in a participatory manner, to plan for health and assure provision of the type and quality of services better tailored to local health needs. Neither Croatian Counties had Health Profiles nor Plans before "Health-Plan for it" program nor non-participating Counties managed to develop one.
2. The Healthy Counties project has successfully engaged stakeholders from political, executive, and technical arena. It involved numerous and various community groups (youth, elderly, unemployed, farmers, islanders, urban families, etc.), hundreds of local politicians, and institutions in the needs assessment, prioritizing and planning for health cycle. None of the previous projects managed to do so.
3. County Health Plans are accepted politically, professionally and publicly.
4. Proposed interventions, for health improvements, rest on local organizational and human resources and are financially (by free will not by legal obligation) supported by the County budgets. With professional and academic scrutiny we tend to avoid the danger of offering easy and quick solutions (campaigning) for hard to solve problems. We tend to give a realistic value to behavioral change programs and push programs that are indeed addressing wider determinants of health.
5. The program's benefits in Croatia are extending both below and above the county level. It is providing support for the more localized Healthy Cities project, as well facilitating a paradigm shift in national Ministries' mindset that a centralized ''one-size-fits-all'' approach is no longer sufficient. (Still, there is lot to be done with the latest one).
6. This program had impressive impact on public health doctors. It brought back their dignity and the sense of mission, proving that "something" could be done. Through this program they realized that their split professional identity (divided between health services, politics and community) could be advantage because they are equipped to act in all those surroundings. With this program we supported public health doctors' professional transformation - from (poorly) trained statisticians into skilful mediators and community developers.
7. Post-war situations, migrations, and the process of transition were the reasons why it was hard to generate credible demographic analyses, statistical studies and quantitative health indicators. Therefore, we chose to use qualitative analysis as a corrective mechanism in the formulation of the public health policy. With the application of these very methods, we introduced a new perspective and strengthen (give credibility to) community views.
8. Above all, this program was faced with heavy constrains as for example short policy cycle (national elections at the end of 2003 and local, county elections in 2005) or passivity of the public sector (county and state administration, health care and social

welfare administration) which were overcame, with casualties but without the change in vision or spirit. We, tutors together with the Counties are, still, seeing this program as the learning opportunity sure that the next time, in the next project cycle, we will do it better.

9. The program's benefits in Croatia are extending both beyond and above the country level. It is providing support for the more localized Healthy Cities project, as well as facilitating a paradigm shift in national Ministries' mindset that a centralized »one-size-fits-all« approach is no longer sufficient. With the experience gained through this program Croatian faculty are extending their assistance to the other South East Europe countries, which are undergoing the same process. The first one to try out and test nationally our training model (since June 2003) was Republic of Macedonia.
10. At the 3rd Biannual Conference on "Strengthening Global Public Health Management Capacity: Leadership, Innovation, and Sustainability", held in May 21–26 in Cape Town, South Africa, CDC's SMDP program awarded "Health–Plan for It" - Healthy Counties program with Management Training Excellence Award, recognizing the use of "Health–Plan for It" program to strengthen the management capacity of county health departments in Croatia (45). The program was chosen for its impact on public health program planning nationwide. Istria County team has been awarded twice with The Applied Management Learning Awards, in 2004 for Istria County Health Plan, and in 2006 for "Improving patient flow process for the early detection of breast cancer in Pula General Hospital".

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