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Self-assessments of the essential public health operations in the WHO European Region 2007–2015

Experiences and lessons from seven Member States

By: Meggan Harris, Maria Ruseva, Dora Mircheva, Philip Lazarov, Tatiana Ivanova and José M. Martin-Moreno

ABSTRACT

This report describes the findings of seven case studies of Member States of the WHO European Region (Cyprus, Estonia, Poland, the Republic of Moldova, Slovakia, the former Yugoslav Republic of Macedonia and Uzbekistan) that carried out self-assessments of the essential public health operations (EPHOs) from 2007 to 2015, using successive versions of the *Self-assessment tool for the evaluation of essential public health operations and services in the WHO European Region*. The case studies show that the EPHO self-assessment tool is a valid instrument for evaluating public health capacities and services at the country level, and an effective process for strengthening intersectoral networks and building capacity and consensus around public health issues. This report also presents the findings of a brief documentary review of the seven corresponding self-assessment reports. The review shows that there is still much work to be done to strengthen public health in the Region; there are gaps and areas for improvement in every single essential operation, but particularly in those requiring intersectoral collaboration. In closing, this report presents specific steps that the WHO Regional Office for Europe, Member States and partner organizations can take to support the strengthening of EPHOs in the Region.

Keywords

ESSENTIAL PUBLIC HEALTH OPERATIONS
HEALTH POLICY
HEALTH SYSTEM PLANS – ORGANIZATION AND ADMINISTRATION
HEALTH SYSTEM REFORM
HEALTH SYSTEMS ASSESSMENT
HEALTH SYSTEM STRENGTHENING
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List of abbreviations

EAP-PHS	European Action Plan for Strengthening Public Health Capacities and Services
EPHOs	essential public health operations
EU	European Union
HiAP	health in all policies
NCDs	noncommunicable diseases
NGO	nongovernmental organization
NIPH-NIH	National Institute of Public Health–National Institute of Hygiene (Poland)
SANEPID	Sanitary Epidemiological Service
San-epid	sanitary-epidemiological
SEEHN	South-eastern Europe Health Network
SWOT	strengths, weakness, opportunities and threats

Executive summary

Since the first self-assessment tool for the essential public health operations (EPHOs) was piloted in south-eastern Europe in 2007, 20 Member States of the WHO European Region have undertaken a self-assessment. This report describes seven country experiences (those of Cyprus, Estonia, Poland, the Republic of Moldova, Slovakia, the former Yugoslav Republic of Macedonia and Uzbekistan), based on in-depth interviews with national public health professionals who were involved in the self-assessments or who have had a role in implementing the resulting recommendations.

The case studies focus on five domains related to the self-assessment. These domains pertain to countries' performance of the evaluation as well as the features of the tool itself:

- institutional basis and stakeholder participation;
- contribution to a whole-of-government, whole-of-society approach;
- contribution to policy-making;
- user experience; and
- future use of the self-assessment tool.

Country experiences in each of these areas affected the likelihood that the EPHO self-assessment would lead to meaningful public health reforms.

In terms of an institutional basis for the self-assessment, strong involvement from central governments was a decisive factor in countries' ability to carry out the process in a rigorous and timely way. With regard to the its contribution to a whole-of-government, whole-of-society approach to health, the 2014 revision of the tool and methodology strongly favoured the development of intersectoral and interdisciplinary ties and strong professional networks, and in this way helped to build support around public health issues. In terms of its contribution to new public health policies and programmes, there was an evident interplay between national leadership, on the one hand, and perceptions of ownership over the self-assessment process, on the other. Both of these factors had an impact on self-assessment follow-up. In the area of user experience, evaluators' perceptions were shaped by internal considerations as well as by the design of the tool itself. Findings clearly showed the importance of good organization and adequate allocation of resources, as well as the potential need to adapt the tool to each country context. Finally, with regard to future use of the tool, the case-study informants universally agreed on the usefulness of the EPHO self-assessment approach and expressed a positive openness to continue working with the WHO Regional Office for Europe to advance this agenda.

The keys to effectively translating a successful self-assessment into a comprehensive strategy to revitalize public health include national leadership, explicit linkage with the policy cycle, broad participation among governmental, academic and nongovernmental partners, and the availability of expert technical assistance to guide the self-assessment itself as well as the prioritization and policy-making processes that follow.

As a complement to the case studies, this report presents the findings of a brief documentary review of the seven corresponding self-assessment reports. The review shows that the most important challenges remain in the enabling operations (information, human resource development, governance) and in adopting a whole-of-government, whole-of-society approach to addressing health inequity and the social determinants of health. In clarifying these important areas of focus, the self-assessment tool functions as a practical instrument for renewing public health in the Region in line with the precepts built into Health 2020 and the European Action Plan on Public Health Capacities and Services.

Introduction

In the nearly 20 years since the WHO Regional Office for Europe published the first list of essential public health functions (EPHFs) in 1998 *(1)*, public health in the WHO European Region has undergone tremendous changes. Eastern European and central Asian countries have worked to move beyond the sanitary-epidemiological (san-epid) systems that defined their public health systems for decades, while western European countries have concentrated their efforts on addressing the formidable consequences associated with rapid population ageing as well as widening economic – and hence health – inequities.

All countries have had to grapple with the challenges brought on by the evolving disease burden, now overwhelmingly dominated by chronic noncommunicable diseases (NCDs), and the Region as a whole has had to rethink its approach to public health. The strong health-systems perspective that characterized European public health at the beginning of the twenty-first century has given way to a more holistic viewpoint, enshrined by the European health and well-being policy framework Health 2020 *(2)* and the European Action Plan for Strengthening Public Health Capacities and Services (EAP-PHS) *(3)*, one of its main pillars of implementation.

The EPHFs have changed as well. First, the name itself was modified to essential public health operations (EPHOs) to avoid confusion with the health system framework functions, which made their debut with the publication of the World Health Report 2000 *(4).* The South-eastern Europe Health Network (SEEHN) piloted the first EPHO self-assessment tool in its nine Member States in 2007–2008. It then developed a computerized tool, and assessments continued in central Asia and in three other European countries (Estonia, Slovakia and Slovenia).

Informants from these countries, along with the project steering committees, provided detailed feedback on their experience of using the tool. Based on this input, and with the aim of aligning the tool with Health 2020 and the evolving vision of European public health, the Regional Office undertook a comprehensive revision of the tool. It then piloted the revised tool in 2014 in Poland and the former Yugoslav Republic of Macedonia, and made it publicly available on its website in 2015 *(5).* To date, approximately two-dozen assessments have taken place in 20 countries of the Region (see Table 1). The fact that the EPHO self-assessment tool has developed and adapted to the needs of these diverse countries is a testament to its durability as a vehicle for assessing public health capacities and services.

While most WHO regions have developed their own lists of and assessment methods for essential public health functions or operations *(6)*, the European Region is the only one currently promoting a self-assessment tool as an integral part of the policy-making cycle. The condensed list of 10 EPHOs helps to define and delineate public health for national policy-makers and other stakeholders from non-health sectors, while the expanded list of suboperations provides a comprehensive checklist of public health services and capacities as understood by WHO. Thus, the self-assessment tool helps to promote a harmonized understanding of public health throughout the Region, both within and outside the health sector, while also serving as an instrument to assess the status quo in the development of reform packages.

In a time when other WHO regions have been challenged by public health crises such as outbreaks of Ebola and Zika viruses, the EPHO approach has attracted considerable attention. Most recently, stakeholders discussed the EPHOs at a WHO Interregional Internal Working Meeting on health systems, the International Health Regulations *(8)* and essential public health, held in March 2016 in Copenhagen. The EPHOs have also functioned as a main avenue of action for the implementation of the EAP-PHS *(3).* It is fitting, therefore, to examine how and by whom the EPHO self-assessments

have been carried out, and to what extent they have had an impact on renewing public health policy in the Region.

Table 1. EPHO self-assessments in the Region, 2007–2016

Framework/version	Country	Year(s) of EPHO self-assessment
SEEHN framework: Evaluation of public health services in south-eastern Europe *(7)*	Albania	2007–2008
	Bosnia and Herzegovina	2007–2008
	Bulgaria	2007–2008
	Croatia	2007–2008
	Montenegro	2007–2008
	Republic of Moldova	2007–2008
	Romania	2007–2008
	Serbia	2007–2008
	The former Yugoslav Republic of Macedonia	2007–2008
Reform of public health and the role of SANEPID[1] in the newly independent states	Tajikistan	2009
	Armenia	2009
	Kyrgyzstan	2011–2012
	Uzbekistan†	2011
	Republic of Moldova†	2012–2013
	Russian Federation	2012–2014
Other EPHO self-assessments using version 1 of tool	Estonia†	2007–2008
	Slovenia	2009
	Slovakia†	2011–2012
Revised version of EPHO self-assessment tool (2014)	**The former Yugoslav Republic of Macedonia**†	2014
	Poland†	2014–2015
	Bosnia and Herzegovina	2014-2015
	Cyprus*†	2015
	Armenia	2015–2016
	Slovenia	2015–2016
	Kyrgyzstan	Ongoing (2016)
	Kazakhstan	Ongoing (2016)

Bold: countries that have undertaken more than one self-assessment
†Featured in case studies

This report provides a closer look at the results of the EPHO self-assessments. Its main focus is the self-assessment process itself, as well as the lessons gleaned from seven case studies of countries' experiences using the tool. Authors have organized the case studies chronologically in order to reflect contextual changes in European public health as well as the accumulation of experience by the Regional Office and WHO country offices in guiding the self-assessment process. As formal assessments took place exclusively in the eastern part of the Region, it was impossible to evaluate any experiences from western European countries, which may differ in goals, obstacles and strengths.

The report also presents a brief, crosscutting analysis of the country reports produced after the national self-assessments in order to identify trends and common challenges across the Region. It concludes with a series of reflections and implications for the Regional Office, Member States and partner organizations.

[1] Sanitary Epidemiological Service

Aims

The aim of the case studies was to understand to what extent the EPHO self-assessments that have been conducted since 2007 contributed to the development and implementation of evidence-based policy to improve public health. The authors assessed the following domains:

- institutional basis and stakeholder participation;
- contribution to a whole-of-government, whole-of-society approach to health;
- contribution to policy-making;
- user experience; and
- future use of the self-assessment tool.

Methodology

The general methodology used for all of the case studies is outlined below; methodological notes are also included in individual case studies to describe their specificities.

Selection of countries and key informants

Based on a comprehensive list of countries that carried out an EPHO self-assessment between 2007 and 2015 (Table 1), the core steering committee of the EAP-PHS implementation report selected 10 countries for detailed case studies. Selection criteria for the list as a whole included the following: (i) countries with different sociopolitical contexts, representing a variety of subregions, (ii) countries with an available EPHO self-assessment report on file, (iii) countries that had carried out more than one self-assessment and (d) countries that had completed a self-assessment using different versions of the tool, with an emphasis on capturing the experience of those that had used the most recent version. Based on these considerations, the following countries were initially chosen: Armenia, Cyprus, Estonia, Poland, the Republic of Moldova, the Russian Federation, Slovakia, Tajikistan, the former Yugoslav Republic of Macedonia and Uzbekistan.

The project coordinator at the Regional Office (MKvK)[2] then requested nominations for key informants from the ministries of health, government focal points or heads of country offices in each country. In the case that there was no country office (for example, in Cyprus), the coordinator contacted an appropriate country expert affiliated with WHO for recommendations. One author (MR) who had been directly involved with many of the self-assessments also provided suggestions for possible informants. The authors then provided focal points with a version of the following descriptions by email to guide their nominations.

- A senior public health actor could be, for example, a member of a steering committee or secretariat for the self-assessment process, perhaps responsible for the self-assessment as a whole, who is able to give us a good idea of the big picture. This individual should have a good understanding of the political context in which the self-assessment took place and a global view of the actors involved.
- A mid-level public health actor could be, for example:
  - someone who coordinated a specialized team of people assessing one or more EPHOs;
  - someone who contributed to the work of one of the specialized teams assessing one or more EPHOs;
  - a public health actor who is familiar with the EPHO self-assessment process that was conducted and is able to comment on the quality of the process and the impact it had, without necessarily having been directly involved; and/or
  - a nongovernmental actor such as an academic or representative of a nongovernmental organization (NGO).

From the resulting list, the Regional Office coordinator chose three key informants for each country: one self-assessment leader/coordinator and two mid-level actors who had taken part in a portion of the self-assessment.

Design of the questionnaire

An independent consultant (MH), working in concert with a senior WHO adviser at the University of Valencia, Spain (JMM), drafted the questionnaire, which was subjected to several rounds of revision

[2] Initials in brackets are those of the authors as well as Martin Krayer von Krauss, the project's coordinator at the Regional Office, and David Hunter, coordinator of the EAP-PHS implementation report.

by another author (MR) and the extended team responsible for developing the EAP-PHS implementation report (DH, MKvK). Authors then piloted the resulting questionnaire on the first case study, and subsequently made minor adjustments to clarify wording and intended meaning before translating the document into Russian and circulating it to country focal points in the Republic of Moldova, the Russian Federation, Tajikistan and Uzbekistan. See Annex 1 for a copy of the questionnaire.

Engagement with key informants

Informants were contacted directly by email (MH: Cyprus, Estonia, Poland, Slovakia and the former Yugoslav Republic of Macedonia) or through the Regional Office (MKvK: Armenia, Republic of Moldova, the Russian Federation, Tajikistan and Uzbekistan). In two cases (the Russian Federation and Tajikistan), repeated efforts to make contact, including follow-ups through the heads of WHO country offices, did not yield a response. The authors discontinued their efforts to engage the selected interviewees in these countries.

Although only one informant responded from the Republic of Moldova, the interview provided enough information on which to base a case study. In the case of Armenia, the sole informant who participated was involved in the first (2009) self-assessment but not the second (2015–2016); thus the authors made the decision not to draft the case study.

Informant interviews

Authors provided all informants with the questionnaire prior to the interview, and all signed informed consent. Authors then conducted interviews via Skype or by telephone and recorded them. Informants completed the multiple-choice items of the questionnaires ahead of time, and conversations then focused on follow-up discussion questions.

Drafting of case study reports

Case studies were based primarily on the responses that informants provided on paper prior to the interviews and orally during the interviews themselves. This information was complemented by the published or unpublished EPHO self-assessment reports, which constituted the main documentary inputs. Additional sources are cited in individual case studies.

Upon drafting a case study, the author(s) circulated it first to the heads of WHO country offices (or national experts) for sense-checking, and then to the informants for their comments and changes. Finally, partners within the Regional Office and on the coordinating team of the interim review on EAP-PHS implementation at Durham University, United Kingdom, subjected the draft case studies to an internal peer review.

Case study: Estonia (2007–2008)

Key points and lessons learned

- Estonia's self-assessment constituted a good learning and discussion exercise within a general climate of reform activity.
- However, its formal impact was limited by a lack of alignment with the national policy cycle and a lack of capacity to perform the evaluation in a timely way.
- Estonian professionals remain open to undertaking additional self-assessments, pointing to an atmosphere of increasing regard for public health as an asset to future reforms.

Methodological notes for country case study

The Estonian case study was based on information from the country's published self-assessment report *(9*) as well as material from interviews with three people involved in the evaluation process: team coordinator Dr Ülla-Karin Nurm, working at the time in the Public Health Department, Ministry of Social Affairs; Ms Heli Laarmann, also in the Public Health Department, Ministry of Social Affairs; and Dr Jelena Tomasova, Deputy Director General for Health Protection at the Health Protection Inspectorate.

Because eight years passed between Estonia's self-assessment and the development of this case study, there is some risk of recall error. However, the authors believe that their methodology – three full interviews and a review by the head of the WHO Country Office in Tallinn – helped to minimize any omission of important details. The passage of time also allows for a more objective appraisal of the real impact of the self-assessment process on public health policy in the country.

Background

Context of the EPHO self-assessment

Estonia was among the first Member States to pilot the initial version of the EPHO self-assessment tool, and the working group responsible for completing the questionnaire in Estonia also took part in seminars to refine the content and methodology of the tool itself. Estonia's self-assessment process was not formally linked to those undertaken in parallel within the framework of SEEHN, although it did follow the same process and methodology.

The opportunity to engage Estonia in the use of the self-assessment tool arose at a time when the Estonian Ministry of Social Affairs was actively working to develop a comprehensive public health reform package. The Regional Office and the WHO Country Office aimed to fulfil their technical advisory role during that policy cycle using the best tools available to them. They also sought to open up the consultation on the development of the self-assessment tool to a country with different political and health system characteristics than those of SEEHN Member States.

Although these circumstances appear propitious, the self-assessment process lacked formal, explicit linkage to the development of the National Health Plan 2009–2020 *(10)*. In the end, it was approved prior to the finalization of the self-assessment report. At the same time, the self-assessment coincided with other national and international initiatives for health. At the regional level, the *Tallinn Charter: Health Systems for Health and Wealth (11)* was attracting considerable attention for the broad consensus it achieved among all Member States of the Region. This influential document exemplified the priorities advanced by the Regional Office at the time, with its promotion of health systems strengthening (rather than public health per se) as the primary avenue through which to address population health challenges. At the national level, parallel assessment and planning processes related to the National Health Plan were also underway. Both of these factors may have

weakened the priority given to the EPHO self-assessment, as well as its potential impact on the comprehensive reform process.

