World Health Organization
REGIONAL OFFICE FOR Europe

Regional Committee for Europe
66th session

EUR/RC66/Inf.Doc./4

Copenhagen, Denmark, 15–18 September 2016

6 September 2016
160576

Provisional agenda item 5(m)

ORIGINAL: ENGLISH

Lessons learned from Member State assessments of Essential Public Health Operations

As part of the Midterm progress report on the implementation of the European Action Plan for Strengthening Public Health Capacities and Services (document EUR/RC66/19), this information document reviews Member States' self-assessments of the Essential Public Health Operations (EPHOs). It summarizes the main findings of seven in-depth case studies, in order to inform Member States on both the scope and quality of the findings, and to extract lessons regarding the optimal organization and methodology of a self-assessment.

The analysis shows that the EPHOs self-assessment tool is a valid instrument to comprehensively evaluate public health capacities and services in Member States of the WHO European Region. For many of the countries undertaking EPHOs self-assessments, the resulting reports are the only comprehensive documents detailing the strengths and weaknesses of public health capacities and services at the national level. The assessment process itself is also valuable, helping to expand and strengthen intersectoral professional networks while contributing to building capacity and consensus around public health issues. The reports show that there is still much work to be done to strengthen public health in the European Region, with gaps and areas for improvement for every single essential operation, but particularly EPHOs such as health promotion that require a true whole-of-government, whole-of-society approach. The key elements to effectively translate an EPHOs self-assessment into a comprehensive strategy to revitalize public health include strong national leadership, explicit linkages with the policy-making cycle, broad participation among governmental, academic and nongovernmental partners, and the availability of expert technical assistance to guide both the assessment and the prioritization and policy-making processes that follow.

Several respondents 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. There was a strong desire for specific tools and international measures that could persuade national leaders that public health is a necessary and worthwhile investment.

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Background

1. In the nearly 20 years that have passed since the first list of Essential Public Health Operations (née Functions) was published by WHO in 1998 *(1)*, public health has seen tremendous changes in the WHO European Region. The eastern European and central Asian countries have worked to move beyond the sanitary-epidemiological systems that defined public health for decades there, while western Europe has concentrated its 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, as the strong health systems perspective that characterized European public health at the beginning of the 21st century has given way to a more holistic viewpoint, enshrined in Health 2020, the European health policy *(2)*, and in one of its main pillars of implementation, the European Action Plan on Public Health Capacities and Services (EAP-PHS) *(3)*.

2. The development and adaptation of the EPHOs have mirrored these changes in Europe and elsewhere *(4)*, proving to be a valid tool for evaluating public health capacities and services in the 20 Member States that have undergone one or more self-assessments (see Table 1). The condensed list of 10 EPHOs helps to define and delineate public health for national policy-makers and stakeholders from non-health sectors, while the expanded list of sub-operations provides a comprehensive checklist of public health services and capacities. 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.

3. This report provides a closer look at the results of the EPHOs self-assessments. It is worth noting that formal assessments have taken place exclusively in the eastern part of the European Region, and thus it was not possible to evaluate any experiences from western European countries, which may differ in terms of goals, obstacles and strengths. We begin with a cross-cutting analysis of nine country reports produced following the national self-assessments, in order to identify trends and common challenges across the Region. We then focus on the assessment process itself, describing the main lessons emerging from seven case studies on Member States' experiences using the tool. We conclude with a series of reflections and implications for the Regional Office for Europe, Member States and partner organizations.

Table 1. EPHOs self-assessments undertaken in the European Region in the period 2007–2016

Framework (version)	Country	Year(s) of the EPHOs self-assessment
South-eastern Europe Health Network (SEEHN) Evaluation of public health services in south-eastern Europe *(5)*	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 in the New Independent States	Tajikistan	2009
	Armenia	2009
	Kyrgyzstan	2011–2012
	Uzbekistan†	2011
	Republic of Moldova†	2012–2013
	Russian Federation	2012–2014
Other EPHOs self-assessments *(*version 1)	Estonia†	2007–2008
	Slovenia	2009
	Slovakia†	2011–2012
Revised EPHOs self-assessments (2014 version)	**The former Yugoslav Republic of Macedonia**†	2014
	Poland†	2014–2015
	Bosnia and Herzegovina	2014-2015
	Cyprus†	2015
	Armenia	2015–2016
	Slovenia	2015–2016
	Kazakhstan	Ongoing (2016)
	Kyrgyzstan	Ongoing (2016)

SANEPID = sanitary-epidemiological system
Countries in **bold typeface** have undertaken more than one self-assessment.
† EPHOs assessments featured in case studies.

