WHO-EM/HLP/066/E

Capacity mapping for health promotion

World Health Organization
Regional Office for the Eastern Mediterranean

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Executive summary

Capacity-building for health promotion may be defined as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. As capacity for health promotion in different countries may vary at different levels, a collective approach has never been used to assess existing capacity in health promotion planning, programme implementation, financing and cross-sectoral collaboration in different countries of the WHO Eastern Mediterranean Region.

As part of a global initiative, an extensive exercise was conducted in the Region to assess the varying capacities of countries for health promotion using a tool developed by WHO and involving participation from regional focal points and WHO headquarters, Geneva. The tool was adapted to local conditions in the Region and responses were sought from all 22 countries. A consultant facilitated the process and elicited responses from 16 of the countries (a 73% response rate). Each country's results were summed for the eight main areas used in the tool, each area having a score ranging from 0 to 5 (5 being the highest). The results showed that health promotion capacity varies in different countries and even within the same country.

Regional averages revealed that countries are doing quite well in implementing collaborative mechanisms within government for health promotion delivery and also in creating partnership with nongovernmental organizations and other sectors, including the private sector. However, financing for health promotion, information systems and professional developments are the weakest areas in health promotion capacity. Another interesting correlation is that countries in the Region that are lagging behind in some, or all, of the Millennium Development Goals also show limited capacity in health promotion.

1. Introduction

Capacity-building for health promotion may be defined as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. As capacity for health promotion in different countries may vary at different levels, a collective approach has never been used to assess existing capacity in health promotion planning, programme implementation, financing and cross-sectoral collaboration in the different countries of the WHO Eastern Mediterranean Region. Health promotion involves actions to improve health at organization, workforce and community levels, and has different meanings in different contexts, including:

- an individual practitioner's ability or power to promote health;
- organizational processes and mechanisms that facilitate the process of promoting health; and
- the level of participation among people in the wider community, as well as the community infrastructure.

The capacity that is required for effective health promotion in one country may be different from that required in another country because of differing social, economic and/or political conditions. Since the countries of the Region are diverse as far as disease pattern, demography, financial strength and health systems are concerned, their health promotion capacity also widely varies within the framework of these and other variables.

2. The process

In 2004, WHO developed a capacity-mapping tool which was shared with the regional focal points for health promotion. The tool was extensively discussed by regional advisers at their meeting in Kobe in October 2004 and subsequently discussed with countries. After further discussion with the regional offices, each region was given flexibility to adapt the tool according to local conditions. There were three versions of the capacity-mapping tool (short, short expanded and long) and each region was mandated to use the version most suited to local conditions.

After consultation within the Regional Office for Eastern Mediterranean and with countries, the Regional Office adapted the short expanded version in English and French and sent this tool to all countries to illicit information. All countries were informed beforehand about the significance and mandate of the exercise. WHO headquarters, Geneva, provided financial support to execute the exercise, which was spread over a period of nine months.

A consultant was hired to assist the Regional Office elicit the correct information. The consultant visited five selected countries in the Region to help prepare their profiles. Sixteen (16) out of 22 countries responded (a 73% response rates) and completed the tool. Some of the information was verified in the majority of the countries. In addition to the information gathered from countries through the health promotion capacity-mapping tool, individual narrative reports were also prepared, based either on information provided by countries or on the consultant's visit. These reports were prepared separately. The summary of this report highlights countries' major strengths and weaknesses with regard to their health promotion capacity.

3. Challenges

In the course of this extensive exercise, several challenges were faced in gathering correct information. These challenges not only delayed the process, but also questioned (in a few instances) the validity of the information provided. Therefore, the Regional Office and the consultant had to return to the country/organization concerned to revalidate the information. A summary of the key challenges is as follows.

- Not all the ministries of health had health promotion focal points.
- Not all WHO Representative's Offices had health promotion staff members.
- Information in other sectors was not always available; if available, it was difficult to illicit.
- Quantification of responses was not easy.
- Reconciliation of the figures was a difficult task.
- Direct contact with nongovernmental organizations and other sectors was sometimes a problem.