Organization of the assessment process

The self-assessment in Estonia was a joint effort between the Regional Office, the WHO Country Office in Tallinn and national public health actors led by the Ministry of Social Affairs. Given the intended nature of the process as a *self*-directed exercise, the strong role of the Regional Office and the WHO Country Office makes Estonia's case somewhat unique. As this version of the tool was still under development, the Regional Office had an interest in understanding the practical functionality of the questionnaire and in adapting it to a real country setting. Thus, Estonia had the opportunity to contribute to the development of the early version of the tool, while WHO experts were able to closely follow and learn from its application during a pilot experience.

Participants carried out the self-assessment mainly by means of collaborative seminars among working groups, usually with intense participation from consultants working for either the Regional Office or the WHO Country Office. The 2007 version of the tool was linked to the four health system framework functions (governance, resource generation, financing and service delivery), and discussions were broadly based on strengths, weaknesses, opportunities and threats (SWOT) analyses of different EPHOs in the country. Participants of the working groups were representatives from the main institutions of the health sector. The assessment and development of the report took approximately two years to complete.

Institutional basis and stakeholder participation

Institutional basis

Informants agreed that there was a poor degree of commitment to the self-assessment from senior administration officials. They offered several reasons for this. One informant pointed to a lack of ownership within the Ministry of Social Affairs that may have undermined any willingness to prioritize the self-evaluation. While members of various technical teams saw WHO's role in promoting public health quite positively, some high-level officers in the Ministry viewed WHO as a peripheral actor, rather than a true partner, in the national public health arena. Leaders in the Ministry showed little enthusiasm for allocating time to complete the self-assessment, but gave high priority to the parallel planning and development of the National Health Plan.

In consonance with the design of the first version of the tool, the self-assessment working groups were made up almost exclusively of government actors working in the health sector, including: the Ministry (the Public Health Department, the Department of Health Care and the Department of Health Information and Analysis), the Health Protection Inspectorate, the Social Welfare and Health Department of the Tallinn City Government, the National Institute for Health Development, the Estonian Health Insurance Fund and the Health Care Board. One person from the Labour Inspectorate also signed the report as a co-author.

Several government stakeholders from outside the area of public health, for example agriculture, industry and the environment, were consulted on certain questions; their participation, however, was mostly limited to input to the working groups.

More diverse institutional representation came from government professionals who also held positions in other organizations. No academic institutions formally took part in the self-assessment.[3] No NGOs or scientific societies were involved. Informants noted that the consensus

[3] Although the National Institute for Health Development is a research organization, it receives its funding from the government rather than an independent academic institution.

reached among the working groups did not extend to higher decision-making levels, where priorities remained different from those pursued at a technical level.

Stakeholder participation

Informants described the interactions during the workshops and working group seminars as quite positive. The extent to which this represented a change from day-to-day interaction is debatable, however, in a small country with limited government administration. As members of the working groups already knew each other well, the self-assessment process did not fundamentally change their working relationships; nor did it open up new avenues for communication among actors who had been working in isolation.

Despite the limited impact of the process on stakeholder relationships, informants still judged that the self-assessment "moderately improved relationships". One explained this nuance by pointing out that the questionnaire's prompts helped to stimulate new discussions and favoured a collaborative approach to solving problems. Although no new intra- or intersectoral relationships were created, new areas for collaboration nevertheless emerged.

Contribution to a whole-of-government, whole-of-society approach to health

The self-assessment coincided with other national and international initiatives to promote more and better intersectoral governance, and informants felt that it complemented and reinforced these parallel efforts. As many professionals were participating in both the self-assessment and the development of the National Health Plan, EPHO-centred discussions about the strengths and weaknesses of the Estonian system likely influenced elements of this important document. Given the lack of official ties between these processes, however, the impact of the self-assessment was entirely informal.

Informants noted that the compact self-assessment report was also very useful. As the only one of its kind in English, it facilitated informed discussions of the Estonian system with international partners, including WHO and the European Union (EU). The exercise proved especially useful for the Health Protection Inspectorate and set the stage for later reforms and improvements in health impact assessment.

As in most developed countries, a whole-of-government approach to public health administration remains a challenge in Estonia. Estonia's small size, however, does facilitate cooperation in areas where a clear overlap of competencies exists (for example, environmental health). One informant referred to *Estonia: towards a single government approach (12)*, a public governance review published by the Organisation for Economic Co-operation and Development in 2011, as evidence of the progress that the country still needs to make in moving from vertical to horizontal governance mechanisms. Eight years after the publication of the self-assessment report, informants felt positive about its impact but admitted that it could have been better exploited.

Contribution to policy-making

The self-assessment was a relatively low-profile element of a broader public health reform movement underway in Estonia at the time. Informants stated that the assessment process provided actionable information on known problems and generated new ideas on how to address them through an integrated approach. It is difficult, however, to point to a specific, tangible effect of the self-assessment on policy-making in the country. By the time the report was published, the policy landscape had already changed, and some of the report's final recommendations were thus rendered null and void. Indeed, there is no mention whatsoever of the EPHOs in the National Health Plan.

Nevertheless, a number of structural improvements in public health have been implemented since the conclusion of the self-assessment. For example, officials amalgamated the Health Protection Inspectorate, Health Care Board and Chemical Notifications Centre into a new institution – the Health Board – to reduce fragmentation and centralize responsibilities in risk assessment, licensing, quality assurance and inspection. They also implemented a new electronic system for collecting information on communicable diseases, passed several amendments to the Public Health Act, made efforts to increase activity in health impact assessment and strengthened preparedness and planning for health emergencies.

Informants shared a general perception of greater respect and recognition for the field of public health in Estonia, both within the government and throughout society. One noted that, in reading the self-assessment report to prepare for the interview, she found that many of the weaknesses highlighted therein had since been dealt with in one way or another.

User experience

Overall, informants felt that the self-assessment process was burdensome. This was due to characteristics of the tool itself as well as how the process was framed within the country. In terms of the tool, one felt that the questionnaire was too long and that the scope of questions was too broad. Another would have preferred that the tool focus on priority areas rather than all aspects of public health. They also noted that some participants found the questions difficult to understand within the Estonian context (where, at the time, public health was generally perceived through a health systems approach).

The language barrier also impeded the user-friendliness of the tool. Not all officials and public health experts in the country could fluently speak or write in English, and thus a great deal of translation was required to enable key experts to understand and respond to questions in Estonian before publishing the report in English. A WHO officer, however, was available to assist with writing the report.

The language barrier may also have contributed to a perceived lack of national ownership of the process and the report. Additionally, one informant pointed out that ownership has to translate into capacity and resources to perform the self-assessment; neither of these was in place at the time, and the Regional Office did not adequately increase national capacity to empower leaders in the Ministry of Social Affairs to take on the self-assessment.

Over the course of the two-year assessment, different WHO consultants participated in missions to guide the process, and yet, as one informant expressed, there was a lack of continuity in their visits. They felt that resources should have been used to train and fund Estonian experts for the self-assessment; this would have freed up precious resources for the evaluation and ensured that the acquired expertise stayed in the country after it was complete.

Future use of the self-assessment tool

Informants were receptive to the idea of performing future self-assessments, particularly using a web-based version of the tool. As the Estonian government administration is digitally based, its workforce is quite comfortable using online tools. The country has also partially overcome some of the obstacles that participants experienced in the first iteration of the self-assessment; for example, the general level of English among public health professionals has improved.

For the self-assessment to lead to policy improvements, however, informants pointed out that several important changes must be made. First, a much clearer link between the self-assessment and the national policy cycle in health sector reform is needed. As the Estonian government is currently working towards reforming the health care system – particularly primary care, hospital

care and the functions of different governmental organizations within the health sector – linking these efforts to a reassessment of public health services could be very useful.

Second, the Ministry of Social Affairs needs to more explicitly support or sponsor the self-assessment process. Given the heavy workload of its professionals, however, it may be more feasible to commission WHO-trained experts at Estonian universities or NGOs to lead the self-assessment. This approach would also have the advantage of increasing the objectivity of the findings.

Conclusions

Overall, the Estonian experience with the EPHO self-assessment tool was positive. Strengths of the process and the team included constructive discussions of mutual challenges, a collaborative and participatory approach (at least within the health sector), a willingness to learn and a degree of openness to applying self-assessment findings in future policy decisions. The self-assessment contributed somewhat to reforming public health capacities and services within a broader context of health systems strengthening, and the changes implemented during this period are still evident.

Its impact, however, was relatively limited. The process lacked sufficient alignment with the national health policy cycle, and this prevented the self-assessment report from contributing to the design of the National Health Plan. Moreover, no stakeholders from outside the health sector played a substantive role in the process (due in part, perhaps, to the more limited scope of the early version of the self-assessment tool). This restricted the potential of the process to advance a whole-of-government approach to health.

Case study: Uzbekistan (2010)

Key points and lessons learned

- The self-assessment process effectively deepened professional understanding of public health, including its definition, scope and services.
- Use of the self-assessment report in professional training continues to foster a holistic understanding of public health among Uzbek professionals.
- The self-assessment report and recommendations catalysed a series of new policies, legislations and reforms; however, a comprehensive national public health strategy and a true intersectoral approach to population health are still pending.
- Public health professionals remain enthusiastic about building on their 2010 self-assessment using the new tool, and point to several factors that could favour success: preparatory training and infrastructure; greater participation from non-health sector actors, including NGOs and civil society; and partnership and technical assistance from WHO.

Methodological notes for the country case study

The Uzbek case study was based on interviews with three leading professionals from the public health sector: Professor Bakhromjon Mamatkulov, Director of the School of Public Health at Tashkent Medical Academy; Dr Olga Mirshina of the Republican Center for State Sanitary-Epidemiology Surveillance; and Dr Shukhrat Shukurov, Coordinator of the Strengthening the System of Prevention and Control unit within the Central Project Implementation Bureau of the Health-3 project (2011–2018) of the World Bank.

One informant was involved directly in the 2010 self-assessment process within a nine-member working group. Another did not participate in the 2010 self-assessment process but explained that her responses to the questionnaire and interview are based on her experience with other WHO-led initiatives, including the national Health 2020 policy and the Climate Change Adaptation to Protect Human Health country project. This informant's contribution to the case study may be weakened by her lack of direct experience with the self-assessment but is included for its potential benefit to future iterations of the process.

Background

Context of the EPHO self-assessment

In the beginning of the 1990s, Uzbekistan had a well developed public health system. It was characterized, however, by strictly centralized structures and funding, an insufficient level of specialized capacity-building and inadequate managerial mechanisms. Based on the Soviet Semashko system, it featured a Sanitary Epidemiological Service (SANEPID) covering only the surveillance of communicable diseases, health protection and health inspection. After Uzbekistan declared independence from the Soviet Union in 1991, important political, economic and social changes took place and population needs evolved. The Uzbek government stipulated the legal basis for protecting population health in the Constitution of the Republic of Uzbekistan in 1992 *(13)* and, in the face of new realities and challenges, decided to radically reform the health system. In 1998, a presidential decree marked the beginning of a phased reform programme to do so. Within the context of the World Bank's Health-2 project (2004–2011), Uzbekistan developed a draft public health strategy in 2008–2009. While this draft was subsequently tabled, a number of public health-related laws and documents were nevertheless adopted and introduced in practice.

In 2009–2010, with the support of WHO, the Ministry of Health of the Republic of Uzbekistan organized a self-assessment of its public health services based on an earlier, web-based version of the tool. This took place prior to the 62nd WHO Regional Committee for Europe in Malta (2012) and the associated adoption of the EAP-PHS *(3).*

Organization of the self-assessment process

Uzbekistan's Deputy Minister of Health and Chief State Sanitary Inspector formally led the country's self-assessment, although he himself was not directly involved in the working group discussions or other activities. A core group of nine senior technical professionals and leaders was established, comprising SANEPID experts and heads of various departments at the Ministry of Health (including health care, mother and child health, human resources and training, and financing) as well as the National Institute of Health Information and the National School of Public Health at Tashkent Medical Academy. Each member was free to involve additional experts with more specific expertise; in total, nearly 30 national public health professionals took part in the self-assessment process.

Following the completion of the self-assessment, stakeholders discussed the draft report at a national conference and refined it during a governmental consultation process in which all other ministries and committees had the opportunity to provide feedback. This feedback was taken into account in the final version of the report. Although the report was published in 2010 *(14)* and its findings and recommendations were subsequently used for specific programmes, the government has not yet endorsed a national public health strategy.

Institutional basis and stakeholder participation

Institutional basis

Informants pointed out that, while there was a degree of institutional participation in the self-assessment, it was limited to the central structures of the health system and public health services. There was no support from public health authorities at subnational or community levels, and participation from intermediate public health actors and academic institutions was insufficient. No other governmental sectors or community stakeholders (such as NGOs) were involved in the self-assessment.

Stakeholder participation

The self-assessment process began with a significant degree of internal tension. This tension stemmed from a lack of mutual understanding both of the definition and scope of public health and of the EPHOs themselves. One informant's relatively low score (3/5) for "trust" at the time of the self-assessment may be explained by this conceptual fragmentation and the apprehension it caused.

However, as the self-assessment proceeded, it provided valuable opportunities for discussing and building consensus around findings and recommendations. All informants agreed that the self-assessment tool, particularly in terms of its focus on specific details related to public health services, helped to improve understandings of public health as defined by WHO. This development of mutual understanding defused negative emotions and encouraged more open and effective interactions among participants. Overall, the process had an unquestionably positive impact on stakeholder relationships.

Contribution to a whole-of-government, whole-of-society approach to health

As the self-assessment process took place exclusively within the realm of the health care system itself, it did not directly contribute to increasing intersectoral collaboration. However, the self-

assessment did have an important indirect impact on furthering a whole-of-government approach. The self-assessment report represented the crystallization of a new consensus around what public health services entail. While other sectors were not closely involved in the formulation of the report, they did have access to the final, published version. The Ministry of Health received very positive feedback for the report from non-health actors, who also perceived greater clarity in its framing of the roles and responsibilities of a public health system. This clarity provided an important foundation for later collaborations.

Since 2010, Uzbekistan has undertaken on two major intersectoral initiatives supported by WHO: the Climate Change Adaptation to Protect Human Health country project, and a national Health 2020 policy and action plan. Both initiatives used a broad, high-level participatory process – involving more than 20 sectors – set up under the leadership of the President. Such an approach was not politically feasible at the time of the self-assessment; however, these recent examples of intersectoral collaboration would likely not have been possible without it.

Contribution to policy-making

While unable to definitively state that the self-assessment had a direct impact on policy decisions, an informant pointed out that the Ministry of Health and the government developed a large number of public health laws after the self-assessment process. These included laws on alcohol, tobacco and smoking, san-epid surveillance, and healthy lifestyle and health promotion, as well as a national programme on nutrition. The Ministry also worked on reforms related to children's and women's health and healthy ageing. This activity has resulted in many governmental decrees and memoranda between sectors.

SANEPID is also currently upgrading laboratories through reconstruction, modernization and re-equipment. The role of Uzbekistan's san-epid stations in NCD prevention and health promotion, however, remains unclear. An informant pointed out that the public health professionals involved in san-epid are focused exclusively on epidemiological work and food safety, while NCD prevention and health promotion are the responsibility of the Ministry of Health's Health Care Department.

Informants suggested that the self-assessment process continues to influence modern concepts of public health in the education system. In particular, one informant stated, "the self-assessment report on [public health services], which was developed based on the WHO Europe tool and a solid SWOT analysis, is still being used by the National School of Public Health … it helps the education of the students in the master's degree programmes in [public health]".

The need for a better, more efficient and broader process of educating professionals and representatives from other sectors – including NGOs – persists. Much stronger health promotion activities are required, as is work with the mass media to increase civic understanding of public health issues.

User experience

Participants in the self-assessment process in Uzbekistan found it to be time-consuming and difficult for two main reasons: (i) the lack of a shared, modern understanding of public health and its specificities and (ii) the length and technical detail of the assessment itself.

Despite the challenges, all three informants confirmed that the process was worthwhile, particularly for the establishment of a clear basis for understanding public health and the opportunity to overcome disagreements within the working group related to the diverging visions and perceptions. This has established a new level of understanding and trust among participants.

Since the 2010 self-assessment, the expanded European vision, definition, scope, operation and services of public health have become part of a programme for the ongoing education and training of Uzbekistan's public health professionals. Informants expressed the importance of supporting and encouraging this programme within Uzbekistan and in other countries.

Future use of the self-assessment tool

Informants acknowledged that the self-evaluation process has certain value for the development and implementation of public health policies and strategies in Uzbekistan. After six years and in the wake of many public health developments in the country, they agreed that a new self-assessment using the revised set of EPHOs and the web-based version of the tool is called for. This could be used to monitor progress in recommended priority areas, including cross-sectoral collaboration; services in disease prevention and health promotion; the social health determinants of health; public health professional capacities; monitoring and evaluation; and investment and fundraising mechanisms.

One informant suggested that the next self-assessment could involve the creation of a national committee based on the composition of the previous working group, but extended to include all sectors as well as health authorities working on subnational levels and within NGOs.

All informants expressed very positive expectations for the web-based version of the self-assessment tool but highlighted two essential conditions for its success: advance (and ongoing) training for public health professionals in the use of the tool, and the establishment of related logistical infrastructure.