Analysis of EPHOs self-assessment reports

4. The seven reports featured in the analysis (see Table 1) were completed in diverse time 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 arising areas for action, while others reported only the completed scores or the recommendations emerging from the exercise. Most of the assessments explicitly recognized positive commitments within the corresponding Member State to improve the EPHOs, a natural reflection of their willingness to carry out the exercise in the first place. At the same time, Member States also identified areas for improvement in practically every operation.

5. In this analysis, we have aimed to extract the main strengths and weaknesses of public health capacities and services identified during these assessments, as well as the principal recommendations emerging from the reports. However, it is important to note that many of the specific weaknesses found in each country (particularly from earlier 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 European Region – particularly in the eastern European and central Asian areas, where all of the formal EPHOs assessments have taken place so far – and a reflection of the quality and rigour of the reports, rather than a direct commentary or critique on the current public health services offered by any country in particular.

EPHO 1 – Surveillance of population health and well-being

6. Surveillance activities exist in all countries, and there are explicit commitments and conceptual frameworks to improve the situation. The collection of basic statistics (vital records, maternal and child health indicators) tends to be sound; however, countries acknowledge certain limitations. For example, Cyprus underlined its insufficient data collection on mental health indicators, an inadequate computerized system for data compilation, and the absence of monitoring and collection of social indicators.

7. In addition to these specific areas in need of improvement, which vary from country to country, nearly all Member States 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 utilization, performance and user satisfaction, and cross-border health).

EPHO 2 – Monitoring and response to health hazards and emergencies

8. This EPHO has been identified as one supported by explicit commitments and implemented through practical activities. Although countries recognize its importance, there is room for improvement in core capacities needed to respond to public health emergencies and in national policies required to implement the International Health Regulations (IHR) (2005). For example, Poland found inadequately integrated intersectoral monitoring of health hazards, whereas the team in 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

9. There is a generic commitment toward this operation in all the Member States, but this support has not always been effectively operationalized in different Member States. 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.

10. As for occupational health and safety protections, Member States 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.

11. While a regulatory framework for food safety is an explicit priority in all the assessed reports, technical capacity is only partially developed in many Member States. 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 some teams in Member States, such as Cyprus, pointing to the need to establish a single food safety agency.

12. Patient safety also seems to have a good legal and institutional framework for protecting patients/providers safety, but implementation is often absent; the team in the former Yugoslav Republic of Macedonia explicitly highlighted this problem. Likewise, Member States found existing regulatory frameworks for road safety, but coordination of and technical capacity for risk assessment were lacking in some countries such as Armenia. Finally, with regard to consumer product safety, the different reports tend to show reasonable development of regulations and enforcement.

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

13. The assessments reflect important challenges in identifying and tackling health inequities through a comprehensive and holistic approach. The reports show that practically all areas under EPHO 4 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.

14. In the area of tobacco, despite the basis of the Framework Convention on Tobacco Control (FCTC) – which Uzbekistan had not yet ratified at the time of the assessment – implementation was not always optimal. Both Estonia and Cyprus attributed this fact to the 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.

15. The area of sexual and reproductive health requires particular attention and improvement according to the assessments, which is made explicit in detail in certain reports such as the one from Cyprus. Even when regulations and a framework are in place, there are shortfalls in funding, research and capacity-building for health care providers (the former Yugoslav Republic of Macedonia). 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.

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

EPHO 5 – Disease prevention, including early detection of illness

17. Regarding primary prevention, immunization programmes tend to be well-established, but vaccination registries and reporting systems require further development, for example, in Cyprus. Other challenges include the provision of health information and education on behavioural and medical health risks in the 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.

18. 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, nor are there cultural mediator/facilitator posts within the Ministry of Health to lead work on adapting health services to their needs.

19. As for secondary prevention, Member States identified both barriers and solutions for breast cancer, cervical cancer and colorectal cancer screening. Besides the need to face financial constraints and insufficiently 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.

20. 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 tackle this challenge.

EPHO 6 – Assuring governance for health and well-being

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

22. Public health strategies should be embedded in overall governance for health. For example, in the Republic of Moldova, the participants in the 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.