4. Interpretation of results

Results were reviewed quantitatively as well as qualitatively. Since eight core areas were examined (see Annex 1), the interpretation of results mainly took into cognizance these eight core areas. However, data were also analysed for subareas under each core area and the results calculated in an Excel sheet (see Annex 2). The analysed results for the eight core areas were plotted graphically. The following methodology was used to analyse and plot the results.

- The Regional Office rated the responses, giving a score from 0 to 5 (5 being the highest) to responses from A to F.
- The responses were mapped in a graphical manner using the scoring criteria and applying the mean and standard deviation.
- Responses to the eight core areas were plotted. Individual responses to subareas were also plotted but not shown here.
- Responses of individual countries were also plotted.

Figure 1 shows the results for the eight core areas in two different manners. Table 1 gives the mean and standard deviations for all eight core areas (and some subareas) for all 16 countries. Figure 2 shows individual country scores for all the eight core areas. An interesting point to note is that, although countries have been shown to perform well in some of the core areas, the minimum and maximum range has wide disparity, leading to low values of standard deviation. This may also be the result of the fact that countries may have performed well in some core areas but less well in other core areas, thus affecting the overall cumulative percentage.

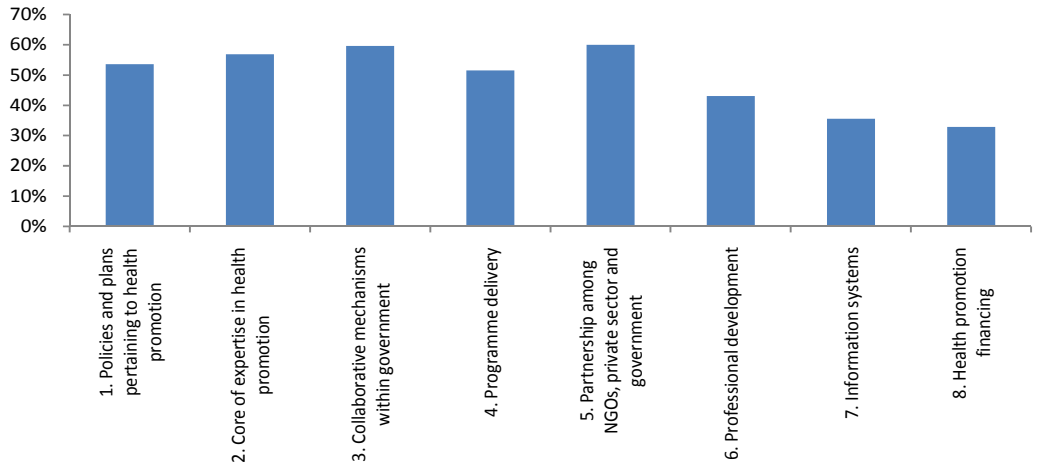

Figure 1. Results from the eight core areas

Table 1. Means and standard deviations for all eight core areas (*n = 16)*

	Mean (%)	SD (%)	Min. (%)	Max. (%)	No. –1 SD
1. Policies and plans for health promotion	54	15	31	81	3
1.1. Availability of legislation	59	24	20	93	2
1.2. Availability of plans, strategies, guidelines, programmes	55	18	11	80	2
1.3. Guidelines to plan, implement and evaluate health promotion activities	40	36	0	100	7
2. Core of expertise in health promotion	57	29	0	100	2
3. Collaborative mechanisms within government	60	36	0	100	4
4. Programme delivery	52	31	0	93	2
5. Partnership among nongovernmental organizations, private sector and government	60	40	0	100	3
6. Professional development	43	27	0	100	4
7. Information systems	36	27	0	87	3
8. Health promotion financing	33	27	0	87	2