Finally, one informant suggested that to achieve positive results in the development and implementation of public health policy, the objectives of leaders must be taken into account. In this sense, stakeholders could work to strengthen the legal basis for public health policy and monitor its enforcement, and engage the general population in public health-related matters through much broader communication platforms.

Conclusions

All informants expressed their belief in the usefulness of the self-assessment tool and process, as well as the possibilities it offers for adaptation to different levels of professional training and education. They stipulated that future assessments should engage a wider range of sectors, institutions and professionals (including those outside the health system) and that, in order to avoid misunderstandings and improve effectiveness, the process must feature effective and transparent coordination. They emphasized that Uzbek professionals would appreciate support from WHO in these undertakings.

Case study: the Republic of Moldova (2011–2012)

Key points and lessons learned

- A very positive self-assessment experience in the Republic of Moldova has set the stage for future public health reform.
- There is sufficient commitment to improving public health as well as political momentum to continue implementing comprehensive public health reforms.
- Further support from WHO is both needed and wanted in order to fully achieve meaningful reform.

Methodological notes for the country case study

The Moldovan case study was based on the English-language summary report from the 2012 self-assessment *(15)*, the Republic of Moldova's national public health strategy (2013–2020) and one Russian-language interview with a key informant involved in the process: Galina Obreja of the National Centre of Public Health. Notes from two workshops that took place in Chisinau on 11–12 April and 8–9 December 2011 also informed the case study. The Regional Office, the WHO Country Office and the Ministry of Health of the Republic of Moldova jointly organized these workshops in order to present, discuss and agree on the results of the EPHO self-assessment, and to subsequently define and agree on the content, process and timetable for the development of the national public health strategy. A national intersectoral working group set up by the Minister of Health later finalized this strategy, and it was published in 2013.

Background

Context of the EPHO self-assessment

Since 1992, the public health system in the Republic of Moldova has undergone various restructurings within the context of wider health sector reforms. Beginning in 2007, the country has contributed to using and advancing the EPHO self-assessment tool both within a subregional initiative under the management of SEEHN and within the framework of the current EAP-PHS. SEEHN Member States used the first version of the self-assessment tool in 2007–2008 to evaluate their public health services and capacities and to lay the foundation for modern public health reforms on a regional level.

As a result of this process, the Republic of Moldova transformed its inherited san-epid system into a broader public health service. It adopted a new law on public health in 2009 and established a new national public health surveillance service focused on communicable diseases. It also established a national agency for food safety and introduced clusters and departments of NCD control at national, municipal and some district public health centres. National surveillance on health risks and indicators of NCDs, however, remains, weak.

The Republic of Moldova also amalgamated 36 of its laboratories into 10 efficiently run facilities. A great challenge ahead is the parallel reorganization of public health services into a network of 8–10 regional centres of public health (rather than 36). This reform will ensure that the limited capacities and resources of small centres are used more effectively.

The reorganization of the health system will continue in the coming years at both national and regional levels. The focus is now on strengthening the institutional framework, revising and renewing funding streams and incentives, and scaling up and transforming health professions. In this way the Republic of Moldova aims to build a system that can effectively address and respond to both communicable diseases and NCDs.

Organization of the self-assessment process

To evaluate the public health services and activities of the Republic of Moldova, and to make recommendations for strengthening capacities, a self-assessment was carried out in 2011–2012 as a joint effort of the Moldovan Ministry of Health, the National Centre of Public Health, representatives of centres of public health and health institutions within the country, the Regional Office and the WHO Country Office. A task force group created by the Ministry of Health was responsible for the self-assessment, and its members were trained on how to apply the tool. They presented findings and discussed recommendations with international experts at the two aforementioned workshops held in 2011.

Institutional basis and stakeholder participation

Institutional basis

The informant judged that the role of high-level government officials from outside the health system in the self-assessment was “poor” to “fair”. While representatives of the statistics office and the ministries of economics, agriculture, education and environment were passively involved (through correspondence) they were not actively engaged in the process. The Ministry of Health and the National Centre of Public Health were very well represented in the group of participants, and a large proportion of technical experts in the country also played a role in completing the questionnaire. Academic institutions were also involved to a good degree, but participation from NGOs and other nongovernmental stakeholders was “fair”.

Stakeholder participation

The informant described stakeholder interactions during data collection and in the workshops as collaborative and open. In cases where a fair level of institutional cooperation was already in place, outcomes were more tangible (for example, the development of a new programme for food products). In other cases, the assessment process provided an opportunity for stakeholders to learn about each other’s public health-related activities for the first time. Several institutions, for example the national Commission for Emergency Situations, engaged the expertise of other public health professionals in the development of their own programme documents.

The self-assessment was highly positive in that it facilitated the creation of personal relationships among professionals working in different institutions. At the same time, the lack of involvement from NGOs and other civil stakeholders was a missed opportunity to broaden support for public health services, especially with regard to tobacco and alcohol control.

Contribution to a whole-of-government, whole-of-society approach to health

The informant viewed the self-assessment’s contribution to promoting a whole-of-government, whole-of-society approach as incomplete. The self-assessment process will likely contribute to reinforcing existing avenues for interdisciplinary and intersectoral collaboration, and to opening up new ones. At a personal level, it provided good opportunities for establishing informal contacts among technical experts in public health and other sectors; these new links will continue to support functional collaborations.

Promoting health in the policies of other sectors has become an important task of the Ministry of Health. Many of their policy documents outline the responsibilities and actions of different ministries and institutions, and focus on the principle of health in all policies (HiAP). Other ministries, however, do not recognize this commitment enough to regularly and proactively involve it in their policies, programmes and projects. Substantial improvement in intersectoral cooperation is still needed.

The Ministry of Health plays a leading role at the governmental level and draws on the proficiency of the National Centre of Public Health for collaboration with other professional institutions at the national and/or local levels. This is particularly important in health promotion and disease prevention, where intersectoral cooperation is central to addressing inequalities and the social determinants of health.

The informant added that WHO could support the growth of collaboration among leaders in public health and other sectors, and that the international work of WHO and the European Commission provides a very strong basis for further promoting public health in the Republic of Moldova.

Contribution to policy-making

The informant felt positive about the quality of the self-assessment findings and the extent to which they generated a better understanding of existing problems and increased awareness of emerging ones. The results enabled stakeholders to clearly identify the system's strengths and weaknesses, to establish both general and specific priorities, and to set clear responsibilities and implementation deadlines for all the stakeholders involved in activities related to public health.

This process contributed to the development of the national public health strategy (2013–2020) and its associated action plan. The strategy draws attention to health promotion, disease prevention, health protection and HiAP, and sets the goal of ensuring fair access to integrated health services by taking into account crosscutting issues such as human rights, reproductive rights, gender equality and humanitarian assistance. It also aims to support the implementation of other programmes and strategies, including the Moldovan government's activity programme European Integration: Freedom, Democracy, Welfare 2009–2013 *(16)*, Moldova 2020 *(17)*, the Healthcare System Development Strategy for 2008–2017 (*18)* and the National Health Policy *(19).* Finally, it is directed to carry out the International Conference on Population and Development Programme of Action *(20)* (post-2014) and the 2030 Agenda for Sustainable Development *(21)* (post 2015).

User experience

The self-assessment in the Republic of Moldova was very well organized, and strengthened by professional participation and institutional support, a strong sense of ownership over the evaluation, excellent partnership with the Regional Office and the WHO Country Office, widespread acceptance and regard for the tool itself, and confidence that the results of the evaluation would contribute to real reforms. WHO is highly respected in the Republic of Moldova, and its responsiveness and technical assistance both during and after the self-assessment have been very positively perceived.

The informant was quite happy with the self-assessment, and felt that it struck a good balance between ease of use and utility. The process functioned as a learning experience that will enrich future analyses and a collaborative method for generating actionable information. Stakeholders and officials will use findings to support the continued development of public health legislation, regulations, and policy frameworks; to fill gaps in human resources for health in terms of numbers, distribution, training, motivation and incentives; to create instruments for improving health promotion and disease prevention in the surveillance system; and to improve services in all areas of public health, delivered at both the population and individual levels.

Future use of the self-assessment tool

The informant was very confident that the tool would continue to be used for monitoring progress and developments in the Republic of Moldova, but pointed out that political leadership for carrying out comprehensive public health reforms is of the utmost importance.

In future iterations of the process, close collaboration with colleagues from a variety of sectors (for example, finance, social affairs, agriculture, transport and housing), as well as with a range of other stakeholders (from, for example, civil society organizations, academic institutions, industry and the media) will be important. These efforts will generate a more robust assessment of strengths, weaknesses and opportunities; a shared vision for the future of public health; and shared ownership and responsibility for the implementation of strategic plans.

Conclusions

The Moldovan self-assessment was a very positive experience for participants at a personal/professional level and at an institutional level. Numerous factors contributed to its success: integration into a specific reform process; institutional support among high-level officials; openness to change and modernization of public health services; and technical assistance provided by the Regional Office and the WHO Country Office. Importantly, results from the self-assessment contributed to the development of the national public health strategy (2013–2020) and its associated action plan, which function together as the implementation arm of the National Health Policy *(19).*

The process itself was also a good learning experience that promoted an understanding of modern public health services that will support the ongoing reform of the Moldovan public health care system. It provided an important first opportunity for many stakeholders to learn about each other's public health-related activities, and thus strengthened the case for shifting both the organizational structure and the culture of the health care system towards interinstitutional collaboration and peer learning.

The self-assessment also showed that there is still important work to be done to improve the structure of the public health system in the Republic of Moldova. The work of all public health institutions needs to reflect a more explicit focus on health promotion and the prevention of NCDs, and the link between the health system and primary health care needs to be addressed more actively. Going forward, the self-assessment tool can provide a critical means of monitoring progress and identifying future priorities.

Case study: Slovakia (2012–2013)

Key points and lessons learned

- The technical quality of Slovakia's self-assessment was high; however, at the time of writing there was insufficient political momentum to implement comprehensive public health reforms.
- The self-assessment process could have been improved through more transparent designation of responsibilities, clearer objectives from the start and increased dissemination of findings.
- Nongovernmental stakeholders could provide additional internal support for the self-assessment process, and external support from WHO and the EU could leverage available tools and incentives to foster accountability and reform.

Methodological notes for the country case study

The Slovakian case study is based on interviews with four informants: Dr Gabriel Gulis, a WHO external consultant from Slovakia who took part in the assessment; Mr Martin Smatana of the Institute of Health Policies; Mr Peter Letanovsky, Adviser of the State Secretary at the Ministry of Health; and an interviewee from the Public Health Authority who did not consent to be named in this report. Of the four interviewees, only two (Dr Gulis and the Public Health Authority informant) were involved in the self-assessment from start to finish. Mr Smatana joined the process towards the end, and Mr Letanovsky began working at the Ministry of Health only after the finalization of the report. The greatest contribution of these last informants is in explaining the use of the finished self-assessment report, rather than describing the methodological specificities of the process itself.

In addition to the written and oral interviews, the authors consulted several unpublished documents related to the Slovak case: the self-assessment report, the *Implementation strategy for promoting public health and the proposal for its implementation* and the agenda for a 2014 policy dialogue on the strategic framework for health.

Background

Context of the EPHO self-assessment

Slovakia carried out its 2012–2013 self-assessment as part of the Biennial Collaborative Agreement (BCA) between the Regional Office and the Slovak Ministry of Health. This coincided with the formal launch of the EAP-PHS *(3)*, in which Member States were called to perform a baseline assessment of their public health activities, identify priorities for future developments and invest adequate resources in implementing reforms. In the same document, the Regional Office committed to providing guidance at the regional level through further development of the self-assessment tool, publication of case studies, facilitation of training workshops and provision of technical assistance. In Slovakia's case, Dr Darina Sedláková, Head of the WHO Country Office, acted as the formal liaison officer responsible for advising the Ministry of Health and technically supporting the team during the self-assessment process.

Slovakia's impetus for undertaking the self-assessment was not rooted in a clearly articulated, proactive reform process. Rather, the launch of the process was somewhat reactive: the Ministry of Health took advantage of the opportunity presented by the BCA and EAP-PHS to pilot the self-assessment tool and, in the process, to serve other purposes in support of the health care system. First, the assessment was seen as a way to help the Ministry of Health respond to pressure from other government sectors, such as the Ministry of Finance, to justify resource allocation to public

health services. The objective nature of the self-assessment results, predicated on guidance from an international body, was useful during prioritization processes at the central level. Second, the concise list of 10 operations helped to define public health for policy-makers outside the health system, who may have only had a rudimentary understanding of public health. Finally, the self-assessment opened the door to modern concepts and practices in a country whose public health services were (and largely still are) based on the SANEPID model, which revolves mainly around inspection and licensing processes.

Organization of the self-assessment process

The Slovak Ministry of Health had formal responsibility for coordinating the self-assessment process. Dr Viliam Čislák, State Secretary of the Ministry of Health at the time, took the lead in delegating responsibilities to a national working group. Dr Čislák appointed two professionals per EPHO, mostly from the Public Health Authority (under the remit of the Ministry of Health) and other technical agencies in public health, and encouraged them to consult other professionals as needed to complete each section. At a functional level, President of the Slovak Public Health Association (SAVEZ) Dr Zuzana Katreniaková led the process.

Institutional basis and stakeholder participation

Institutional basis

Informants judged the role of high-level government officials outside the health system in the self-assessment as “very poor” to “fair”. Assessments of “very poor” stemmed from the perception that the national government lacked real interest in improving the health system. This lack of interest and engagement has improved slightly since 2012, particularly with the development of a strategy framework for health for 2014–2030; however, informants still sense little commitment to increasing investments in public health services. Assessments of “fair” stemmed from observations that several high-level officials from other ministries took an interest in the process and attended the final consensus meeting in which the participants presented the self-assessment results. This opened tentative opportunities for informal networking on common initiatives.

The Ministry of Health supported the project on a general level, ensuring that the national working group had the necessary time and institutional coverage to complete the process. On the other hand, high-level Ministry of Health officials were not particularly active in meetings and generally confined their involvement to input on written reports. In part, this was due to the fact that the Ministry of Health did not have a dedicated department of public health; the state secretary was directly responsible for this remit, but carried a heavy additional work burden and could not devote adequate time to the project.

The main protagonists of the self-assessment process were professionals working in public health institutes and departments within the Public Health Authority, as well as technical experts in the area of public health. Academic institutions also had a good level of involvement; their representatives led several of the EPHO working groups and welcomed opportunities to contribute their perspectives to the process.

Apart from SAVEZ, scientific societies did not participate in the self-assessment. Technical experts from areas outside the health system (for example, housing or labour) were also absent. This was primarily due to Slovakia’s institutional setup of ministries and their institutions. Stakeholders from NGOs and other nongovernmental institutes were not invited to participate.

Stakeholder participation

One informant felt that the Public Health Authority was too dominant in the self-assessment process, promoting a traditional SANEPID service model and resisting change, particularly in regards

to EPHOs 6 (health promotion) and 8 (organizational structures and financing). The informant felt that more diverse representation among participants, particularly from NGOs, would have served to introduce a more objective perspective into the process. Another informant perceived this conflict at an institutional level, but felt that within the national working group this friction largely dissipated. Indeed, he believed that good collaboration was fostered at the level of the working group, although admittedly this was not enough to overcome all institutional fragmentation post-assessment.

In summary, participation in the self-assessment was concentrated among public health professionals and academics, reflecting the existing public health infrastructure set forth in Slovakia's public health act *(22).*

Contribution to a whole-of-government, whole-of-society approach to health

Informants viewed the assessment's contribution to promoting a whole-of-government, whole-of-society approach to health as incomplete. All perceived positive efforts and initiatives from Slovak professionals, but these were not sufficiently supported by organizational structures; the human resource capacity that would have helped to bring about lasting change was also lacking.

For example, one informant saw positive engagement from representatives of different sectors at assessment meetings, including the final consensus conference. This provided good opportunities to make informal contacts and network on cross-sectoral projects, but the absence of joint financing and other multisectoral governance schemes – as well as the low priority given to health on the national development agenda – limited any positive developments that may have followed. Another cited national legislation on the requirements of health impact assessment as a key tool to promote intersectoral working; however, he also admitted that insufficient capacity to implement these requirements across government has impeded real progress. A third informant was very positive about the potential of using the findings of the self-assessment to design future reforms that would involve actors across government, but this possibility seemed to be undermined by the political and functional independence of the Public Health Authority. This is in contrast to its formal dependence on the Ministry of Health.

When asked about what assistance the Regional Office could offer Slovakia to advance intersectoral work between public health leaders and other governmental sectors, informants first clarified that the WHO Country Office is very responsive to the needs articulated by the Ministry of Health. They noted that it also facilitates Slovak authorities' knowledge of new public health policies, strategies and best practices from WHO. They perceived the role that the Head of the WHO Country Office plays in providing technical assistance as very important – more so, in fact, than that of consultants based in the Regional Office or elsewhere. This is due to the fact that outside consultants are prone to change, disrupting the continuity of processes and destabilizing both momentum and trust.