23. The performance of the health impact assessment (HIA) varies by country: in Cyprus, it has been introduced in a basic way to evaluate the health impacts of national policies and plans in various economic sectors; Estonia found it to be underdeveloped (at the time of the assessment) although its improvement was an explicit priority; and the former Yugoslav Republic of Macedonia noted that a HIA was in an early stage and only very rudimentary activities had been undertaken. A common goal in Member States is to promote the HIA in various economic sectors, such as transport, agriculture and housing to ensure that it becomes an integral aspect of policy across all sectors. Furthermore, the health technology assessment (HTA) 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

24. A cross-evaluation of the different assessments reveals 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 it 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 Poland and Cyprus, there is poor available data related to the health workforce and the current and future demand for health services. The different teams suggest applying tools to project future human resources needs and performing complementary studies or analyses on the current health workforce.

25. Cyprus mentions the need for improvement in governance, financing, resource generation and service delivery operations for planning in human resources development. There is also a need to train new and reskill current public health workers. Polish assessors recommended assessing the current state of the public health employment and indicated staff shortages, and the team of the former Yugoslav Republic of Macedonia pointed to the need for developing institutional collaboration with regard to matching the future workforce with population needs.

EPHO 8 – Assuring sustainable organizational structures and financing

26. The assessment teams generally explain the organizational structure of the Ministry of Health, and its linkage to all independent public agencies on health, with clarity and coherence. In the Macedonian report, the importance of Ministry leadership was stressed 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. 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, as explained in Cyprus. At the same time, there is a certain degree of

fragmentation and a lack of appropriate continuity of care within the health systems. Poor communication and coordination between healthcare 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.

27. 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 signaled that the budget should better specify the investments in public health, clarifying what it is specifically earmarked for public health programmes.

EPHO 9 – Advocacy, communication and social mobilization for health

28. The analysis shows that further work is needed to create a strategic way forward to develop this operation. For example, the Uzbek report focused on improving communication technologies, but not strategic communication. Slovakia, the former Yugoslav Republic of Macedonia and Cyprus acknowledged the need for a strong framework to use 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 the domain of health communication effectively. In Poland, the need to strengthen advocacy for social determinants of health and health inequalities also emerged as a clear recommendation. Overall, the assessment showed that the implementation of risk communication strategies, along with the introduction of 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

29. Prioritizing public health objectives according to explicit criteria as well as resource and capacity limitations remains a challenge. This process is basically non-existent or very poor in all the assessed MS. 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 applying the 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, including a comprehensive investment in health through a life-course approach, focusing on the adoption of healthy and active ageing initiatives. Another shortcoming identified is the integration of research activities in continuing education and training, which is essential to foster links and fluid communication between the academic public health groups and national policy-makers.

30. 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 public health system, including public health research.

Case studies: the EPHOs self-assessment process and outcomes

31. As a complement to our analysis of the EPHOs self-assessment reports, our team undertook 20 interviews with professionals involved in the assessment process in seven countries (see Table 1). Selection criteria for the list as a whole included the following:

- countries with different sociopolitical contexts, representing a variety of subregions;
- countries with an available EPHOs self-assessment report on file;
- countries that had carried out more than one assessment; and
- 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.

32. Based on these considerations, ten countries were initially chosen: Armenia, Cyprus, Estonia, Poland, Republic of Moldova, Russian Federation, Slovakia, Tajikistan, the former Yugoslav Republic of Macedonia and Uzbekistan; due to the lack of response, we finally excluded Armenia and the Russian Federation from the analysis.

33. The aim of the case studies was to understand to what extent these evaluations contributed to the development and implementation of evidence-based policy to improve public health. This objective is influenced by several different domains of the assessment process: institutional support, collaboration and 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 utilization of the EPHOs self-assessment tool and countries' openness to using it in the future, comprise the main areas of our analysis.

Institutional basis, collaboration and participation

34. "Institutional basis" refers to the support given to the assessment process from senior leaders in the government (Prime Minister and/or heads of other ministries). In that sense, two countries stood out for the strong backing provided by national leaders to the Ministry of Health for the EPHOs self-assessment and subsequent reform process: the former Yugoslav Republic of Macedonia and Poland. The former Yugoslav Republic of Macedonia directly tied the 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; this set the stage for the EPHOs assessment that immediately followed.

35. Other countries' assessments also had strong links to public health reforms, but the institutional support was mostly limited to Ministry of Health leadership (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. In the case of Slovakia and Cyprus, the Ministries of Health supported the assessment process itself, but the resulting reforms have not crystallized in Slovakia and are still pending in Cyprus. A change in Ministers mid-assessment in Cyprus, combined with a difficult economic and political climate for the health sector, has called into question the potential for a highly positive reform package. Finally, Estonian leaders did not capitalize on the opportunities provided by the EPHOs 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 for Europe.