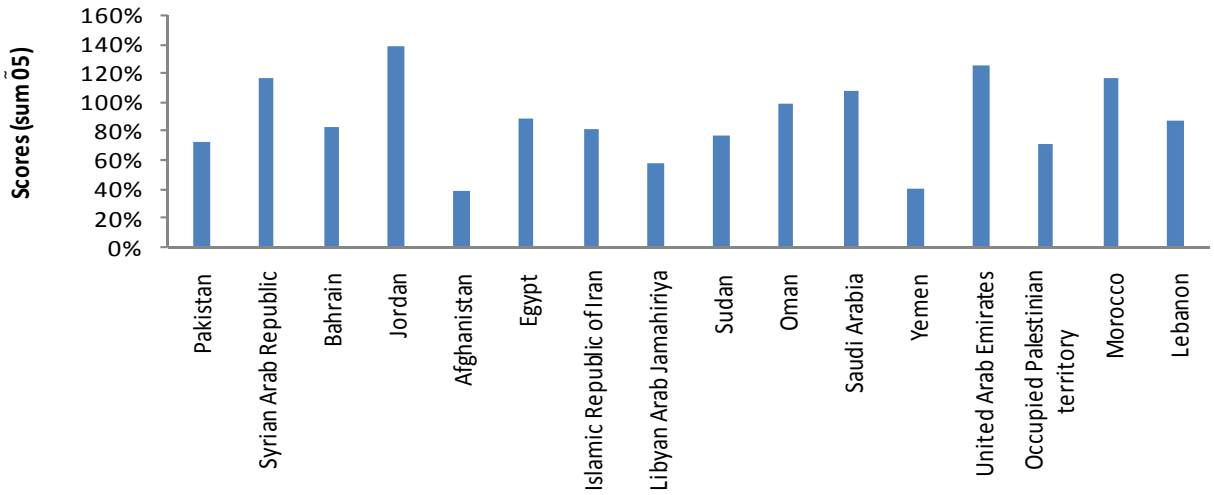

Figure 2. Individual country scores for all eight core areas

5. Summary of results and country reports

1. The overall impression that can be drawn from these country reports is that health promotion is essentially a set of programmes that may differ from country to country depending on the country's level of development and most important health issues. Health promotion is rarely an integrated policy of the government.
2. In view of the above, health promotion is anchored within the activities of the ministry of health, rather than within the ministries and organizations of the government. Programmes and policies that focus on health promotion in other ministries, such as education, environment, interior, public works, etc, are rare. This may be due to the weaker stewardship function of the ministry of health in governments of the Region.
3. Health promotion programmes are rarely transcribed into legislation. An exception may be made for tobacco control (although even this remains weak in general).
4. Health promotion activities have no constituency of their own. Health promotion activities and programmes are variously "housed' in primary health care divisions, public health directorates, community health, health sector reforms, preventive medicine, etc.
5. Most of the health promotion programmes in most countries have been developed in partnerships with the nongovernmental sector. This is a positive aspect, as it invites more community participation. The contribution and involvement of the for-profit private sector is rare.
6. Most of the health promotion programmes have developed as "national programmes" managed by WHO, in cooperation with the ministry of health, often according to the priority programmes of WHO at the global and regional level. This is not to be construed as a minus. In fact, it illustrates the positive influence that WHO can have in introducing community-based, promotion and preventive programmes.
7. Countries that have independent financing for health promotion on its own merit are rare.
8. Countries (including government, academia, nongovernmental organizations) that have developed human resources that are well educated and prepared to

carry on the programmes of health promotion, including social marketing, community empowerment, advertisement, volunteering, mass media, etc., are rare.

9. Countries that have established adequate and useful information systems and evaluative processes for health promotion programmes and policies are rare.
10. There are many efforts to establish health promotion programmes. However, relevant and successful models seem to be lacking or may be unknown.
11. Several health promotion programmes appear to be active in all the countries. These are:

    - tobacco cessation.
    - control of noncommunicable diseases, including cardiac illnesses, hypertension, diabetes and cancer;
    - maternal health, including safe pregnancy and reproductive health.
    - child health, including integrated management of child health.

12. Other programmes are being implemented in most (but not all) of the 16 countries which have important implications for the health of the population and health promotion, including:

    - nutrition
    - water safety and sanitation
    - food safety
    - environmental health, including waste management.
    - occupational health
    - injury control.

13. Some of the health promotion programmes are specific to a few of the countries, depending on their level of development and health priorities. Thus, for countries that still suffer from infectious and communicable diseases, health promotion programmes focus on the control of tuberculosis, schistosomiasis, leishmaniasis, leprosy, malaria, filariasis, guinea worm and, last but not least, HIV.
14. Health promotion programmes in the more developed countries include programmes for the control of congenital diseases (genetic counselling and premarital testing), mental health, health of the older population, oral health, chemical safety, emergency preparedness, blindness and deafness control.
15. Health promotion programmes in the countries are often delivered or coordinated within settings such as schools (school health), basic development needs and healthy communities (villages, cities, schools, nations).