Contribution to policy-making

Informants unanimously agreed that the findings of the self-assessment were relevant, reliable and of high quality. They noted that recurring weaknesses identified during the overall analysis of the EPHOs emerged as top priorities. Even those informants who professed very good prior understanding of health system strengths and weaknesses welcomed the concise and organized self-assessment report, emphasizing that it helped both the health sector and other sectors see the system as a whole. They considered the brevity of the report (at just eight pages) to be a major asset. It has now become an accessible advocacy tool for use in budgetary discussions and priority-setting processes at central and intersectoral levels.

One informant who took part in the assessment but is not currently working at the Ministry of Health was unsure of the extent to which the report had been accepted within the Ministry. This uncertainty is due in part to the absence of any official publication describing the self-assessment and its results. Making the report public, he felt, would have increased pressure on high-level policy-makers to act on its recommendations.

Informants within the Ministry were more confident about the degree to which the report is used internally. One stated that the findings were used as a basis for several initiatives aiming to improve public health services. For instance, public health is one of five major priorities for the health sector in the strategic framework for health for 2014–2030. This framework, which is based on Health 2020 *(2)*, was developed out of three strategies (for integrated health care delivery, health promotion and long-term care) with support from the WHO Country Office. It guides the drafting of national health strategies (including the planned new public health strategy) and action plans for improving health in Slovakia. The Ministry of Health also used the summary report from the self-assessment to develop plans for a pilot project to improve public health services that would have been financed with EU structural funds. However, due to the diverse interests of involved stakeholders and the upcoming general elections, none of these had been officially adopted at the time of writing.

One Ministry of Health informant speculated that the Public Health Authority may have perceived the self-assessment as an encroachment on their remit, and that this could have undermined their support for the project. Officials have since put forward another implementation plan – this time on health promotion – but once again the resources necessary for its launch have not materialized. One tangible result of the self-assessment was the creation of a department of public health within the Ministry of Health shortly after it ended. However, this department requires further staffing and financing to be a true governing unit for public health in the country.

Thus the strengths of the self-assessment process and report have yet to crystallize into real reform, although informants were hopeful that this might happen in the midterm. One felt that three years was too short a timeframe for building the momentum and partnerships necessary to launch a system-wide effort, particularly when the traditions of SANEPID still have considerable power and influence and there is no decisive push from the national government to make public health a national priority. Another informant thought that these conditions would remain relatively intractable unless considerable incentives and/or ramifications came into play at a higher level.

User experience

According to informants, the self-assessment process got off to a relatively difficult start. Challenges in the process had to do with coordination (related to ensuring a transparent, participatory, multistakeholder process) and technical aspects (related to understanding the technical contents of the tool and interpreting them within a national context).

First, Ministry of Health officials were not entirely aware of the institutional coverage or resource commitment that would be required for a successful self-evaluation, and therefore did not effectively communicate the methodology or objectives to the national working group. Informants who participated in the process stated that the rationale behind the designation of responsibilities was not always clear, and this led to initial confusion and concern. As a result, the assessment took nearly two years to complete. One informant considered the self-assessment process “quite burdensome and time-consuming” relative to the value of the findings, though largely attributed this disproportionate burden to the initial lack of coordination rather than the tool itself.

Second, the version of the tool Slovakia used contained weaknesses that have since been corrected, including a non-user-friendly web-based format and prompts for time-consuming SWOT analyses

for each sub-item. Informants were generally supportive of the potential for a web-based tool, but specified that future iterations must incorporate good functionalities for collaborating with other group members. Interestingly, one informant thought that making the assessment easier was not necessarily desirable, as the paper-based format invited more deliberation and generated a greater personal investment in the assessment process. Likewise, the informant viewed the detailed nature of the questionnaire as positive and necessary, as it obligated informants to consider a range of specific points before settling on a score for each item.

Finally, the translation of unfamiliar terms was frequently a barrier for participants. Given the limited dissemination of public health research and guidance in the Slovak language, the most innovative concepts in the field are largely inaccessible to Slovak professionals. Unsurprisingly, more traditional practices related to hygiene and inspections remain dominant in the country. The self-assessment tool thus served as an introduction to some contemporary public health concepts, but the professionals carrying out the assessment did not always immediately grasp them. A glossary of key terms may have helped to facilitate understanding.

Future use of the self-assessment tool

Informants were unsure of the likelihood of Slovakia performing another self-assessment in the near future. Several important obstacles would first need to be overcome, most importantly the lack of political leadership to carry out a comprehensive reform of public health capacities and services. Informants shared a certain frustration in this regard and speculated on how the Regional Office, the EU or other international bodies might leverage enough political or financial influence to catalyse change in the country. In addition, several cited resistance to change at the top tier of the Public Health Authority as a factor that reduced the potential for reform.

Informants also agreed that despite certain intransigency at an institutional level, there is considerable openness to change and reform at a personal level among public health professionals, especially to widening policy attention to address priorities beyond curative health care services, hospitals and control of infectious diseases. One informant listed several priorities that will become increasingly important in the coming years: migrant health, health promotion, environmental epidemiology, mental health, health impact assessments, vaccination coverage, and health system administration and financing. Continued assistance from WHO in these areas could contribute to building momentum for more systematic changes.

Conclusions

All in all, the Slovakian self-assessment was only partially successful. On the one hand, it brought different stakeholders to the table, forged a consensus among working group members on the main priorities for the future and provided actionable information that could be useful for policy-makers. Within the relatively small core group of professionals working on the self-assessment, participants felt qualitative improvements in their working relationships, including increased trust, better communication and a new sense of commitment to a common objective. The self-assessment was also a good learning experience, promoting a shared understanding of what modern public health services should look like and what they should provide to the population.

On the other hand, the assessment was not well integrated into national institutions or the policy cycle; three years after its completion, the application of many of its findings is still pending. Even though individual participants from different institutions made inroads towards improved collaboration, the lack of direct participation from institutional leaders undermined the potential to translate those improvements to better institutional linkages post-assessment. Likewise, the Regional Office's ultimate goal of promoting evidence-based public health reforms in line with the EAP-PHS could not be realized if public health reforms never figured among the explicit national

objectives of the self-assessment. Indeed, a critical mass of support for reform in Slovakia has not yet coalesced.

Informants highlighted several measures that may contribute to future progress:

- publication and dissemination of the self-assessment report to national media, NGOs and scientific bodies in order to foster accountability and promote societal awareness of the need for public health services;
- binding incentives from international bodies to foster reform, including from the EU;
- grant support for pilot projects on public health programmes;
- published guidance on public health from the Social Protection Committee of the EU;
- incorporation of cost–benefit and cost–effectiveness analyses on public health resources into the self-assessment tool; and
- continued, stable support from the WHO Country Office on specific priority issues.

Case study: the former Yugoslav Republic of Macedonia (2007, 2014)

Key points and lessons learned

- A very positive self-assessment experience in the former Yugoslav Republic of Macedonia has set the stage for future public health reform.
- Keys to success included integration of the self-assessment within an explicit reform process, excellent cooperation with the various governmental sectors in charge of other public health policies, strong engagement among Macedonian professionals and WHO partners, and a positive commitment to improving public health.
- Further support from the Regional Office is both needed and wanted in order to fully achieve meaningful reform.

Methodological notes for the country case study

The Macedonian case study is based on the reports for both the 2007 and 2014 assessments *(23)* and on interviews with three key informants: Professor Dragan Gjorgjev of the National Institute of Public Health; Dr Neda Milevska-Kostova of the Centre for Regional Policy Research and Cooperation (Studiorum); and Dr Jovanka Kostovska, Head of the Department for Preventive Health Care at the Ministry of Health. Professor Gjorgjev was involved in both assessments and thus had the opportunity to compare and contrast the two experiences. Dr Milevska-Kostova and Dr Kostovska participated in a joint interview, with Dr Milevska-Kostova acting as interpreter.

Background

Context of the EPHO self-assessment

Since 2007, the former Yugoslav Republic of Macedonia has been one of the Regional Office's most active partners in using and advancing the self-assessment tool in the Region, both under the administration of the previous WHO Regional Director for Europe and within the framework of the EAP-PHS *(3).* Indeed, the former Yugoslav Republic of Macedonia spearheaded SEEHN's explicit request for the first version of the tool in 2007–2008, which aimed to evaluate public health services and capacities among its Member States (as well as Estonia and Slovenia). The resulting report, *Evaluation of public health services in south-eastern Europe,* set the foundation for various public health reforms that aimed to modernize services and increase capacity *(24).* Officials created a regional health development centre in Skopje with the explicit mission of strengthening public health services in south-eastern European countries *(25)*; this centre has taken a leading role in advancing public health since its establishment.

Thanks to this work, the country's public health institutions and networks are relatively robust and its ties with the Regional Office (through the WHO Country Office) are close and long-standing. Thus, it was natural that the former Yugoslav Republic of Macedonia was the first Member State to volunteer to pilot the revised self-assessment tool in 2014. Their request for technical assistance was rooted in an explicit initiative to develop a multisectoral, evidence-based framework policy for health in line with Health 2020 and the EAP-PHS *(2,3).* The framework policy Health 2020: Together for Health for All will include specific action plans supported by five strategic pillars (for example, public health and a life-course approach to health).

Organization of the self-assessment process

The self-assessment began with a three-day workshop in Ohrid in August 2014, organized by the Ministry of Health in cooperation with the WHO Country Office and with the technical support of

the Regional Office. Following the introduction and training session on the self-assessment tool and its objectives, the participants were divided into four multidisciplinary working groups of 7–15 people, according to the methodology proposed by WHO technical consultants. Each group was responsible for (i) comprehensively completing one EPHO (of EPHOs 2–5), (ii) coordinating the completion of one or two additional crosscutting EPHOs and (iii) participating on specific portions of the rest.

Although the working groups made considerable progress during the opening workshop, they did not have access to all of the data necessary to fully complete the questionnaire. They continued working throughout the month of September, contacting additional stakeholders for input and meeting three to five times at a group level before finalizing the questionnaire. At the end of September, the coordinators met to unify their approaches and agree on the strategy for drafting the report. It took another three months to produce the final draft. In total, over 50 people representing approximately two-dozen institutions took part in the process.

Institutional basis and stakeholder participation

Institutional basis

Informants were generally positive with regard to the support received from the highest institutional level, but they included a caveat: while important institutions – including the Prime Minister's office – were represented at the workshop in Ohrid and supported the work there, they were not directly involved in the rest of the self-assessment process. This raised concerns that policy-makers' personal commitment to public health reforms may not be strong enough to sustain the investment of time and resources needed to follow through on implementation. However, at the assessment stage, there was sufficient high-level support to ensure legitimacy and broad participation from stakeholders throughout different areas of government.

The Ministry of Health and the National Institute of Public Health were very well represented among the group of participants, and a large proportion of technical experts in the country played a role in completing the questionnaire. Managers of public health agencies and departments played a smaller role during the assessment itself; however, they also attended and participated in the policy dialogues that were held afterwards to discuss the findings and the next steps. Technical experts from organizations outside the health system – for example the Ministry of Environment and Physical Planning, the Crisis Management Centre and the Protection and Rescue Directorate – also contributed strongly to the multidisciplinary working groups.

Informants rated representation from academic institutions and universities as "fair". This was somewhat conflated with participation from other groups, as many participants held different positions both inside and outside educational settings (university professors, technical consultants). However, there were several participants (for example, those from the School of Public Health) whose institutional affiliations were exclusively academic.

Finally, although participation from government sectors was generally broader and more intense than that of outside organizations, certain NGOs were involved in the self-assessment process. Studiorum, a nongovernmental think tank dedicated to health and social policy, played an important role in developing methodology, coordinating technical work and drafting the report. Several others, including the Red Cross and the Organization of Consumers of the former Yugoslav Republic of Macedonia, also took part.

Stakeholder participation

Informants described stakeholder interactions both during the workshop and in the follow-up and data-collection phases that followed as collaborative and open. Where a fair level of institutional

cooperation was already in place, the outcomes of the assessment process were more tangible – for example, the self-assessment process led to a new joint strategy for environment and health between the Ministry of Environment and Physical Planning and the Ministry of Health. In other cases, the process provided the first opportunity for different stakeholders to meet and to learn about one another's public health-related activities. In directly facilitating the creation of personal relationships between professionals working in different institutions, the self-assessment process was highly valuable.

The Ministry of Health acted as a mediator for the working groups, helping to put them in touch with different stakeholders at the national and local level. These personal introductions among technical experts working under different ministries and agencies notably reduced perceptions of institutional fragmentation, established new lines of communication among diverse sectors and opened up possibilities for cross-sectoral collaboration. While future work is needed to consolidate these gains, the assessment process both improved existing stakeholder relations and created new personal connections where few had previously existed.

Contribution to a whole-of-government, whole-of-society approach to health

The self-assessment process contributed to better intersectoral collaboration for public health and generated considerable momentum for meaningful improvements in system performance. The evaluation had three immediate benefits:

- it strengthened and expanded the personal and professional networks among technical experts in public health and other sectors;
- it mapped current institutional competencies and responsibilities after a series of dynamic institutional changes in the country; and
- it increased awareness of the need for continuous collaboration among those providing public health services and resulted in the creation of new institutional mechanisms for this collaboration.

With regard to personal and professional networks, and in line with the preceding section, the self-assessment brought many people together for the first time to engage in a collaborative learning experience. In this regard, the 2014 version of the tool was much more effective than the pilot version in 2007, which was more limited in scope and in participation. These new ties were largely made on a technical level, among a professional class of civil servants that remains relatively stable even when the government changes hands.

One informant noted that well after the conclusion of the process, the Ministry of Health received a call from a technician at the Ministry of Agriculture to let them know that one of the shortcomings revealed by the self-assessment – the lack of a law on phytosanitary control – had been rectified. In the day-to-day work of the public health community, these new links may have a decisive role in articulating functional collaborations.

The self-assessment tool also helped to map different responsibilities and institutional remits in a highly dynamic context. As a candidate state for membership in the EU, the former Yugoslav Republic of Macedonia has recently implemented a large number of organizational changes with the objective of conforming to EU legislation. These abrupt, numerous and simultaneous transitions related to institutional functions have led to some challenges in government administration, particularly with regard to understanding the new division of roles and responsibilities. In this context, the self-assessment and resulting report helped to organize knowledge on the current situation; delineate the responsibilities of dozens of agencies, departments and units responsible for providing public health services; and facilitate the delegation of specific public health-related issues to the appropriate agency.

The Ministry of Health has followed up on the self-assessment process by requesting that all ministries and agencies contributing to future iterations nominate a focal point responsible for coordinating collaborative work in areas related to public health. In a country where HiAP has not been fully realized, this move represents a valuable step on the road towards greater intersectoral and interinstitutional organization in public health services and systems.

Although this measure has true potential to increase communication and understanding of public health concepts at a multisectoral level, one informant highlighted that consequential changes at a policy level would only come with a sustained commitment to that goal. In the case of the focal points, this requires that they have the authority and mandate to make decisions and to act with the support of their respective ministries or government agencies.

At the same time, greater integration of the EPHOs on the local level and even greater participation from groups within the country is needed. Informants anticipated that low motivation among civil servants working in the public administration could form a potential obstacle to a government-wide effort to improve public health. This implies that, if a whole-of-government approach is to become a functional reality, good management must complement good leadership. Thus, while the assessment has created momentum around intersectoral collaboration, there is no room for complacency going forward.

Contribution to policy-making

Informants were generally positive with regard to the quality of the findings and the extent to which they generated better understanding of existing problems and increased awareness of emerging ones. Indeed, the preliminary work in Ohrid brought different systemic weaknesses to light even for technical experts who had initially been confident of the strength of Macedonian public health services. This built the case for critically analysing the performance of different services using an objective questionnaire based on international guidelines.

Data collection, and particularly self-scoring, was prone to a degree of observer bias; gaps in available data also complicated the completion of all items in the questionnaire. However, the detailed criteria used for scoring may have helped to offset the risk of bias, and the post-retreat assessment work notably improved the quality of the responses. All in all, the working groups identified a number of weaknesses in different areas of the health system. While some, such as the availability of protocols or standard operating procedures for different services, were related to specific areas, others, such as the lack of a systematic strategy for developing human resources for public health, emerged as key priorities for system-level performance.

The resulting summary report contained approximately 40 pages of findings, organized around the 10 EPHOs and their suboperations. Since its finalization in late 2014, the report has not been adapted for publication for the general public; however, it is publicly available on the electronic platform for the development of the Macedonian Health 2020 *(23).* Internally, it has been used as a basis to formulate the action plan on public health, to inform a strategic framework for environment and health (under consideration by policy-makers at the time of writing), to generate evidence-based consensus among diverse stakeholders on the need to develop a plan to control NCDs in 2016, and to identify areas for improvement in human resources for health. Macedonian officials will undertake a comprehensive evaluation of human resources for health as a basis for a strategic plan in 2016.

Finally, if political will is in place, the report could also be used as a solid basis for a new public health act that would modernize the organization of activities and help to secure financing for public health. Specific, cross-cutting needs – for example, in human resources for health,

information systems and research – became clear in the report; if properly addressed, these have the potential to lead to system-wide improvements through policy-making and implementation.

User experience

The former Yugoslav Republic of Macedonia's assessment went quite smoothly for several reasons: good organization, professional participation and institutional support, a strong perception of ownership over the evaluation, excellent partnership with the Regional Office, and widespread acceptance and regard for the tool itself.

