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Planning for health in the South East Europe: the Croatian experience

The war and subsequent disintegration of the former Republic of Yugoslavia during the 1990's resulted in the creation of independent nation-states of Croatia, Macedonia, Slovenia, Bosnia and Hercegovina, Serbia and Montenegro. The recent history of armed conflict, political turmoil and severe economic change has resulted in tremendous individual and societal stresses throughout the region (1-4). In the case of Croatia, the transition to new forms of government and economic systems has resulted in a deterioration of public health services (5-6). A process of decentralization of the health sector, which started at beginning of the year 2000, has resulted in local County governments assuming public health planning responsibilities which had formally been highly centralized. This paper describes the evolution of a project aimed at strengthening local public health planning capacity at the County level of Croatia.

The World Health Organization's Urban Health/Healthy Cities Program in Europe provided Croatia with an early model for developing new social structures and organizational relationships to improve local public health. The initiative recognized the importance of political will and cross-sector alliances and strove to develop participatory mechanisms so that individuals, voluntary associations, and city governments could think about, understand, and make decisions together regarding local public health issues (7-9). Unfortunately, the Healthy Cities experience has remained quite localized and undervalued by the formal health policy system at the higher County and National levels. Public health professionals involved in the Healthy Cities project decided that future engagements at the higher County level would likely yield more positive results.

Healthy Counties

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 had been developed by the Public Health Practice Program Office of the U.S. Centers for Disease Control and Prevention (10). Faculty from the Andrija Stampar School of Public Health adapted the instrument to fit the Croatian context and translated it into the local language.

The expert panel identified the following as the weakest points in existing public health policy and practice at the county level:

- Priority setting and policy formulation
- Strategy formulation and comprehensive planning for solving priority issues

- Coalition building among community groups and other stakeholders
- Policy assurance, an issue stemming from the lack of objectives and therefore an inability to determine whether they are achieved
- Lack of analysis of existing health resources.

In 2001, Open Society Institute, New York financially supported and facilitate ongoing collaboration between Andrija Stampar School of Public Health (University of Zagreb Medical School) and the US Centers for Disease Control and Prevention. The same autumn two faculty members from Stampar School attended the CDC's Management for International Public Health course in Atlanta. Returning to Croatia they developed unique training program, Healthy Counties, aiming to assist counties to asses population health needs in participative manner, select priorities, plan for health and, ultimately, assure provision of the right kind and quality of services (better tailored to the population health needs). Program incorporates a multi-disciplinary and inter-sectoral approach, permanent consultation with community ("bottom-up" approach) and use of qualitative analysis. Curriculum was developed as a blend of recognized management tools, public health theory and practice and use of SMDP's Healthy Plan-it™ material. Program main goal was to increase County-level capacities to conduct health planning and provide more effective public health services.

After two months of consultations with stakeholders in the Ministry of Health, Ministry of Labor and Social Welfare, County Governors, National Institute of Public Health and Andrija Stampar School of Public Health, officials reached consensus about the aims and content of the program. 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. All trainees understood from the outset that training inputs were expected to yield measurable outputs within a few months. Each county team was expected to plan and conduct assessments, and elaborate a County Health Profile and a County Health Plan.

Organization of training

Teams from three counties completed a cycle of four 4-day workshops conducted over a period of four months. Each County team was composed of 9 to 10 representatives: at least three from the political and executive component (County Councils and Departments 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). In order to maximize the participative nature of the workshops, the number of trainees at any given training activity was limited to 30. Since mutual learning and exchange of experience was an important part of the process, each cohort was composed of three counties from different parts of Croatia with different levels of local-governance experience. The Ministries supported the direct costs of training (training packet development, teaching and staff expenses) and the counties covered trainees' lodging and travel expenses. A different county hosted each workshop and provided the training venue.

Description of curriculum

Each cohort of counties went through the following curriculum:

Workshop 1 – Assessment (4 days intensive training)

County team members reviewed the core public health functions and practices, and became familiar with participatory needs assessment approaches, 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. Homework assigned to the county teams for completion prior to the next workshop 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.