36. In terms of participation, the countries using the 2014 assessment tool (the former Yugoslav Republic of Macedonia, Cyprus and Poland) were much more likely to have involved academic partners, NGOs and other ministries. While country informants admitted there was still room for improvement in extending participation, most had positive experiences to share in terms of creating new intersectoral ties and building on those that were already established. On the other hand, the countries using the previous version of the tool reported less involvement from stakeholders outside the health system; this fact may be attributed to the narrower scope of the first iteration of the tool.

37. All of the countries reported positive experiences in collaborative work, highlighting the usefulness of the tool in stimulating discussions of mutual challenges and collaborative problem solving. Slovakia and Poland noted that even though the assessment process was not enough to entirely overcome pre-existing institutional tensions, good progress was made in that regard. Some informants, particularly in smaller countries (such as, Estonia, Cyprus), noted that some collaborative ties in place prior to the assessment were already quite strong, but the discussions around the EPHOs helped to open new areas for cooperation (Estonia) and to break down institutional barriers (Cyprus). Uzbekistan stands out as a case where serious mistrust and misunderstandings around the scope of public health gave way to greatly improved institutional and personal relationships.

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

38. On a practical level, fostering a whole-of-government, whole-of-society approach entails catalyzing interdisciplinary and intersectoral collaboration in pursuit of public health reforms. This has been a cornerstone of Health 2020 and of the EAP-PHS, and the progress that the Regional Office for Europe has made since the 62nd session of the Regional Committee for Europe in Malta in 2012 to integrate those concepts into the EPHOs assessment tool and beyond is evident. While Slovakia, the Republic of Moldova and Uzbekistan (all using the first version of the EPHOs assessment tool), reported incomplete or the lack of progress in creating new intersectoral ties, the three countries that used the 2014 version (the former Yugoslav Republic of Macedonia, Poland and Cyprus) highlighted better interorganizational collaboration and mapping of

competencies as a major added value of the assessment/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.

39. It is worth noting that while the EPHOs self-assessments help to articulate these connections, there is a clear trend toward increasing intersectoral governance in many parts of Europe. Estonia, the former Yugoslav Republic of Macedonia, Cyprus, the Republic of Moldova and Poland all pointed to nascent efforts to foster intersectoral collaboration throughout their governments, in health as well as in other areas like environmental protection and climate change mitigation. At the same time, the experiences of Slovakia and Uzbekistan show that there are still pockets of the Region where there is a lack of capacity or institutional resistance to these changes.

Contributions to policy-making

40. It is not a straightforward task to quantify the contributions of the EPHOs self-assessments to new public health policies, as there are two separate factors at play. First of all, national political leadership remains the foremost determinant of whether the government will develop and implement meaningful public health reforms. At the same time, countries may or may not look to the Regional Office for Europe for guidance in designing those new public health policies.

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

42. Elsewhere, Uzbekistan was not able to pass a comprehensive policy package following the assessment; however, numerous vertical programmes have been developed based on its findings, and the assessment report is still consulted as a working document for public health professionals. The potential for Cyprus to implement a broad strategy on public health based on the results of its 2015 assessment is strong, but the Ministry of Health in that country is under intense pressure (both nationally and internationally) to overhaul its healthcare scheme, and it is not clear how feasible it will be to integrate new public health policies and investments into that reform. Finally, despite the Slovak Ministry of Health’s support for the EPHOs assessment, the institution is positioned somewhat defensively within the national government and lacks sufficient leverage to enact meaningful change.

User experience

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

44. With regard to organizational aspects and other setting-related factors, some countries launched their self-assessment without having resolved basic questions regarding its coordination, the designation of responsibilities or the allocation of human resources. In particular, informants in Slovakia and Estonia highlighted that their initial expectations on how the assessment would be did not prepare them for what the tool required; it is probably not a coincidence that the assessments in these countries took more time to complete than elsewhere. Language difficulties were also a concern for a number of informants, and several mentioned that a glossary would have been useful to understand the terms used.

45. As for users' opinions of the tools, these varied widely between countries and to a lesser extent within them, with no clear middle ground. Several of the informants in Slovakia, the former Yugoslav Republic of Macedonia, Cyprus and Uzbekistan were enthusiastically in favour of the detailed nature of the questions, praising the tool's approach and its capacity to elicit highly relevant and specific information on every aspect of public health. Polish and Estonian informants, on the other hand, would have favoured a more streamlined design, with fewer questions that focused attention on priority areas. Evaluators in Poland also felt they lacked adequate guidance from the Regional Office for Europe with regard to involving multisectoral stakeholders and developing prioritized recommendations for action.