The decision to hold the initial workshop several hours outside the capital city of Skopje was part of the coordinators' deliberate effort to fully engage participants in the self-assessment process and reduce the chances that they would be pulled away by competing commitments. Although working groups were not able to complete the entire questionnaire at the retreat, they did have the chance to fully review the operations and methodology together with consultants from the WHO Country Office and the Regional Office. The decision to structure the assessment through four working groups, with representation from diverse stakeholders, maximized the potential for building consensus and working in a multidisciplinary way. Moreover, international participants in the Ohrid retreat spoke of Macedonian professionals' excellent and enthusiastic attitude, which reflected a strong sense of ownership as well as the confidence that the results of the evaluation would contribute to real reform.

Informants also highlighted the partnership between the Ministry of Health and the WHO Country Office as a key to success. WHO is a highly respected institution in the former Yugoslav Republic of Macedonia, and participants perceived its responsiveness and technical assistance both during and after the assessment very positively.

Finally, informants were quite happy with the questionnaire, despite – or perhaps because of – its complexity and length. The detailed nature of the questions brought to light important problems that they had not previously considered, effectively striking a balance between ease of use and utility of the findings. Informants pointed out that several questions were unclear to participants either because of their unfamiliarity with a particular concept or because its lack of application to the Macedonian context. In these cases, representatives from the Regional Office facilitated understanding.

One informant underlined the complexity of achieving true intersectoral collaboration with a broad spectrum of participants, but emphasized that the real challenge is to take advantage of the momentum created by the self-assessment and present findings to policy-makers in a way that will lead to true reform.

Future use of the self-assessment tool

Approximately one year after the completion of the report, the Ministry of Health has already taken important steps to facilitate the future use of the self-assessment tool at a systemic level. First, with support from the WHO Country Office, it commissioned the translation and adaptation of the questionnaire to the national context, ensuring its accessibility to a wider body of professionals. Second, in partnership with the Regional Office and the Ministry's information-technology team, it developed a pilot version of a web-based tool that is already available through its own electronic platform. Over the next few months, key technical experts will validate this version before presenting and testing it among a wider group of stakeholders. They can then use it to periodically reassess public health services and capacities in order to draw lessons from policy implementation and inform policy-making processes. While the tool has been adapted to the national context, its

structure and content were not altered; this ensures that its results can be fed into regional databases.

Informants at the Ministry of Health were very confident that the tool would continue to be used every one or two years in order to monitor specific suboperations that were weak in the first assessment. While informants were very positive about the comprehensive self-assessment, repeating it at short intervals was seen as unnecessary. The high functionality of the tool will allow it to be tailored to specific areas in the short term, and applied in full at lengthier intervals.

Conclusions

The self-assessment in the former Yugoslav Republic of Macedonia was a very positive experience for participants, both at a personal/professional level and an institutional level. Numerous factors contributed to its success:

- the integration of the self-assessment into a specific reform process;
- the institutional support for the self-assessment among high-level officials;
- public health professionals' openness to change and to modernizing public health services;
- the respect and recognition for public health that exists throughout the health sector;
- the small size of the country, which made coordination more manageable; and
- the technical assistance provided WHO, without which the assessment would not have been possible.

Although the above considerations are all valuable, the most decisive factor in driving future reforms will likely be steady commitment to carrying the work forward. The strong evidence base provided by the report, backed by consensus from over two-dozen institutions, will provide an excellent starting point for public health action. Future action – and support from WHO – will revolve around developing and implementing a strong action plan for public health, creating institutional mechanisms to articulate services and reinforcing the acceptance of the role of public health within a strong health system. Partnership from the Regional Office can play an important role in bringing about these reforms, while the institutional networks and public health tradition in the country will favour the potential for leveraging meaningful change.

Case study: Poland (2014–2015)

Key points and lessons learned

- Poland's self-assessment is part of a broad effort led by the Ministry of Health and the National Institute of Public Health-National Institute of Hygiene (NIPH-NIH) to modernize public health capacities and services in the country.
- Despite weaknesses in the self-assessment process, there is excellent potential to implement reforms within an evidence-based legislative framework in line with the EAP-PHS.
- The Regional Office and WHO Country Office may play an important advisory role in addressing key issues in the future, such as implementing national reforms at a local level, developing the health information system, and building political momentum for other necessary measures.

Methodological notes for the country case study

The Polish case study was based on the English-language summary report from the self-assessment, as well as three interviews with key informants involved in the process: Professor Miroslav Wysocki, Director of the NIPH-NIH, who answered in consultation with other NIPH-NIH colleagues; Mr Dariusz Poznański, Deputy Director of the Public Health Department, Ministry of Health; and Professor Wojciech Hanke of the Nofer Institute of Occupational Medicine.

Background

Context of the EPHO self-assessment

The self-assessment process in Poland came at an ideal moment for the country, coinciding with the milestone Public Health Act, passed after a whirlwind legislative process on the eve of national elections in 2015. After many years of political gridlock and inaction on developing an effective regulatory framework for public health services – despite widespread recognition of its necessity – the outgoing government made public health reform a legislative priority.

Structured along the 10 EPHOs that constitute the essence of the EAP-PHS *(3)* and the basis of the self-assessment tool, the law regulates – and finances – the necessary structures for modern public health services for the first time. Developed in conjunction with academic and civil partners, including the NIPH-NIH, the law essentially mandates a comprehensive, evidence-based overhaul of public health capacities and services. Among the new structures that must be put into place are intersectoral coordinating mechanisms, such as an interministerial board with representation from diverse public sectors and a scientific advisory committee with involvement of both academic institutes and NGOs.

In this context, the self-assessment represented a valuable opportunity to carry out a baseline assessment upon which to articulate the implementation of the law. It took place in parallel to the passage of the Public Health Act and the (still ongoing) development of the new National Health Programme, the strategic executive document that operationalizes the legislation. Significantly, the same professionals responsible for the policy-making process carried out the self-assessment. Thus, even before the draft report was finalized, the self-assessment process actively contributed to the ongoing deliberations at the Ministry of Health and at the NIPH-NIH.

Organization of the self-assessment process

The Ministry of Health handed over leadership to the NIPH-NIH, which took the primary responsibility for coordinating work to complete the self-assessment tool. The institute also engaged other stakeholders, both within and outside of the health sector, forming different working groups based on their areas of expertise and assigning responsibilities for one or more EPHOs. While there was no formally constituted oversight committee, the Ministry of Health and the WHO Country Office organized a series of workshops, inviting both the professionals involved in the assessment as well as outside experts to participate in the evaluation of the report and the formulation of recommendations. All in all, the process involved about 50 professionals and took approximately a year and a half, beginning in mid-2014 and finishing at the end of 2015.

The decision to essentially outsource the coordination of the self-assessment process to actors outside the government had some interesting advantages for the Ministry of Health. It eased the pressure to commit human resources and time to the initiative and also reduced the potential for bias in the production of the report. At the same time, the assessment could feed into streams of other projects being carried out by the NIPH-NIH and supported by the Ministry of Health, including a Norwegian-funded project on reducing social inequalities in health. As the NIPH-NIH has been a close partner of the Ministry of Health in designing the ongoing reforms, the advantages that their involvement conferred were fortunately not counterbalanced with any loss of knowledge capital at the policy-making level. Of course, one of the main advantages for the Ministry of Health – the alleviation of the pressure for resources – was not due to an actual reduction of the burden, but simply to its transfer elsewhere.

Institutional basis and stakeholder participation

Institutional basis

Overall, there was uneven involvement at different levels of the system, with regard to both the assessment process itself and in the reform process driving that work. The informants pointed to the leadership of the Minister of Health as decisive in carrying forward the Public Health Act. However, with only a few exceptions, most of the stakeholders involved in the assessment were from the health sector – for example from the Nofer Institute of Occupational Medicine, the National Food and Nutrition Institute and several medical universities. This was also true of the evaluation (oversight) committee.

The organizations from other sectors carrying part of the burden included the Motor Transport Institute and the Central Institute for Labour Protection, while other non-health experts from areas such as emergency preparedness and response were consulted by the working groups during the completion of the questionnaire. Two of the informants rated the involvement of NGOs as “fair” or “good”; however, this is not reflected in the report, suggesting that this participation was mostly symbolic.

Stakeholder participation

All of the informants felt that the assessment process was generally positive in terms of how it affected stakeholder relationships, although there were evident limits on what it could accomplish. The links that improved the most were probably between the government and academic partners; one informant mentioned that different members of the scientific community expressed pleasant surprise upon learning of different ongoing government programmes and policies. While the ties between the NIPH-NIH and the Ministry of Health were already quite strong at a formal level and at the highest levels of leadership, these links were not necessarily as fluid at highly specialized technical levels. In that sense, the assessment helped to bring some government and academic experts together and to moderately improve their relationships.

The assessment brought together other stakeholders as well, although for every positive example of collaboration they mentioned, informants also described a moment of discord or a disagreement on how to move forward. Some of this may have been due to the structural status quo in the country. For example, emergency preparedness and management is not considered to lie within the remit of public health in Poland, and while the public health community seemed open to exploring the implications of a different perspective on that front, professionals working in the crisis management system may not have been as eager to embrace a more collaborative leadership approach.

There were also signs of a lack of ownership towards the self-assessment process, with some professionals declining to complete their assigned questions due to their (at times unfounded) confidence in the excellence of Polish services; one informant mentioned patient safety as a particularly important example of this kind of incident. Despite the inability to achieve a consensus on all points, however, informants viewed positively the opportunity to open new dialogues and were optimistic that they could build on those improvements in the future.

Contribution to a whole-of-government, whole-of-society approach to health

The self-assessment has been only one facet of a complex push to improve intersectoral collaboration and renew public health in Poland. Given its concurrence with a major effort to reform public health at a national policy-making level, it is fairer to describe the progress currently being made at a broader level than to ascribe those achievements solely to one process. Indeed, the social and political momentum needed to pass a comprehensive reform act had already accumulated at many levels: nationally, there was widespread and nonpartisan recognition of the need to modernize public health services. Politically, there was a strong desire to pass meaningful social legislation, both as a means to shore up support for the impending elections and to leave a legacy mark in the case of a change of government. In turn, the technical assistance and support from the NIPH-NIH and the WHO Country Office, together with the positive, external political pressure embodied by the EAP-PHS, afforded the additional legitimacy and evidence base to design the umbrella legislation that would frame both the self-assessment and the National Health Programme.

In terms of specific opportunities, a dedicated budget to implementing new programmes is highly significant, and certainly some of the new intersectoral governance structures built into the Public Health Act and National Health Programme will provide the opportunity for better collaboration on particular issues. Some of these, such as the control of chronic NCDs, will require contributions from a range of governmental and nongovernmental actors, many of whom had not had many opportunities to collaborate at the time of writing. The legacy of the san-epid model of public health, along with the social focus on providing specialist health care services to the population, have served as obstacles to achieving linkages between public health and primary care and to pursuing a true health-in-all-policies approach. However, there is room for considerable optimism that Polish stakeholders will gradually overcome these issues.

Contribution to policy-making

All informants agreed that the assessment provided actionable information on current challenges in areas that were known to have problems as well as others that were not previously considered. Although this assessment represented a strong score (4/5), the contributions of the process may have been largely informal. During the preparation of the present case study, it was not possible to examine the Polish version of the assessment report, which informants described as more complete and detailed than the English summary. The report was described as an important resource during the development of the National Health Programme, but it would be an overstatement to say that

the self-assessment findings formed a basis for this initiative. Rather, the same people developing the public policy were simultaneously completing the assessment, through discussion within a comprehensive, evidence-based framework.

Consensus among these stakeholders was achieved on some, but not all issues. Enhancing the health information system emerged as a clear need: monitoring, surveillance, health services research and evaluation, and administrative systems to monitor human resources for health all figured as priorities in the report, as did the establishment of specific programmes and structures for the control of NCDs. Other needs, such as the development of a human resource strategy, were recognized as acute; however, informants expressed doubts about whether this issue could attract sufficient political support to bring about meaningful changes. Likewise, a number of questions were not completed at all; informants attributed this shortcoming to different causes: inability to reach a consensus, lack of available experts willing or able to answer questions, absence of accessible data and the shortage of the time or resources to complete the items.

The development of the National Health Programme has also underscored challenges that were not covered in detail by the self-assessment, chief among them the articulation of a strategy to implement national health priorities at a local level. This issue, and other horizontal areas of action such as human resources, may be useful targets for future collaboration between WHO and the Polish Ministry of Health. Respondents were very supportive of WHO's contributions to Polish policy-making, seeing it as very helpful and necessary in bringing about positive change.

User experience

According to informants, the self-assessment tool itself presented two main challenges: the first and most significant was the intensity of time and resources needed to adequately complete the process, while the second was a moderate difficulty in understanding the assessment questions through a national lens. Participants raised other concerns directly with the WHO Country Office. It was noted that the text of the tool used in Poland – while corresponding to the latest revision from 2014 – had not been definitively finalized at the time of the assessment; this fact, together with the unavailability of the web-based tool, may have undermined the potential effectiveness of the process. Moreover, participants highlighted the lack of explicit recommendations in the user's guide on what level of involvement was expected from different stakeholder groups, and how those viewpoints might be consolidated and synthesized in a prioritization exercise.

With regard to the proportionality of the work burden, on the one hand, and the usefulness of the findings, on the other, informants were equivocal about which direction the scales tipped. All agreed that the process was cumbersome and that the tool contained unnecessary redundancies; coordinators at the NIPH-NIH, who assumed a large part of the responsibility for completing the items, would have favoured a shorter and more streamlined set of questions. Sources within the Ministry of Health were more ambivalent on this point, acknowledging the value of detailed findings even while recognizing that the assessment required a time commitment that was not always possible. Overall, resource constraints represented an important challenge in using the tool.

Another principal challenge for some respondents was that of understanding the questions in a Polish context. One informant alluded to the very different trajectories of public health traditions in eastern and western European countries to explain some of the difficulties experienced in understanding the concepts under evaluation; another mentioned (by email) that the language barrier was an issue for some participants, adding considerably to the time needed to complete the questions. Informants at the NIPH-NIH, on the other hand, found the criteria to be clear.

Future use of the self-assessment tool

Informants expressed openness to repeating the assessment at some future date, although given the complexity of the tool and the ponderous speed of the policy cycle, the appropriate interval was seen as relatively long. In any case, informants were receptive to the design of a web-based tool and hoped that their country would repeat the process or another like it at some point. Likewise, they were open, if not enthusiastic, to applications of the tool outside the policy sphere, possibly in the area of education and professional training.

Conclusions

The main strength of the self-assessment in Poland was undoubtedly its concurrence with an explicit reform process, supported by a dedicated budget and a comprehensive legislative framework. The strong commitment to this effort voiced by department heads within the Polish Ministry of Health, together with the excellent partnership exercised by the NIPH-NIH, both help to minimize some of the weaknesses of the assessment itself, which include limited engagement with civil partners and other government sectors, and incomplete or absent answers to a number of the questions. Although it is difficult to know from the English version of the report how rigorous and detailed the Polish version is, the fact that the professionals designing public policy measures were also involved in the assessment points to the potential for a meaningful influence.

The self-assessment only constitutes one part of a multipronged effort to rejuvenate public health in Poland, making it impossible to judge its value in isolation. In any case, there are reasons both to be optimistic about the future of public health in the country and also to double down on efforts to support its improvement. By strengthening partnerships, emphasizing the importance of long-term investments and building increased social capital for public health, Poland can ensure that the National Health Programme sets a strong foundation for population health in the country.

Case study: Cyprus (2015)

Key points and lessons learned

- A well-timed and rigorous self-assessment process produced a consensus-based picture of public health capacities and services in Cyprus, on the cusp of a major national health reform.
- High-level leadership, combined with a collaborative management approach to the assessment process, facilitated the application of new working methodologies and the creation of new intersectoral professional networks for public health.
- The partnership and technical assistance provided by the Regional Office were key to success, but the Regional Office's continued support – together with a more concerted effort to leverage national alliances from nongovernmental actors – will be necessary to advance a reform agenda that guarantees a sustainable and equitable approach to population health and well-being.

Methodological notes for the country case study

The Cypriot case study draws its material from the country's unpublished self-assessment report, as well as from interviews with three key informants involved in the process at varying levels: Dr Myrto Azina-Chronides, Ministry of Health, served as the operational manager of the core secretariat; Dr Pavlos Pavlou, Director of the Health Monitoring Unit at the Ministry of Health, was a team leader for EPHO 1; and Mrs Maria Epaminonda, Executive Director of Cyprus Family Planning Association, participated in a several sub-items of the assessment related to the NGO's work.

Background

Context of the EPHO self-assessment

The self-assessment in Cyprus took place in a challenging political and economic context, in the wake of a €10 billion bailout to the country's banking system in 2013 by the EU, the International Monetary Fund and the European Central Bank. In compliance with the terms of the Memorandum of Understanding, the Cypriot government committed to implementing a national health scheme by 2015 in order to provide universal health coverage to its population. Although this goal is the centrepiece of the ongoing health reform programme, implementation has been delayed by the lack of agreement on how the new national insurance programme will be articulated. As the Ministry of Health works to forge a consensus among stakeholders on that front, it also continues to be responsible for the management of the country's fractious hospital system, a remit that may constrain its capacity to pursue systemic actions elsewhere.