To conclude this brief overview of health promotion in 16 countries of the Region, health promotion has made a good start and has become anchored within the health system. However, it now requires efforts to consolidate its programmes, legislate its recommendations and its very existence, and educate its human resources. In brief, health promotion needs to be an integral and important discipline of health and a vital component of its programmes.

Annex 1. Health promotion capacity profile (expanded version)

Note. The letters A–F stand for the following stages (see detailed explanation in footnote): A, fully implemented; B, partially implemented; C, actioned; D, under development; E, being considered; F, not currently actioned.

	Key requirements for effective health promotion	Stage of development for year 2003–2004					
		A	**B**	**C**	**D**	**E**	**F**
1.	**Policies and plans pertaining to health promotion**						
1.1	Are there available policies/legislations/regulations at the national, regional, provincial and/or local levels (availability of completed or draft documents is enough for verification) on the following:	☐	☐	☐	☐	☐	☐
	1.1.1 Promotion of healthy lifestyles, such as reduced consumption of tobacco products and fatty, sugary or salty food and increased physical activities	☐	☐	☐	☐	☐	☐
	1.1.2 Addressing socioeconomic determinants such as increased access to clean and safe environment, universal health services, universal education and employment opportunities	☐	☐	☐	☐	☐	☐
	1.1.3 Reduce consumption of illicit drugs and alcohol	☐	☐	☐	☐	☐	☐
	1.1.4 Road traffic injury prevention	☐	☐	☐	☐	☐	☐
	1.1.5 Reduce environmental risks	☐	☐	☐	☐	☐	☐
	1.1.6 Promote occupational health and safety						
	(Further additions/deletions could be made for the above list)						
1.2	Are there national plans of actions, strategies, guidelines or programmes on the following:						
	1.2.1 National tobacco control plans	☐	☐	☐	☐	☐	☐
	1.2.2 Mental health promotion plans	☐	☐	☐	☐	☐	☐
	1.2.3 National plans for a priority infectious disease *(an appropriate priority disease for each country will be named)*	☐	☐	☐	☐	☐	☐
	1.2.4 Settings-based health promotion, such as schools and workplaces	☐	☐	☐	☐	☐	☐
	1.2.5 National traffic injury prevention plans	☐	☐	☐	☐	☐	☐
	1.2.6 Rapid response plans for health crisis management						
	1.2.7 Information, education and communication/health education/social mobilization or related others						
	(Further additions/deletions could be made for the above list)						
1.3	Recent (within last 5 years) guidelines for staff members to plan, implement and evaluate health promotion activities	☐	☐	☐	☐	☐	☐
2.	**Core of expertise in health promotion**						
2.1	Does the country have an identifiable/designated "health promotion" unit/section/centre/department within the national ministry of health, or a group described differently but with similar functions which are explicitly stated?	☐	☐	☐	☐	☐	☐

