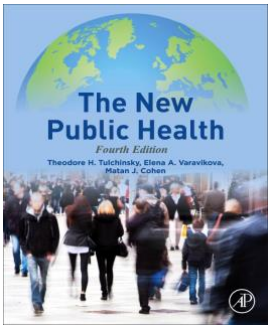

Healthy Counties public health capacity building in Croatia

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For NPH4 Chapter 10

In 2001, the Croatian Ministry of Health accepted the Andrija Štampar School of Public Health initiative to develop, in cooperation with United States Centers for Disease Control and Prevention (CDC SMDP), Atlanta the “learning by doing” training program that would increase county level public health and managerial capacities before the government legally formalized the counties’ obligation to plan for health and organize the provision of primary and secondary level health care services. Program started in spring 2002. The training curriculum was developed as a blend of recognized management tools, public health theory and the practice and use of the CDC SMDP Healthy Plan-it material.
Between March 2002 and March 2009, eight training cohorts involving about 244 participants from 20 counties and the City of Zagreb (with the status of a county) completed the program. Each County officially appointed (ten to twelve) members of the county health team that undergo through the six month long modular training. Counties capacity building training aimed to connect and improve collaboration between political (elected county officials), executive (county departments of health and social welfare) and professional (institute of public health) components that formulate and implement health policy at the county level. Training, as well, provided the foundation for their better collaboration with community (NVO and media representatives’ participation in training). Three by three counties went through the six months long training. During the process of education in the 1st faze of the program (2002 to 2009) each County produced a health profile and health plan with prioritized health needs and identified actions to address them. Since the presence of county health documents did not solve the problem of implementation, the second round of the Healthy Counties training modules (2008 to 2012) was design with the aim to facilitate Health strategy documents implementation, support networking across levels and sectors, encourage synergy development and institutionalization of change. Only six (out of twenty counties) completed the second modular training. The Program’s impact was measured twice, in 2006 and 2012. Evaluation combined the self-evaluation of a) the progress made by county teams in three main public health functions (assessment, policy development and assurance), b) the process

measurement (procedures chart), and tutors' evaluation (tutorial notes) used to verify the results obtained by the previous two methods. Thirteen county health teams took part in 2012 evaluation. The scores of each participating team were higher on the final than on the first or second performance matrix, although not in all functions. The analysis of textual responses in performance matrices clarify what kind of improvement was made. In the assessment function, county teams introduced new participative methods of health needs assessment, used variety of data available from other sources, and performed investigations in health and social needs of vulnerable groups. In the policy development function, major improvements were made in constituency building by increasing the number of agencies and local authorities involved in priority setting and health policy development (rather than only health services planning). Teams that made improvements in assurance function mentioned - managing resources by allocating them preferably into the programs addressing health priority needs and education of the public. Procedures chart was used to assess the overall progress and progress made in specific areas as a) application of newly gained knowledge, improvement of methods of work, b) development of new products and c) establishment of the local project legitimacy. Six counties that participate in the second round of modular training had achieved better result. Tutorial notes indicated the influence of external political context (national elections in late 2003 and 2010, local elections in mid-2005 and 2009) on the Program and local projects and provided a qualitative insight into county teams' performance matrix and procedure chart results.
In the 2012 evaluation, the local public health policies and practices of 13 participating counties were improved, although to a varying extent. The differences in improvement depended on the differences in the strength of political, executive, and professional components of the teams. County teams that made major improvements in the assessment function, had a weak or non-existing executive and political component, but a strong professional public health component. On the other hand, major improvements in policy development function were achieved by the teams with strong executive and political component. However, due to weak professional and community components, these teams did not develop participative approach neither in needs assessment nor in constituency building. Istria, Primorsko-goranska and Međimurje counties having the most committed and balanced teams have achieve progress in all three functions. A factor contributing to the overall local project achievements were local political stability and personal commitment of program leader. In more than half counties participating in the training, the officials changed during the local elections in 2005 or 2009. This proved to be a drawback for project development (in five counties) or reason to completely abandoned project in several others that did not take part in the evaluation.

Today this Program is still operational, it is continuing through the Croatian Healthy Cities Network activities, supporting acquisition of new knowledge and skills in the ten member Counties and the City of Zagreb, especially in relation to evidence informed policy making and monitoring and evaluation.

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