Despite these considerable challenges, the ongoing health system reform process has also opened a window of opportunity for meaningful changes in the health sector. In that sense, the EPHO self-assessment was a well-timed process, with the potential to deliver solid recommendations based on evidence and consensus among a broad group of stakeholders.

Given the imposing challenges in the health care sector, Cyprus would likely not have been able to take advantage of the opportunities offered by the EPHO self-assessment tool to strengthen public health services had it not been for the robust support provided by the Regional Office. This took the form of an implementation support team led by the in-country WHO consultant Maria Marcoulli. As the formal liaison with the Regional Office charged with supporting implementation of the EAP-PHS in Cyprus, she worked hand-in-hand with the other two Cypriot self-assessment coordinators at the

Ministry of Health, First Health Officer Olga Kalakouta and Myrto Azina-Chronides, to complete the process.

Organization of the self-assessment process

The Ministry of Health launched the self-assessment process during a meeting in March 2015, where a large group of stakeholders was introduced to the tool and trained in its use. While initially there were plans to establish an oversight committee consisting of Ministry of Health officials, academics, other stakeholders and independent experts, in the end organizers opted not to put this structure into place due to concerns that such a committee would make the process less agile. Thus, the ultimate responsibility for the report was concentrated between the chair and assistant chair of the core secretariat.

These organizers divided groups into specialized teams, each with its own coordinator, and then offered three options for completing the questionnaire: (i) the specialized team could take full responsibility for filling in their section of the questionnaire, (ii) the specialized team could work hand-in-hand with the coordinators to complete their responses or (iii) the coordinators could complete as much as possible in a preliminary way, and the specialized teams could then correct and elaborate on the second draft. Several specialized teams made good progress on some portions of the questionnaire during the meeting; participants left other sections to be completed later on.

In the meantime, the Minister of Health, together with the First Health Officer, secured the support of other government actors through the interministerial governance board. Building on this strong institutional coverage, the coordination team then formally invited these ministries to take part. The freely given consent of the ministries allowed the self-assessment team to engage technical experts outside the health system directly.

Over the course of the next six months, the core secretariat and specialized teams completed the questionnaire together with an extended support team and other stakeholders from within and outside of the health sector, including professionals working under other ministries, academic institutions, scientific societies, NGOs and others. Once the tool was completed, the core secretariat took responsibility for drafting the report based on the findings.

Institutional basis and stakeholder participation

Institutional basis

Coordinators were very happy with the institutional involvement and participation achieved during the self-assessment. In a country where intersectoral communication in the government is often hindered by the need to filter requests through sometimes opaque bureaucratic channels, the high-level government support for the process allowed the self-assessment team to directly contact the responsible actors throughout the system, whom they identified through an inclusive snowball sampling process.

Although stakeholders outside the health sector were generally receptive to the idea of the self-assessment, they were not always able to cover their usual workload demands and make the additional time necessary to respond to the Ministry of Health's requests, nor did they have the technical expertise in public health to understand the contents of the questionnaire without assistance. In this sense, WHO technical support increased the country's self-assessment capacity in a decisive way; the implementation support team had both the mandate and the time needed to follow up in person with administrators across government. Taken together, the solid institutional support, rigorous identification of stakeholders and availability of technical assistance contributed to achieving broad participation from different stakeholders. The level of participation varied widely, however, with some actors' contributions being limited to the initial meeting.

Stakeholder participation

The actors at the Ministry of Health who were in charge of the self-assessment were very pleased with how the process affected their relationships with other stakeholders, reporting that it "greatly strengthened" communication, trust, commitment to a common objective, communal working, satisfaction with other actors and transparency. The freedom to contact professionals from other corners of the government administration generated valuable personal relationships forged through a collaborative and mutual learning experience. Not only did other sectors learn about their role in public health, professionals in the Ministry of Health also learned about organizational structures and initiatives happening elsewhere, both under the remit of other ministries and in other areas of the health sector.

The Ministry was gratified by the response of NGOs; at least one followed up by requesting training sessions on specific points that had surfaced during the self-assessment. Ministry actors felt that the self-assessment allowed them to demonstrate their personal commitment to population well-being to academic and community partners outside the policy-making sphere, where their work is usually confined.

It should be noted that this appreciable increase in collaboration was not necessarily felt at all levels. Within specific specialized teams (and depending on the stakeholders required to complete the questionnaire), the self-assessment may have done less to foster new connections. For example, the Health Monitoring Unit, in charge of EPHO 1, noted that its day-to-day work was already dedicated to collecting data from an array of sources; in that sense the self-assessment neither improved nor worsened its relationships with other actors. An NGO agreed with this judgement, noting that the small size of the country favours access to policy-makers. In this sense, the self-assessment was consistent with an already healthy relationship between their group and the Ministry of Health but it did not fundamentally change that relationship in any way.

Contribution to a whole-of-government, whole-of-society approach to health

In consonance with the positive interaction and collaboration experienced during the self-assessment process, coordinators were very optimistic that it would lead to reform. The justification for this optimism was three-fold. First, the self-assessment introduced new ways of working together, contributing to a sense of teamwork and common purpose among different actors and particularly within the government. Given the excellent sense of collaboration and the nascent professional networks emerging from the self-assessment, it is likely that professionals in the Cypriot government will work to apply that methodology in the future rather than revert to previous bureaucratic channels.

Second, the multidisciplinary and intersectoral collaboration seen in the self-assessment is consistent with the cooperative approach to governance supported by national leaders. Although this area of action is relatively new in the country and few formal intersectoral governance structures have been consolidated, the government is actively promoting key interministerial projects, such as the climate change adaptation strategy led by the Department of Environment, and this trend is conducive to a more systemic approach to different national priorities, including in health.

Third, the assessment opened new avenues for action in an area – health – that is a national development priority, subject to international agreements and attention. While the political spotlight is focused more on health care than on public health, the two areas overlap to a great degree and have the potential to reinforce one another. If internal allies in Cypriot society can be rallied at the grassroots level, and with the proper external support and interest from WHO, the EU and other international bodies acting from the top down, there is good potential for the pillars of

the health reform programme – equity, solidarity, financial protection and patient choice – to also sustain reforms aimed at strengthening population health and the health system as a whole.

Contribution to policy-making

Participants working under the Ministry of Health were very supportive of the self-assessment's potential to lay a solid foundation for evidence-based policy-making. This approval was common to one informant who thought that the self-assessment "basically confirmed information we already knew" (a score of 1/5) and another who found it to be "very useful, both to generate actionable information in the current context and as a learning experience that will enrich our analysis of future problems" (a score of 5/5).

On the lower end of the scoring spectrum, a technical expert said that while the self-assessment did not shed new light on any problems, it did help their department to articulate its strengths, weaknesses and continuing needs; in essence, it helped to organize the information in a way that would be useful for policy-makers. This informant noted that some bias would always be inherent to self-scoring, and this was also true in the case of the Cypriot report; however, the narrative description of the situation was both pertinent and valid. Coordinators within the Ministry were very satisfied with the results and judged the findings to be highly reliable. Overall, they found the information well organized, comprehensive, and based on evidence and consensus.

This objectivity seemed to hold true even in areas where the findings were not circulated among the extended teams during the revision process. One informant from an NGO noted that, from their organization's perspective, the report had no value as a tool for advocacy because it had not been made public, and in fact, it had not even been disseminated to all of the participants. While the findings were in line with the NGO's knowledge of the issue (that is, there was clearly no intentional misrepresentation of the information), this lack of transparency undermined the report's utility for the community.

This points to one noteworthy weakness of the Cypriot self-assessment: the relative lack of follow-up in the immediate aftermath of the report's finalization. Not all stakeholders had the opportunity to comment on the draft report, and the Ministry of Health has not proceeded with its plans to organize a workshop or policy dialogue to translate the report's findings into prioritized and actionable recommendations.

The reasons for this are varied: the most important was probably the change in ministers of health mid-assessment, which caused some inevitable disruption in what was a very incipient policy cycle. A WHO country expert speculated that this challenge may have been ameliorated had the oversight committee been in place to ensure better institutional continuity, but an official at the Ministry of Health had doubts about the potential effectiveness of such a committee given the status quo in the country.

Some actors also felt that emphasis was placed on collecting baseline information, but not necessarily putting it into use – at least not immediately. Finally, a visiting WHO consultant responsible for providing technical advice to the coordinators of specialized teams with regard to prioritizing recommendations had to leave before this process could be completed, effectively cutting the prioritization process short at the team level.

As a result, the report contains a summary of findings, but no explicit recommendations for action. Less than six months after the finalization of the report, the Ministry of Health has yet to initiate this type of specific action to develop a public health framework strategy. The report puts the public health service in a very strong position to do so, as it would be relatively straightforward to draft a solid, strategic document with a broad base of intersectoral support at short notice. If timed

correctly, public health reforms could feasibly be integrated into a rigorous strategy to strengthen the entire health system.

One coordinator pointed to the summary report's consolidation of reliable and current information on virtually every ongoing public health activity as an added value. This has since proven very useful in fielding requests for information from other ministries and nongovernmental sources, facilitating the Ministry of Health's capacity to be responsive to other stakeholders on initiatives originating outside the health system.

User experience

Overall, the informants were quite positive about using the self-assessment tool, although this judgement came with qualifications. One member of the core secretariat admitted to being quite intimidated upon receiving the full version of the questionnaire, anticipating considerable difficulties in coordinating the responses from all of the people who would need to take part in it. Moreover, although actors within the health system generally understood the questions well, those outside of the health system often needed coaching to be able to fill in the information. Again, technical assistance from the Regional Office was essential in overcoming these obstacles, and in the end, the user experience was quite satisfactory.

The same informant had a high regard for the design of the tool, whose open questions allowed respondents to provide nuanced answers that truly reflected the national situation. Likewise, there was support for the length and the level of detail, despite the work burden this entailed, as the questionnaire elicited high-quality and relevant information about the national situation. Although it was impossible to finish the self-assessment in the allotted two-month timeframe (the full self-assessment took six months), organizers still considered that "the value of the findings outweighed the burden of the assessment process".

One department-level manager agreed with these general points, although this informant considered the self-assessment burden to be roughly balanced with the utility of the findings, saying that the process was time-consuming but the investment paid off by generating a structured and articulate picture of the national situation.

Future use of the self-assessment tool

Organizers were confident that certain suboperations would be assessed every year or so, particularly the operations that scored poorly during this initial assessment process. Beyond that, the future use of the self-assessment tool will depend on contextual factors, the availability of technical assistance and the development of the tool itself. In a country with important resource constraints, technical assistance was seen as absolutely essential to enabling future work; indeed, without this assistance, the 2015 self-assessment would have taken considerably longer. Informants perceived a web-based tool as a useful upgrade, although they considered that creating a functional tool capable of responding to the organizational needs of a health system would be a challenge.

Informants were also supportive of the tool's adaptation to other settings: to guide curriculum development for public health professionals, to shape training sessions with NGOs and other health advocates, to help media identify partners in the Ministry of Health and to inform national policy in health.

Conclusions

The self-assessment in Cyprus has generated positive momentum and good will in the pursuit of improving public health, particularly between different arms of the public administration. The

process was very helpful in fostering a sense of teamwork and collaboration, and these new relationships are likely to favour an intersectoral approach to problem-solving and policy-making in the future. Moreover, the resulting report leaves the country's public health services in an excellent position to implement evidence-based reforms within the health reform programme that is currently under development.

At the same time, the focus of policy-makers, the media and civil society is concentrated on the need to implement a national insurance programme and to ensure access to health care services for citizens. In the context of the continuing financial difficulties facing the country, which will inevitably entail the prioritization of scarce resources, this focus may carry risks for the potential implementation of broad-based, system-wide reform of public health services.

However, neglecting population-based services would also have negative repercussions on curative services tailored to individuals, eroding sustainability and challenging quality assurance. In this context, national advocates for public health programmes and international partners of Cyprus, including the Regional Office and the EU, might highlight the functional linkage between public health and primary care, as well as general health system capacity-building (health services research, human resource development, information systems, etc.) that will set the stage for long-term reform and the construction of robust and equitable public health services.

Findings of the EPHO self-assessment reports

The seven reports emerging from the EPHO self-assessments were completed in diverse periods and political contexts, using heterogeneous methods based on different versions of the tool. Some countries emphasized qualitative aspects, such as the strengths, weaknesses and areas for action, while others strictly reported the completed scores or the recommendations emerging from the exercise. Most of the assessments explicitly recognized positive commitments within the corresponding countries to improving the EPHOs, a natural reflection of their willingness to carry out the exercise in the first place. At the same time, countries also identified areas for improvement in practically every operation.

This analysis aims to extract the main strengths and weaknesses of public health capacities and services identified during these self-assessments, as well as the principal recommendations of the reports. However, it is important to note that many of the specific weaknesses found in each country (particularly from earlier self-assessments) have since been addressed, frequently through public health reforms implemented on the basis of the reports. Thus, this analysis should be considered a sample of the challenges faced collectively by Member States of the Region – particularly in eastern European and central Asian countries, where all of the formal self-assessments have taken place so far – and a reflection of the quality and rigour of the reports, rather than a direct commentary or critique of the current public health services offered by any country in particular.

EPHO 1 - Surveillance of population health and well-being

Surveillance activities exist in all countries, and there are both explicit commitments and conceptual frameworks to improve them. The collection of basic statistics (vital records, maternal and child health indicators) tends to be sound; however, countries acknowledge other limitations. For example, the report from Cyprus underlined insufficient data collection on mental health indicators, an inadequate computer system for data compilation and an absence of collection and monitoring of social indicators, and Estonia's report (in 2007) revealed the absence of a coordinated system for environmental health indicators. Indeed, nearly all reports pointed to the need for greater integration of existing data sources as well as better data and documentation to assess health system performance (including monitoring of health system financing; health care use, performance and user satisfaction; and cross-border health).

EPHO 2 - Monitoring and response to health hazards and emergencies

This EPHO is supported by explicit commitments and implemented through practical activities. Although countries recognize the importance of this operation, there is room for improvement in the core capacities needed to respond to public health emergencies and in the national policies required to implement the International Health Regulations *(8).* For example, Poland found a lack of adequately integrated intersectoral monitoring of health hazards, whereas the former Yugoslav Republic of Macedonia acknowledged that more work should be done to promote global partnership with other countries and networks.

EPHO 3 - Health protection, including environmental, occupational, food safety and others

There is a generic commitment to this operation in all countries that have undertaken a self-assessment, but this has not always been effectively operationalized. In the area of environmental health protection, the legislative framework for air, water and soil quality was reasonably well established, although there were explicit limitations. For example, Cyprus mentioned the need to

improve environmental risk assessment practices and intersectoral coordination between governmental departments.

As for occupational health and safety protections, countries tend to have a basic national policy for the protection of workers' health, but adjustments are necessary to ensure appropriate standards. For example, Uzbekistan recognized that cross-sectoral integration of occupational health into other national policies is a particular challenge.

While a regulatory framework for food safety is an explicit priority in all the assessed reports, technical capacity is only partially developed in many countries. The Polish report proposed creating a nationwide food consumption monitoring system in order to provide a basis for health risk assessment. Fragmentation of the responsibilities across various authorities also seems to be a common problem, with teams in countries such as Cyprus pointing to the need to establish a single food safety agency.

Patient safety also seems to have a good legal and institutional framework, but implementation is often absent; the team in the former Yugoslav Republic of Macedonia highlighted this problem. Likewise, countries found existing regulatory frameworks for road safety, but coordination and the technical capacity for risk assessment were lacking in some.

Finally, with regard to consumer product safety, the reports tend to show reasonable development of regulations and enforcement.

EPHO 4 - Health promotion, including action to address social determinants and health inequity

The self-assessment reports reflect important challenges in identifying and tackling health inequities through a comprehensive and holistic approach. The reports show that practically all areas in this operation are in need of improvement: tobacco, alcohol and substance abuse control; nutrition and physical activity; sexual and reproductive health; mental health; violence and violence against children and women; and injury prevention. The weaknesses identified are frequently related to other enabling EPHOs, such as human resources, financing, research and governance.

In the area of tobacco, despite the basis of the WHO Framework Convention on Tobacco Control *(26)* – which Uzbekistan had not yet ratified at the time of the self-assessments – implementation was not always optimal. Both Cyprus and Estonia attributed this to a lack of capacity or trained human resources. Similarly, the areas of alcohol and substance abuse and nutrition and physical activity urgently require more investment and resources for research.

The area of sexual and reproductive health requires particular attention and improvement. This is stressed in certain reports, such as that of Cyprus. The former Yugoslav Republic of Macedonia also made it clear that, even when regulations and a framework are in place, countries can struggle with shortfalls in funding, research and capacity-building opportunities for health care providers. Basic policies are in place to prevent violence against children and women and to prevent injury, but further investments are needed in research, human resources, capacity building and full implementation of standards and protocols.

Finally, policies and practices related to mental health are also in need of investments to ensure implementation, especially with involvement of local government and communities. This is particularly important given that the greatest increase in incidence and burden of disease is due to mental ill health in countries such as Estonia.

EPHO 5 - Disease prevention, including early detection of illness

Regarding primary prevention, immunization programmes tend to be well established but vaccination registries and reporting systems still require further development, for example in Cyprus. Other challenges include the provision of health information and education on behavioural and medical health risks in primary health care settings and hospitals. For example, the former Yugoslav Republic of Macedonia noted inadequate counselling at specialized health care levels and insufficient clinical guidelines in primary health care.