	Key requirements for effective health promotion	Stage of development for year 2003–2004					
		A	**B**	**C**	**D**	**E**	**F**
2.2	If the answer to 2.1 above is no, does the country have a unit/section/department or a group described differently but which performs functions relating to health promotion?	☐	☐	☐	☐	☐	☐
2.3	Have local health promotion intervention studies been published in professional journals at the national, regional or international levels?	☐	☐	☐	☐	☐	☐
2.4	Have any national health promotion experts been recruited to provide technical support to other countries on a regular basis?	☐	☐	☐	☐	☐	☐
3.	**Collaborative mechanisms within government**						
3.1	Is there systematic coordination of health promotion activities within national/state or lower level public health programmes in the ministry of health?	☐	☐	☐	☐	☐	☐
3.2	Is there any evidence of collaboration between the public health sector and the curative service sector within the ministry of health for joint health promotion activities at the national and provincial levels?	☐	☐	☐	☐	☐	☐
3.3	Is there evidence of collaboration between ministries within the national government for coordinating joint health promotion activities at the national, provincial and local levels?	☐	☐	☐	☐	☐	☐
4.	**Programme delivery**						
4.1	Determine the presence of one or more nationwide structure/mechanisms branching out nationwide to regions for delivery of health promotion activities	☐	☐	☐	☐	☐	☐
4.2	Is there use of evidence-based health promotion planning, implementation and evaluation?	☐	☐	☐	☐	☐	☐
4.3	Establish whether there is use of combinations of intervention strategies in health promotion activities (intervention strategies include empowerment through health communication; development of environments that are supportive of health, e.g. policies and laws on food or tobacco; reorientation of services and advocacy for health)	☐	☐	☐	☐	☐	☐
5.	**Partnership among nongovernmental organizations, private sector and government**						
5.1	Determine whether there is collaboration between nongovernmental organizations/civil societies and national government for joint health promotion activities	☐	☐	☐	☐	☐	☐
5.2	Determine whether there is collaboration between private sector establishments and national government for joint health promotion activities	☐	☐	☐	☐	☐	☐
5.3	Determine whether there is collaboration between private sector establishments and nongovernmental organizations/civil societies for joint health promotion activities	☐	☐	☐	☐	☐	☐
6.	**Professional development**						
6.1	Does the government support (in cash and/or in kind) health promotion education and training at the undergraduate level?	☐	☐	☐	☐	☐	☐
6.2	Does government support (in cash and/or in kind) health promotion education and training and education at university and postgraduate levels?	☐	☐	☐	☐	☐	☐
6.3	Is there a national professional association for health promoters or one that caters for the interests of health promoters?	☐	☐	☐	☐	☐	☐
7.	**Information systems**						
7.1	Is there a mechanism to track and report on behavioural risk factors at the national or provincial levels?	☐	☐	☐	☐	☐	☐
7.2	Is there a mechanism to track and report on social and environmental risk factors at the national or provincial levels?	☐	☐	☐	☐	☐	☐

	Key requirements for effective health promotion	Stage of development for year 2003–2004					
		A	**B**	**C**	**D**	**E**	**F**
7.3	Is there a mechanism to track and report on health promotion activities at the national or provincial levels?	☐	☐	☐	☐	☐	☐
8.	**Health promotion financing**						
8.1	Does the country have a separate budget line for health promotion at the national or provincial/state government level?	☐	☐	☐	☐	☐	☐
8.2	Are there arrangements for funding of health promotion at the national or provincial/state government level from dedicated taxes or levies on tobacco, alcohol, gasoline, or other products and services?	☐	☐	☐	☐	☐	☐
8.3	Is there a separate budget line designated for health promotion at provincial, district levels?	☐	☐	☐	☐	☐	☐
		Government expenditure			**Aid organizations grants & loans**		
8.3a	Using the national health account if available, or any available estimate, indicate the percentage of the total (1) government expenditure, and (2) grants and loans from aid organizations spent on health promotion at the national level during the financial year 2003	%			%		
8.3b	What has been the trend of the (1) government expenditure on health promotion, and (2) grants and loans from aid organizations for health promotion since the financial year 2000?	☐ increased significantly ☐ increased slightly ☐ no change ☐ decreased slightly ☐ decreased significantly ☐ fluctuated			☐ increased significantly ☐ increased slightly ☐ no change ☐ decreased slightly ☐ decreased significantly ☐ fluctuated		

A: *Fully implemented*. This means that the activity is totally in place and working well for all the health promotion priorities at a national level. There should be evidence to demonstrate this.

B: *Partially implemented*. This means that the activity is partially in place and now in operation for some, or all, of the health promotion priorities at a national level. There should be evidence to demonstrate this.

C: *Actioned*. This means that work has started but that it is too early to assess impact or outputs.

D: *Under development*. This means that there has been a national commitment to implement the activity, and that work is under way to develop it.

E: *Being considered*. This means that the activity is being considered for implementation but no firm commitment has yet been given at a national level.

F: *Not currently actioned*. This means that the activity has either not been considered or has been rejected for implementation at this time.