46. In general, nearly all of the countries pointed to the time commitment necessary to complete the assessment as a potential barrier. One coordinator of the Cypriot assessment stressed that their country could only complete the tool 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 assessment was still perceived as an added burden on professionals who were already struggling to manage their usual workload.

47. Finally, several respondents 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. There was a strong desire for specific tools and international measures that could persuade national leaders that public health is a necessary and worthwhile investment.

Future use of the assessment tool

48. The case study informants universally agreed on the usefulness of the EPHOs self-assessment approach. While very receptive to a web-based tool, they qualified that it would need to be well designed by professionals who were knowledgeable in public health for it to be truly effective.

49. The ability to pick and choose the sub-operations to assess was also seen as very useful for subsequent assessments; informants felt that performing the full assessment was initially very helpful to identify gaps and weaknesses, but monitoring progress would not require such a comprehensive approach.

50. In fact, the former Yugoslav Republic of Macedonia has already taken specific steps to incorporate the assessment tool into its usual operations, translating the English version into Macedonian, assigning focal points in different government ministries to coordinate responses, and designing its own web-based instrument. They plan to monitor progress on specific sub-operations found to be weak, while leaving the comprehensive 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 in the initial assessment.

Maximizing the impact of EPHOs self-assessments

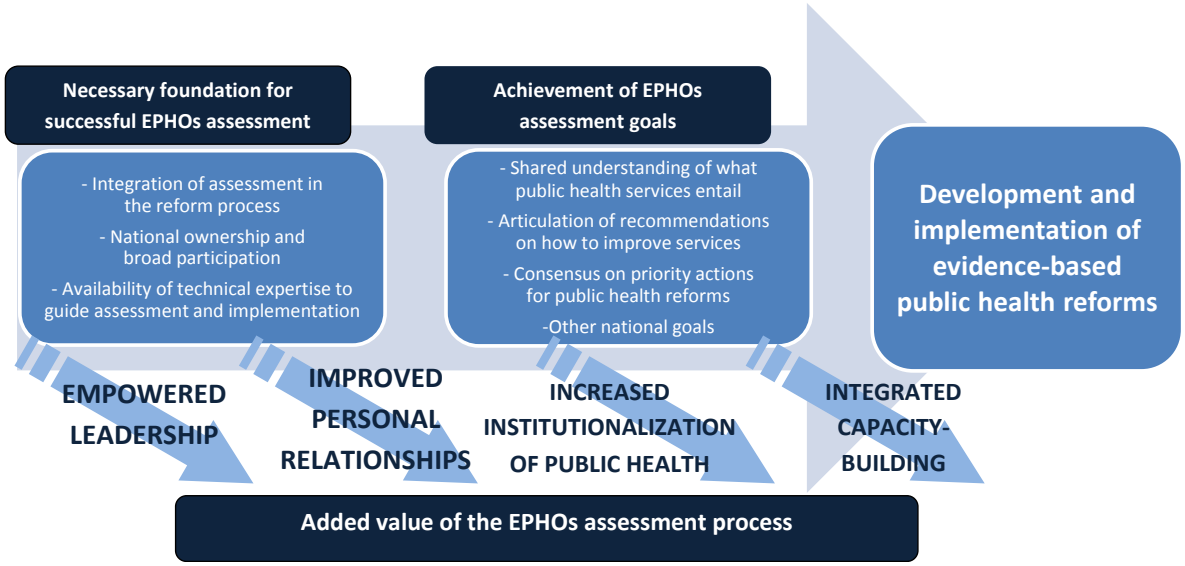
51. Member States face many of the same trials, but each must characterize the challenges and solutions in their own context; the EPHOs self-assessment is a valid and practical instrument in that regard. Although every assessment is unique, it is possible to extract key aspects that favour success. We have also identified a number of added values from the assessment, which work independently to strengthen public health capacity and foster alliances for comprehensive and intersectoral reform (see Fig. 1).

52. The Regional Office for Europe advocates linking the assessment process to the policy cycle, and the intermediate goals detailed in Fig. 1 address that eventuality. However, it is worth noting that individual countries may be pursuing other complementary objectives, for example, to map competencies in the provision of public health services (key takeaways from the assessments in the former Yugoslav Republic of Macedonia and Cyprus), 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).