With regard to a particularly timely issue – the provision of health services to migrants, homeless people and ethnic minorities – Cyprus acknowledged that there is no information system for monitoring access to and quality of health services for these vulnerable population groups. They also identified a need for cultural mediator/facilitator posts within the Ministry of Health to lead work on adapting health services to their needs.

As for secondary prevention, countries identified both barriers and solutions for breast cancer, cervical cancer and colorectal cancer screening. Besides the need to face financial constraints and insufficient numbers of trained staff (as made explicit by the former Yugoslav Republic of Macedonia), further efforts are needed to improve awareness programmes, strengthen capacities of social patronage services and provide training for health professionals.

In tertiary prevention, developing palliative care stands out as particularly important. As mentioned by Cyprus, the need for palliative care has never been greater due to the ageing population and increase in chronic diseases, yet palliative care services are still underdeveloped. Integrated strategies may pave the way to addressing this challenge.

EPHO 6 - Assuring governance for health and well-being

The self-assessments were carried out in countries with a strong interest in public health capacities and services, including explicit political commitment to population health within national priorities. However, the reports tend to show that this interest is not always matched with a process to deliver the desired outcomes. The analysis shows a need for setting up clearer and more specific terms of reference for all key stakeholders involved in the policy development and implementation processes in public health.

Public health strategies should be embedded in overall governance for health. In the Republic of Moldova, for example, participants in the self-assessment agreed to broaden the scope of the national public health strategy and to include special chapters on governance and leadership in line with Health 2020 *(2).*

The performance of health impact assessments varies by country: Cyprus has introduced them in a basic form to evaluate the impacts of national policies and plans in various economic sectors; Estonia found their capacity to be underdeveloped (in 2007) although improvement in this area was an explicit priority; and the former Yugoslav Republic of Macedonia noted that its capacity for health impact assessment is still in its early stages. Many countries share the common goal of promoting health impact assessment in various economic sectors, such as transport, agriculture and housing to ensure that it becomes an integral aspect of policy across all sectors. Furthermore, health technology assessment should support decision-making on the procurement of medical equipment and the introduction of new technologies.

EPHO 7 - Assuring a sufficient and competent public health workforce

The analysis revealed a scarcity of data related to the health workforce and the demand for health services in the areas of deployment, staff retention and attrition, staff productivity and service

needs. In some cases, information does exist but is not used. In the former Yugoslav Republic of Macedonia "there is no strategy for human resources in health, and it represents a top-priority activity"; and in Cyprus and Poland, there is poor available data related to the health workforce and the current and future demand for health services. Different teams suggested applying tools to perform complementary studies or analyses on the current health workforce and project future human resources needs.

The team from Cyprus mentioned the need for improvement in governance, financing, resource generation and service delivery operations for planning in human resource development. There is also a need to train new and re-skill current public health workers. Poland's team recommended assessing the current state of public health employment and indicated staff shortages, and the former Yugoslav Republic of Macedonia's team pointed to the need for developing institutional collaboration to match the future workforce with population needs.

EPHO 8 - Assuring sustainable organizational structures and financing

The self-assessment teams generally explained the organizational structure of the ministries of health and their linkage to all independent public agencies on health with clarity and coherence. In the Macedonian report, the importance of ministry leadership was underlined as a means to improve multisector and sector-wide collaborations. Public health institutions and professional associations have the capacity to lead their constituencies; however, further financial and governance strengthening is needed.

As the team from Cyprus explained, one of the main shortcomings in the articulation of effective work structures seems to be the lack of appropriate information systems capable of reflecting the realities of service providers. At the same time, there is a certain degree of fragmentation and a lack of appropriate continuity of care within health systems. Poor communication and coordination between health care providers compound these problems, leading to inefficiencies and imbalances. Reports from countries such as Uzbekistan indicated the absence of a specific cross-sector agency or coordinating committee for public health at the government level, making it difficult to fully develop, adopt and implement a comprehensive policy/strategy and action plan on the basis of effective intersectoral collaboration.

The former Yugoslav Republic of Macedonia acknowledged that there is a developed but sometimes unclear delineation of the organizational competencies for enforcing public health regulations, while Cyprus signalled that the budget should better specify investments in public health and indicate what funds are earmarked for public health programmes.

EPHO 9 - Advocacy, communication and social mobilization for health

The analysis shows that further work is needed to strategically develop this operation. For example, Uzbekistan's report focused on improving communication technologies but not strategic communication. Those of Cyprus, Slovakia and the former Yugoslav Republic of Macedonia acknowledged the need for a strong framework for using communication as a strategic tool for public health, to support leadership and influential advocacy for improving health, to enhance community engagement and empowerment, to consider shortages in all four areas for improvement (governance, financing, resource generation and service delivery) and to implement health communication effectively. In Poland, the need to strengthen advocacy for social determinants of health and health inequities also emerged as a clear recommendation.

Overall, it is clear that risk communication strategies as well as quantitative and qualitative measurements to assess public health programmes are needed to support robust capacity development in monitoring and evaluating public health communication campaigns.

EPHO 10 - Advancing public health research to inform policy and practice

Prioritizing public health objectives according to explicit criteria as well as resource and capacity limitations remains a challenge. This process is nonexistent or very poor in all countries that undertook a self-assessment. There is a need to endorse a stronger mandate for a standardized prioritization process to advance public health research. Moreover, the use of existing evidence (epidemiologic and health system data) for decision-making is limited and, as explicitly recognized by Cyprus, there are difficulties in applying research-generated public health evidence to inform policy development and service delivery.

There is also a need to further align the public health research agenda with the Health 2020 objectives *(2)*, including a comprehensive investment in health through a life-course approach and a focus on the adoption of healthy and active ageing initiatives. Another identified shortcoming is the integration of research activities in continuing education and training, which is essential to fostering links and fluid communication between the academic public health groups and national policy-makers.

As a partial counterpoint to these limitations, however, and as stated by the Slovak team, one positive feature underlying these exercises is the explicit political commitment to strengthen the system of public health, including public health research.

Review of the EPHO self-assessment process and outcomes

The ultimate goal of an EPHO self-assessment is to contribute to the development and implementation of evidence-based policy to improve public health. This goal depends on several intermediate objectives:

- the promotion of a shared understanding what public health services entail;
- the articulation of recommendations on how to improve services; and
- the facilitation of an informed basis for selecting priority actions for public health reform.

Several different domains of the self-assessment process influence these objectives: institutional basis and stakeholder participation; contributions to a whole-of-government, whole-of-society approach; and contributions to policy-making. These domains, together with the aspects directly related to use of the EPHO self-assessment tool and countries' openness to using it in the future, comprise the main areas of the following analysis.

Summary of results

The authors undertook 20 interviews in English and Russian with informants from seven countries in the Region that used the EPHO self-assessment tool to evaluate their public health capacities and services: Cyprus, Estonia, Poland, the Republic of Moldova, Slovakia, the former Yugoslav Republic of Macedonia and Uzbekistan. Their experiences in the domains described above are summarized here.

Institutional basis and stakeholder participation

Two countries stood out for the strong backing that senior government leaders (the prime minister and/or heads of other ministries) provided to the ministry of health for the self-assessment and subsequent reform processes: the former Yugoslav Republic of Macedonia and Poland. The former Yugoslav Republic of Macedonia directly tied the self-assessment results to the development of new public health policies, while Poland passed sweeping public health legislation mandating the comprehensive overhaul of public health capacities and services in line with the EAP-PHS *(3)*; this set the stage for the self-assessment that immediately followed.

Other countries' self-assessments also had strong links to public health reforms, but institutional support was mostly limited to leadership from ministries of health (that is, without the close involvement of other ministries or the head of government). For example, both the Uzbek and the Moldovan ministries of health provided strong backing to the assessment and public health reforms that followed. The Cypriot and Slovakian ministries of health supported the self-assessment process itself, but recommended reforms are still pending both countries. In Cyprus, a change in ministers mid-assessment and a difficult economic and political climate for the health sector have undermined the potential for a positive reform package. In Estonia, leaders did not capitalize on the opportunities provided by the self-assessment but did implement parallel improvements in public health policy; four years after the assessment, the country also developed a new public health law with the support of the Regional Office.

In terms of participation from a wide variety of stakeholders, countries using the 2014 assessment tool (Cyprus, Poland and the former Yugoslav Republic of Macedonia) were much more likely to have involved academic partners, NGOs and ministries in non-health sectors. While informants admitted that there was room for improvement in extending participation, most shared positive experiences of creating new intersectoral ties and building on those already established through the self-assessment process. Countries using the first iteration of the tool – which had a narrower scope – reported less involvement from stakeholders outside the health system.

Finally, informants from all countries reported positive experiences in working collaboratively. This highlights the usefulness of the tool in stimulating discussion around shared challenges and facilitating collaborative approaches to solving problems. Informants from Poland and Slovakia noted that even though the self-assessment process was not enough to overcome all pre-existing institutional tensions, good progress was made towards this goal. Some informants, particularly in smaller countries (for example, Cyprus and Estonia), noted while certain collaborative ties were already quite strong prior to the self-assessment, the discussions about the EPHOs helped to open up new areas for cooperation (Estonia) and break down institutional barriers (Cyprus). Uzbekistan stands out as a case where serious mistrust and misunderstanding around the scope of public health gave way to greatly improved institutional and personal relationships.

Contribution to a whole-of-government, whole-of-society approach to health

On a practical level, fostering a whole-of-government, whole-of-society approach entails catalysing interdisciplinary and intersectoral collaboration in pursuit of public health reforms. This has been a cornerstone of Health 2020 and the EAP-PHS *(2,3)*, and the progress that the Regional Office has made since the 62nd Regional Committee in Malta (2012) to integrate those concepts into the self-assessment tool and beyond is evident. While the countries that used the first version of the tool (the Republic of Moldova, Slovakia and Uzbekistan) reported incomplete or absent progress in creating new intersectoral ties, the three countries that used the 2014 version (Cyprus, Poland and the former Yugoslav Republic of Macedonia) highlighted interorganizational collaboration and the mapping of competencies as a major added value of the self-assessment and the subsequent policy-making process. Cyprus and the former Yugoslav Republic of Macedonia made the most progress in overcoming intergovernmental communication barriers, while Poland strengthened ties primarily with academic partners.

While the self-assessments are helping to strengthen these connections, there is also a clear trend towards increasing intersectoral governance in many parts of the Region. Informants from Cyprus, Estonia, Poland, the Republic of Moldova and the former Yugoslav Republic of Macedonia all pointed to nascent efforts to foster intersectoral collaboration throughout their governments in the areas of health, environmental protection and climate change mitigation. At the same time, the experiences of Slovakia and Uzbekistan show that there are still parts of the Region where a lack of capacity or institutional resistance to these changes persists.

Contribution to policy-making

Two factors complicate efforts to quantify the contributions of the EPHO self-assessments to new public health policies. First, national political leadership remains the foremost determinant of whether a government will develop and implement meaningful public health reforms. Second, countries may or may not look to the Regional Office for guidance in designing those new public health policies.

As a result of the interplay of these two factors, the link between the self-assessment process and the passage of a comprehensive national strategy on public health was explicit in only two of the seven case-study countries: the Republic of Moldova and the former Yugoslav Republic of Macedonia. In Poland, the self-assessment provided substantial and timely input to public health reforms pursued in parallel, but the reform package was not solely or fundamentally based on the self-assessment report. Estonia was also developing a national strategy on public health at the time of their self-assessment, but the link between the two was essentially coincidental and informal – the Ministry of Social Affairs did not assume clear ownership of the assessment, and the national health strategy was passed prior to the publication of the self-assessment report.

Uzbekistan was unable to pass a comprehensive policy package following the self-assessment; however, numerous vertical programmes were developed based on its findings, and the self-

assessment report is still consulted as a working document for public health professionals. The potential for Cyprus to implement a broad public health strategy based on the results of its 2015 self-assessment is strong; however, the Ministry of Health is under intense pressure (both nationally and internationally) to overhaul its health care scheme, and the feasibility of integrating new public health policies and investments into that reform is not clear. Finally, despite the Slovak Ministry of Health's support for the self-assessment, the institution was positioned somewhat defensively within the national government at the time of writing, without enough leverage to enact meaningful change.

User experience

Evaluators' opinions of the self-assessment were shaped by internal considerations (organization of the self-assessment, time and resources allocated to carrying it out) as well as by the design of the tool itself (length, level of detail, clarity of criteria). Countries also experienced general challenges related to the work burden and the effective dissemination of results to policy-makers.

With regard to organization, some countries launched their self-assessment without first resolving basic questions regarding coordination, designation of responsibilities or allocation of human resources. In particular, informants in Estonia and Slovakia emphasized that their initial expectations of the self-assessment process did not prepare them for what it actually required. Not surprisingly, these countries needed more time to complete the assessments than elsewhere. Language difficulties were also a concern, and several informants mentioned that a glossary of key terms would have been useful.

As for users' opinions of different versions of the tool, these varied widely between countries and to a lesser extent within them, with no clear middle ground. Several informants in Cyprus, Slovakia, the former Yugoslav Republic of Macedonia and Uzbekistan were enthusiastically in favour of the detailed nature of the questions; they praised the tool's capacity to elicit highly relevant and specific information on every aspect of public health. Informants in Estonia and Poland, on the other hand, would have preferred a more streamlined design with fewer questions and a sharper focus on priority areas. Informants in Poland also felt they lacked adequate guidance from the Regional Office with regard to involving multisectoral stakeholders and developing prioritized recommendations for action.

More generally, informants from nearly all the countries pointed out that the time commitment necessary to complete the self-assessment is a potential barrier. One coordinator of the Cypriot assessment stressed that their country could only complete the process in a timely way thanks to the presence of an in-country WHO consultant who assumed a considerable portion of the work burden. In Estonia, despite similar support in the form of a WHO temporary officer, the self-assessment was perceived as an added burden on professionals who were already struggling to manage their usual workload.

Finally, several informants in different countries mentioned that the greatest challenge was not performing the assessment, but rather engaging national leaders in the effort to improve population health. They expressed a strong desire for specific tools and international measures (cost–effectiveness studies, political pressure, and financial incentives and disincentives) to persuade national leaders that public health is a necessary and worthwhile investment.

Future use of the self-assessment tool

The case-study informants universally agreed on the usefulness of the EPHO self-assessment. While very receptive to a web-based tool, they qualified that in order for it to be truly effective, it would need to be well designed by professionals who were knowledgeable in public health. They also specified that the ability to pick and choose which suboperations to assess would be very useful;

they felt that performing the full assessment was initially very helpful to identify gaps and weaknesses but that monitoring progress would not require such a comprehensive approach.

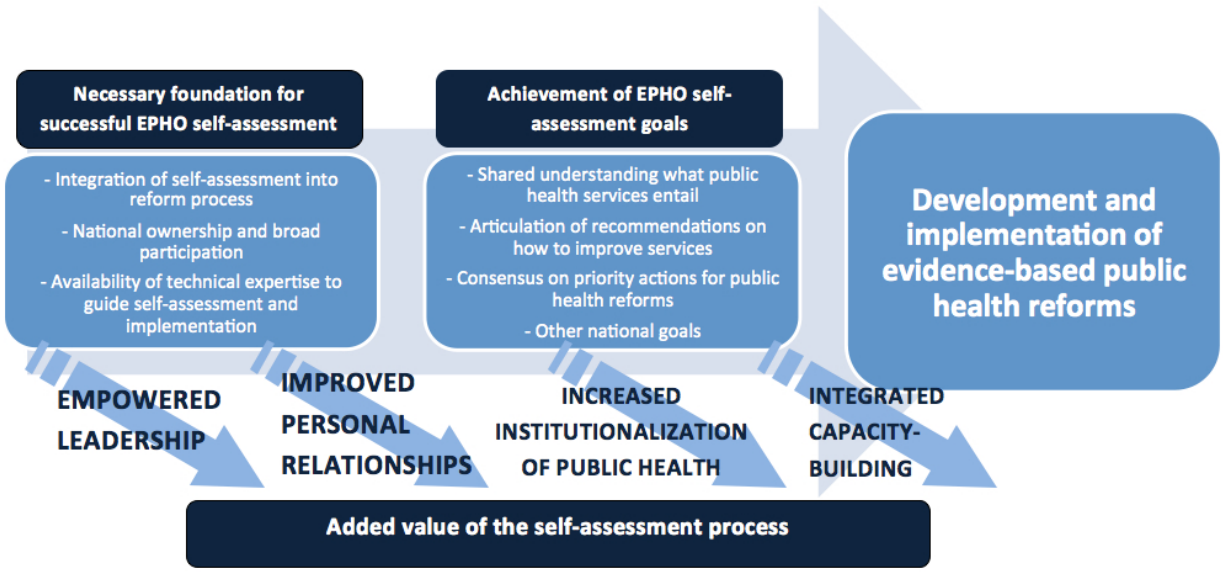
In fact, officials in the former Yugoslav Republic of Macedonia have already taken specific steps to incorporate the self-assessment tool into their operations by translating the English version into Macedonian, assigning focal points in different government ministries to coordinate responses and designing a web-based instrument with support from the Regional Office. They plan to monitor progress on specific suboperations that were found to be weak, while leaving the comprehensive self-assessment for an undetermined future date. Likewise, Cypriot officials were confident that parts of the tool would continue to be used to evaluate the areas that had scored poorly initially.