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

Through application of "Healthy Plan-it", an educational program developed by the CDC's Sustainable Management Development Program, county teams were guided through a health planning process. They were first introduced to different techniques for selecting priorities among community health needs, then to problem-solving and decision-making techniques. Reaching consensus in groups that were so diverse and new to one another was a potential problem. Consequently, the trainers employed a variety of confidence building exercises and consensus techniques, which assisted in the achievement of desired team goals.

Each team selected five county health priority areas on the second day of the workshop and began to develop plans for addressing them. The teams learned how to identify and analyze problems, find the root causes of problems, and trace the possibilities for solving problem inside complex, multi-organizational systems. Prior to the next workshop, the teams had to identify county "health stakeholders" and conduct consultations with them about selected priorities. Following these meetings, each county team revised priorities, added or selected new ones and began drafting their County Health Plans.

Workshop 3 – Policy development (4 days intensive training)

This module began with an introduction to the process of building constituencies. Participants learned interpersonal communication, collaboration, advocacy and negotiation skills. Collaboration with the media, public relations and social marketing were addressed. 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.

Workshop 4 – Assurance (4 days intensive training)

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 projects from a larger, national perspective. Skills like resource planning and management (both human and financial), implementation, quality assurance, monitoring and evaluation were also part of this training.

Homework for this module was to finalize the County Health Profiles and County Health Plans for public presentation six month later. The assignment required the teams to present the results as well as describe the process 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. Teams had to present their County Health Profiles and Plans locally to their own County Councils, and then nationally to other (not yet involved) Counties, and Ministries.

A tutorial system of guidance and monitoring was introduced after the fourth workshop to ensure that team members not lose their commitment and enthusiasm. County team coordinators met mentors monthly and follow-up workshops on county health policy development were held every three months. Alumni from the first cohort were involved in training of the second and third cohorts, providing new trainees with practical advice and guidance from recent graduates of the program. Expert help and support to the counties was provided by the faculty on request throughout the process of development of the County Health Plans.

By beginning of September 2004, six training cohorts had completed the Healthy Counties program (15 county teams and the city of Zagreb) and produced County Health Profiles and County Health Plans with prioritized health needs and specific recommendations for addressing them. In nine counties County councils accepted and approved (own) county strategic health documents and in five assured finances for project implementation in priority areas.

Currently, training focuses on a trainee subset from the Healthy Counties project. The trainees consisted of ‘troikas,’ groups of 3 people in county leadership positions: one elected official, one professional civil servant from the county administration, and one professional from county public health institute. The troikas liaise own county team with other counties and trainers from Stampar School. During 2003/2004 troikas were gathered on several occasions and additionally trained in following topics: Evidence based public health - Programs of early detection and breast cancer treatment (Mljet, October 2003), Comprehensive (medical and social) care for the elderly (Samobor, March 2004), and Total Quality Management – as a tool for managers in health sector (Uvala Scott, May 2004).

Discussion

The shift from a socialist government with centrally planned economies to more representative governments and market-based economies is taking place rapidly throughout the Balkans. The simultaneous process of decentralization and health sector reform had imposed great pressures on local governments to better plan and manage their public responsibilities. Even though local governments are

faced with this new challenge, they are also presented with greater freedom in selecting priorities, allocating resources, and satisfying local health needs. These opportunities require increased capacities at the local level to identify and prioritize needs, plan, implement and evaluate interventions.

The Healthy Counties program has built county 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. 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. The Healthy Counties project has successfully engaged stakeholders from political, executive, and technical arena. It involved variety of community group's (youth, elderly, unemployed, farmers, islanders, urban families, etc.), local politicians, and institutions in the needs assessment, prioritizing and planning for health cycle. County Health Plans are accepted politically (by County Councils), professionally and publicly. Proposed interventions, for health improvements, rest on local organizational and human resources and are (in the moment in five Counties) financially supported by the County (Public needs) budgets. With the experience gained through this program Croatian faculty are extending their assistance to neighboring Balkan nations which are experiencing the same post conflict transitions to different forms of governments and economic systems. The first one to try out and test nationally our training model (since June 2003) was Republic of Macedonia.

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