53. Regardless of the extent to which countries succeed in implementing new reforms, the process may still be very positive. Administrators emerge from the evaluation with a clear idea of what they need and from whom, facilitating day-to-day operations as well as long-term strategic planning. Professional networks benefit greatly from EPHOs self-assessments, which can help overcome bureaucratic obstacles through a shared learning experience among different sectors and disciplines. Wide participation helps to embed public health concepts into institutions across government and society, marking a path toward better intersectoral cooperation where none had previously existed. Finally, capacity-building is closely integrated into the EPHOs self-assessment, providing participants with the opportunity to apply updated international guidelines to their own

context and to create new partnerships and mutual learning experiences with other governmental and nongovernmental actors.

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



Moving forward: implications for the WHO Regional Office for Europe, Member States and partners

54. With regard to how the Regional Office, Member States and partner organizations could further support EPHOs in the European Region, a number of proposals and needs emerged from both direct input of key informants and implications arising from the self-assessment reports.

Implications for the Regional Office

55. Further development of the current EPHOs 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 EPHOs self-assessment reports, including sections dedicated to cross-cutting priority recommendations and EPHO-specific recommendations;
- development of an agile, web-based tool, sensitive to different organizational structures and contexts; and
- a streamlined package of operations, for example, with selected sub-operations from the intelligence (1–2) and enabler (6–10) EPHOs that could be applied at a general system level or to specific vertical programmes.

56. Technical assistance during the self-assessment could be provided through:

- adequate preparation for the assessment (agreeing on assessment goals with national partners, 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.

57. Adaptation and realignment of the strategy for strengthening public health capacities and services based on EPHOs assessment report findings, such as:

- regional advocacy for strengthening health system core capacities to prepare for and respond to public health challenges, particularly NCDs and public health emergencies (IHR (2005));
- operational guidance on incorporating a whole-of-government, whole-of-society perspective to address health inequity and the social determinants of health; and
- political support for key adjustments, such as increasing the budget allocated to core NCD interventions.

58. Advocacy and guidance at the national and regional levels through:

- raising awareness and visibility for public health among national leaders, through political pressure and interest from the Regional Office;
- provision of tools for Ministries of Health and other health authorities to demonstrate the value of public health services, for example, through cost-effectiveness studies; and
- specific guidance and assistance on creating intersectoral governance mechanisms, as well as on other emerging national priorities.

Implications for Member States

- Agree on assessment goals at the outset, and allocate sufficient time and organizational resources to allow for a timely conclusion.
- Provide high-level leadership (such as the Prime Minister or President) to empower the Ministry of Health and explicitly tie the EPHOs assessment to the policy-making cycle (for example, with a follow-up policy dialogue or national planning process).
- Ensure participation of and ownership over the assessment among a broad coalition for public health, including government, nongovernment and academic partners.
- Publish self-assessment reports in full, and adapt the main findings for media and the general public.
- Adapt the EPHOs self-assessment tool to the national context, for example, through translations or specific packages of operations for monitoring activities in different agencies or departments.
- Establish focal points throughout government agencies to coordinate self-assessment responses and monitor improvements.

Implications for partner organizations

- Establish specific mechanisms to support the assessment process, 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 (such as from the Social Protection Committee of the European Union).
- 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

59. Over the past 10 years, nearly two dozen Member States have carried out a self-assessment using the EPHOs tool. It has proven to be a useful vehicle both for achieving a common understanding of what European public health is and for evaluating capacities and services in Member States. For many of the countries undertaking an EPHOs self-assessment, the resulting reports provide the only comprehensive documentation detailing the strengths and weaknesses of public health capacities and services. At the regional level, the most important challenges emerge in the enabling operations (information, human resource development, governance) and in incorporating a whole-of-government, whole-of-society perspective to addressing health inequity and the social determinants of health. In that regard, the EPHOs have proven to be a valid and practical instrument for renewing public health in the Region in line with the precepts of Health 2020 and the European Action Plan on Public Health Capacities and Services.

60. That said, the case studies illustrate that political will for change is more important than the availability of a useable tool to effect that change. While the EPHOs self-assessment was well integrated into the policy cycle of the former Yugoslav Republic of Macedonia and the Republic of Moldova, and those countries went on to pass comprehensive strategies to revitalize public health services, the assessment was less centrally (or only marginally) important in Poland, Estonia and Uzbekistan, and those three countries 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, with strong institutions and advocates who work daily to develop programmes and policies that promote and protect population health and prevent disease. These professionals are the ones who build the foundation for leadership and the momentum for change, and so even as the Regional Office for Europe 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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