Discussion: maximizing the impact of EPHO self-assessments

The review of the seven EPHO self-assessment reports shows clear strengths but also room for improvement across operations, including a more integrated public health surveillance system, fundamental adjustments to the requirements of the International Health Regulations *(8)*, better intersectoral coordination among governmental departments for health protection, a sharper focus on tackling health inequities, and improved primary health care and NCD prevention. Other priorities include developing health impact assessments within national policies and plans, re-skilling public health workers and formulating national strategies for human resources in public health, strategically developing communication and social mobilization for health, and applying research-generated public health evidence to policy development and service delivery. Analysis uncovered evidence of consistent weaknesses in these areas in all or most of the country reports; this suggests that these challenges are common across much of the Region.

Although countries face many of the same trials, each must characterize the challenges and solutions in their own context; the EPHO self-assessment is a practical instrument in this regard. When viewed collectively, these unique self-assessments also reveal key aspects that favour success across the board. Added values of the self-assessment process that strengthen public health capacities and foster alliances for comprehensive and intersectoral reform are presented in Fig. 1.

Fig. 1. Characteristics of a successful EPHO self-assessment



First, a solid political, economic and social foundation is needed for a self-assessment to lead to the development and implementation of evidence-based strategies to strengthen public health. Above all, this entails the commitment of leaders who are willing and able to translate assessment results into policy. This leadership sets the tone for the self-assessment, builds morale among evaluation teams and ensures that the resources required to perform a self-assessment are put to good use.

Second, the national self-assessment team needs representation from all major stakeholders, and participants (including leaders) need to feel a sense of ownership over the process. Acceptance of the tool is an important factor in this regard, and countries should feel supported in any efforts they perceive necessary to adapt the tool to their country or context (for example, through translations, streamlining of suboperations, etc.). In addition, it is important not to limit the assessment teams to actors within government. Political priorities may be quite sensitive to changing circumstances in the economy, foreign affairs or other current events, while academic partners, NGOs and patient/citizen groups can help sustain positive momentum for progress.

Finally, it is important to have technical assistance to guide the self-assessment as well as the prioritization process and development of recommendations. WHO country offices are well placed to provide such assistance, but so are national schools of public health, scientific societies and advocacy groups. Training for national actors in self-assessment methodologies may be a good way to build capacity at a country level; partnering with national or international organizations that award grants for public health activities could also ensure that countries are able to overcome resource-related obstacles.

Participants should also be aware of the self-assessment goals. The Regional Office advocates for the final goal of developing and implementing comprehensive strategies for public health – that is, tying the self-assessment process into the policy cycle. For this to happen, evaluators should cultivate a shared understanding of public health, develop recommendations on improving services and build consensus on priority actions for public health reforms among all stakeholders.

However, individual countries may be pursuing other complementary objectives, for example to map competencies in the provision of public health services (key takeaways from the self-assessments in Cyprus and the former Yugoslav Republic of Macedonia), justify expenditures on those services in interministerial or budget negotiations (Slovakia) or draw up implementation plans for public health legislation that has already passed (Poland). These goals do not conflict with the final objective, but rather represent alternative paths to the same destination.

Regardless of the extent to which countries achieve self-assessment goals, the self-assessment process can still function as a positive force. It can help administrators to develop a clear idea of what they need and from whom, thereby facilitating day-to-day operations as well as long-term strategic planning. It can also help professionals to overcome bureaucratic obstacles through the establishment of new partnerships with different sectors and disciplines. Indeed, this was one of the most significant improvements in the 2014 version of the tool. Moreover, the greater the number of stakeholders involved in the self-assessment, the more public health concepts are embedded into institutions across government and society. Self-assessments do not represent a shortcut in this regard – they can be quite resource-intensive – but for many governments whose traditional institutions are isolated from one another, they do mark a path towards better intersectoral cooperation where none had previously existed.

Finally, capacity-building is well integrated into the self-assessment process. The tool not only consolidates the most updated international guidelines in virtually all areas of public health, it also provides participants with the opportunity to apply these guidelines to their own context and to create new partnerships and mutual learning experiences with other governmental and nongovernmental actors.

Moving forward: implications for the Regional Office, Member States and partner organizations

The EPHO self-assessment tool – and the self-assessment process – should be considered a living entity. Over the past 10 years, the tool has proven flexible enough to adapt to evolving priorities in public health at the regional level as well as to context-specific structures and services at the level of countries. Overall, case-study informants were very positive about WHO's work in relation to the self-assessments, particularly the stable collaborations with WHO country offices, and were eager to deepen existing partnerships and create new ones. However, in a globalized world where public health is facing challenges on multiple fronts – clearly reflected in the self-assessment summary reports – there is no room for complacency.

There are a number of specific measures that the Regional Office, Member States and partner organizations could take to support the strengthening of EPHOs in the Region. The following proposals and needs were directly identified by key informants or implied within the self-assessment reports.

Implications for the Regional Office

The Regional Office could further develop the EPHO self-assessment tool through:

- a glossary of key terms;
- additional guidance on organizing the assessment, achieving optimal stakeholder involvement and performing prioritization exercises;
- a standard template for EPHO self-assessment reports, including sections dedicated to cross-cutting priority recommendations and EPHO-specific recommendations;
- an agile, web-based tool, sensitive to different organizational structures and contexts; and
- a streamlined package of EPHO operations, for example, with selected suboperations from the intelligence (1–2) and enabler (6–10) EPHOS that could be applied at a general system level or to specific vertical programmes.

It could provide Member States with technical assistance during the self-assessment process through:

- adequate preparation for the assessment, for example, agreeing on assessment goals with national partners and managing expectations regarding the resources needed for assessment;
- professional training and support for nationally based experts; and
- support for generating human and logistical resources to carry out the assessment.

According to findings from the EPHO self-assessment reports, it could adapt the EAP-PHS to include:

- regional advocacy for strengthening core capacities to prepare for and respond to public health challenges, particularly NCDs and public health emergencies (according to the International Health Regulations *(8)*);
- operational guidance on taking a whole-of-government, whole-of-society approach to addressing health inequities and the social determinants of health; and
- political support for key adjustments, such as increasing the budget allocated to core NCD interventions.

Finally, the Regional Office could provide advocacy and guidance at national and regional levels by:

- raising awareness and visibility for public health among national leaders;
- providing tools for ministries of health and other health authorities to demonstrate the value of public health services, for example through cost–effectiveness studies; and
- offering specific guidance and assistance on creating intersectoral governance mechanisms, as well as on other emerging national priorities.

Implications for Member States

Member States could increase the efficiency and effectiveness of EPHO self-assessments and subsequently strengthen the EPHOs by taking steps to:

- agree on assessment goals at the outset and allocate sufficient time and organizational resources to allow for a prompt conclusion;
- provide high-level leadership (for example, from a prime minister or president) to empower the ministry of health and explicitly tie a self-assessment into the policy cycle (for example, with a follow-up policy dialogue or national planning process);
- ensure participation in and ownership of the self-assessment among a broad coalition for public health, including governmental, nongovernmental and academic partners;
- publish self-assessment reports in full and adapt the main findings for the media and the general public;
- adapt the tool to a national context, for example, through translations or specific packages of operations for monitoring activities in different agencies or departments; and
- establish focal points throughout government agencies to coordinate self-assessment responses and monitor improvements.

Implications for partner organizations

Partner organizations could also contribute to the strengthening of EPHOs by taking steps to:

- establish specific mechanisms to support self-assessment processes, such as grants for in-country assessment teams;
- leverage political, social or financial incentives to encourage evidence-based policies to strengthen public health;
- publish operational guidance on public health issues (for example, from the Social Protection Committee of the EU); and
- incorporate EPHOs into other public health documents or activities (for example, public health curricula), to achieve harmonized understanding of concepts at an institutional level.

Conclusions

In 2007–2015, nearly two-dozen Member States of the Region carried out a self-assessment using the EPHO self-assessment tool. The tool has proven to be a useful vehicle for achieving a common understanding of what public health in the Region is, and for evaluating capacities and services in individual Member States. For many of the countries undertaking an EPHO self-assessment, the resulting reports provide the only comprehensive document detailing the strengths and weaknesses of their public health capacities and services. These reports are regularly used as a reference for governmental and health actors at the country level. As they are generally written in English, published versions of the reports could constitute a valuable resource for international public health research.

The results of the self-assessments reveal that, at the regional level, the most important challenges lie in the enabling operations (information, human resource development, governance) and in incorporating a whole-of-government, whole-of-society approach to addressing health inequity and the social determinants of health. In clarifying these important areas of focus, the self-assessment tool functions as a practical instrument for renewing public health in the Region in line with the precepts built into Health 2020 and the EAP-PHS.

This being said, the case studies illustrate that political will for change is more important than the availability of a useable tool. While the EPHO self-assessment was well integrated into the policy cycle of the Republic of Moldova and the former Yugoslav Republic of Macedonia – two countries that went on to pass comprehensive strategies to revitalize public health services – the assessment was less centrally (or only marginally) important in Estonia, Poland and Uzbekistan – three countries that also succeeded in passing very meaningful reform and public health legislation.

These countries all have in common a broad and growing recognition of the importance of public health, as well as strong institutions and advocates who work daily to develop programmes and policies that promote and protect population health and prevent disease. These professionals build the foundation for leadership and the momentum for change, and so even as the Regional Office works to improve the tools and mechanisms for developing policy, it must also empower public health communities and leaders through training, advocacy and outreach.

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Annex 1. Questionnaire for the case studies

INSTRUCTIONS

PRIOR TO FACE-TO-FACE INTERVIEW: Please complete your personal information and answer the multiple-choice questions (in blue boxes) by underlining your choice or using an X. Return the document to interviewer at least one day before the interview is to take place. Please also familiarize yourself with the remaining discussion questions, which will be the focus of the oral interview. The points for consideration are meant to stimulate discussion, but not to limit the scope of the interview; informants are invited to add further reflection based on their country's experience.

PERSONAL INFORMATION

Name:
Professional title:
Address:
Email:
Phone:

Background

1. Please briefly describe the assessment process and your involvement in your own words (political context, lead institution(s), organization of responsibilities, length of process, etc.). What were the motivations driving the assessment? Could you qualify the extent to which you believe the assessment process was successful?

Institutional basis, collaboration and participation

2. On a scale of 1 to 5, how would you characterize the involvement of the following stakeholders during the EPHO self-assessment process?

	1 very poor	2 poor	3 fair	4 good	5 optimal
High-level government officials beyond the Ministry of Health (e.g., Prime Minister, Minister of Treasury/Economics-Chancellor of the Exchequer, etc.)					
High-level government officials from within the Ministry of Health (e.g. Minister of Health, Chief Medical Officer, etc.)					
Public health agency or department managers (e.g., head of food safety, environmental protection, etc.)					
Technical experts in public health areas under the health system remit (e.g., vaccinations, surveillance)					
Technical experts in public health areas outside the health system remit (e.g., housing, labour, transport)					
Academic institutions (e.g., universities, schools of public health)					

Public health-related scientific societies and professional associations
Nongovernmental organizations and other nongovernmental stakeholders

3. Discuss your answers, considering:
   - the contributions of each stakeholder group to the process as a whole;
   - the advantages and/or disadvantages this entailed; and
   - the appropriateness of each stakeholder's influence (i.e., whether your stakeholder group generally agreed with the balance of power between the stakeholders contributing to the self-assessment process).

4. a) Approximately how many professionals contributed to the self-assessment process?

   o 0–5
   o 6–10
   o 11–15
   o 16–20
   o 21 or more

   b) How many institutions or organizations did they represent?

   o 0–5
   o 6–10
   o 11–15
   o 16–20
   o 21 or more

5. On a scale of 1 to 5, how do you think the EPHO self-assessment process affected the following aspects of existing stakeholder relationships?

	1 Worsened relationship; generated conflict	2 Entailed moderate difficulties	3 Neither improved nor worsened relationships	4 Moderately improved relationships	5 Greatly strengthened relationships
Communication					
Trust					
Commitment to a common objective					
Communal working					
Satisfaction with other actors					
Openness and transparency					

6. Discuss the reasons for your answers, considering:
   - the general status quo in your health system with regard to interdisciplinary and intersectoral working;

- consensus-building exercises within the assessment process; and
- how the EPHO self-assessment process helped or hindered communication, and how that could inform future assessments in other countries.

7. On a scale of 1 to 5, characterize the extent to which you believe the assessment process will contribute to fostering interdisciplinary and intersectoral collaboration in pursuit of public health reforms in your country.

   i. *Not at all*. The EPHO self-assessment process was only useful to actors from within the strict boundaries of the health system.
   ii. *A little*. The self-assessment process was mostly useful for actors within the health system, but may have a limited impact on collaboration with other sectors.
   iii. *Possibly*. The self-assessment process may have a positive (but mostly informal) impact on interdisciplinary and intersectoral collaboration.
   iv. *To some extent*. The self-assessment process will probably contribute to opening new avenues and reinforcing existing pathways for interdisciplinary and intersectoral collaboration.
   v. *To a great extent*. The self-assessment process definitely contributed to greater collaboration between the health sector and other sectors of society, and these collaborations are very 'ly to substantially facilitate future work together.

8. Discuss the reasons for your answers, considering:
   - the institutional set-up of your country;
   - current or planned activities in health impact assessments, joint financing schemes or other multisectoral governance mechanisms;
   - national development priorities;
   - helping or hindering factors in the assessment tool itself; and
   - potential support that the WHO Regional Office for Europe could offer moving forward.

Contributions to policy-making

9. Regarding the degree to which the assessment process helped to identify actionable information (i.e., information that is useful to develop solutions) in areas in need of improvement, please select the sentence you agree with the most.

   o The assessment process basically confirmed information we already knew.
   o The assessment process generated new information of the current challenges our public health services face, but the information was not actionable.
   o The assessment process provided actionable information on known problems, generating new ideas on how to address them through an integrated approach. However, it did not really generate new information on issues that may have been neglected.
   o The assessment process provided actionable information on the current challenges our public health services face, in both areas we knew had problems and others that we hadn’t previously considered.
   o The assessment process was very useful, both to generate actionable information in the current context, and as a learning experience that will enrich our analysis of future problems.

10. Discuss the reasons for your answer to the above, as well as any changes or modifications to the assessment process that you would recommend (for your country or in general) going forward. Would you do anything differently?

11. On a scale of 1 to 5, how useful would you say the assessment findings were for your country in terms of helping to support future public health reforms?

    i. Not at all useful
    ii. Slightly useful
    iii. Moderately useful
    iv. Quite useful
    v. Very useful

12. Discuss the reasons for your answer, considering:
    - relevance and reliability of the findings;
    - the level of support for the findings among political decision-makers and senior policy-makers;
    - the linkage with a specific reform process (timely and targeted?);
    - how helpful the findings were in terms of identifying priority areas for action; and
    - support provided by the Regional Office as a follow-up to the assessment

Ease of use

13. On a scale of 1 to 5, describe how proportionally burdensome it was to organize and carry out the assessment, in terms of the usefulness of the findings.

    i. Far too burdensome and time-consuming. The effort far outweighed the value of the findings.
    ii. Quite burdensome and time-consuming. The assessment was useful, but too resource intensive.
    iii. Balanced. The assessment was time-consuming, but the findings could not have feasibly been discovered without that process.
    iv. Advantageous. The value of the findings outweighed the burden of the assessment process.
    v. Added value. The value of the findings outweighed the burden of the assessment process, and in addition, the process was valuable in and of itself as a tool to stimulate discussion and exchange of ideas.

14. Discuss the reasons for your answers, considering:
    - the support provided by the Regional Office in helping to organize the assessment;
    - the degree of fragmentation/integration of your national system, and its impact on the performance of the assessment;
    - the clarity of the assessment criteria and questions; and
    - the length and level of detail of the self-assessment questionnaire.

Future use of the assessment tool

15. How likely is it that your country will perform future assessments using the EPHO approach, in order to monitor progress and developments?

    o Definitely not
    o Not likely
    o Possibly

- o Probably
- o Definitely

16. Discuss the reasons for your answer, considering:
    - institutional support in your country (in government and among different technical agencies and institutions);
    - support received by the Regional Office in translating the assessment results to concrete action; and
    - the practical feasibility of carrying out periodic assessments.

17. The WHO Regional Office for Europe is preparing a computerized tool to facilitate the EPHO self-assessment. Do you consider that this will make it potentially easier to carry out periodic self-assessments?

- o Definitely not
- o Not likely
- o Possibly
- o Probably
- o Definitely

18. Discuss the reasons for your answer, considering:
    - institutional support in your country;
    - familiarity with information technology within the team;
    - capacity/motivation to repeat the assessments to assess the trends in operations; and
    - other potential measures that would increase the ease of assessments (translations, etc.).

19. What did you consider most challenging?
    - Coordinating the assessment process (i.e. ensuring an equitable, transparent, multistakeholder process that resulted in actionable recommendations that were adequately disseminated to policy-makers).
    - Understanding the technical contents of the self-assessment tool and interpreting them in the national context.

20. Do you see the assessment tool as a useful instrument to adapt to other settings?
    - Education and professional development
    - Technical agencies
    - Media
    - National policy
    - Other

21. Do you have any additional comments?