Annex 2. Health promotion capacity profile

	Pakistan	Syrian Arab Republic	Bahrain	Jordan	Afghanistan	Yemen	United Arab Emirates	Occupied Palestinian territory	Morocco	Lebanon	Egypt	Islamic Republic of Iran	Libyan Arab Jamahiriya	Sudan	Oman	Saudi Arabia
1. Policies and plans pertaining to health promotion																
1.1. Availability of legislation on:																
1.1.1. Promoting healthy lifestyles, tobacco, fats, sugary, salty foods, physical activity	E	B	B	A	E	D	B	C	A	D	F	D	F	B	A	B
1.1.2. Addressing socioeconomic determinants, environment, universal health, education, employment	B	B	B	B	D	F	A	C	A	F	B	E	A	D	A	E
1.1.3. Reducing consumption of illicit drugs and alcohol	B	B	B	B	A	F	A	D		F	C	D	C	B	A	A
1.1.4.Road traffic injury prevention	B	B	B	B	E	C	A	D	A	D	B	E	D	D	A	C
1.1.5.Reducing environmental risks	B	B		A	E	F	A	D	A	E	B	B	D	E	A	C
1.1.6.Promoting occupational health and safety	B	B		C	E	C	B	D	A	E	B	D	C	E	C	C
1.2. Availability of national plans, strategies, guidelines, programmes on:																
1.2.1. Tobacco	B	B	B	A	E	C	C	D	A	B	F	C	F	B	A	A
1.2.2. Mental health	B	C		D	C	D	D	D	B	C	F	D	F	B	C	A
1.2.3. Priority infectious disease	F	B		A	B	B	A	D	A	B	B	B	B	A	A	A
1.2.4. Settings-based: schools, workplaces	B	C		A	D	F		C	A	B	B	B	B	B	A	A
1.2.5. Traffic injury	B	B		A	E	E	B	D		B	B	D	D	E	A	C
1.2.6. Health crisis management	F	B		B	C	D	A	C		B	A	D	D	B	C	B
1.2.7. Social mobilization	F				B	D		B		B	C	D		B	D	C
1.3. Guidelines to plan, implement and evaluate health promotion activities	B	F	B	C	C	E	D	E		F	F	B	F	A	C	B
2. Core of expertise in health promotion																

	Pakistan	Syrian Arab Republic	Bahrain	Jordan	Afghanistan	Yemen	United Arab Emirates	Occupied Palestinian territory	Morocco	Lebanon	Egypt	Islamic Republic of Iran	Libyan Arab Jamahiriya	Sudan	Oman	Saudi Arabia
2.1. Designated health promotion department or unit with health promotion functions within ministry of health		B	A	A	A	B	A	A		A	A	A	A	A	A	B
2.2. Designated health promotion department or unit with health promotion functions within the country											A					
2.3. Publications on health promotion intervention studies in journals	B	B	A	A	B	E	C	B		A		B	F	F	E	A
2.4. Health promotion experts recruited to support other countries on a regular basis	F	F	B	A		F	A			A		F	F	F	E	
3. Collaborative mechanisms within government																
3.1. Coordination of health promotion activities within ministry of health		B	A	A	B	E	A	A		B	C	B	F	B	A	B
3.2. Collaboration between the public health and curative sector within ministry of health for joint health promotion activities		B	**A**	A	B	F	B	B		B	B	C	D	E	B	B
3.3. Collaboration between ministries for joint health promotion activities		B	A	A	B	F	A	D		B	B	C	F	B	E	B
4. Programme delivery																
4.1.Presence of nationwide mechanisms for delivery of health promotion activities		A	B	A	B	B	B	E	A	B	B		F	E	E	C
4.2. Use of evidence-based health promotion planning, implementation and evaluation		C	C	B	B	E	C	C	A	F	B	C	F	D	E	E
4.3. Use of combinations of intervention strategies in health promotion through empowerment, communications, advocacy		B	C	A	D	E	C		B	B	A	D	F	B	E	E
5. Partnership among nongovernmental organizations, private sector and government																

	Pakistan	Syrian Arab Republic	Bahrain	Jordan	Afghanistan	Yemen	United Arab Emirates	Occupied Palestinian territory	Morocco	Lebanon	Egypt	Islamic Republic of Iran	Libyan Arab Jamahiriya	Sudan	Oman	Saudi Arabia
5.1. Collaboration with nongovernmental organizations for joint health promotion activities	A	B	A	A	A	F	A	A	A	B	F	D	F	B	E	C
5.2. Collaboration with private sector for joint health promotion activities	A	C	B	A	B	F	A	B	A	B	F	D	F	E	E	C
5.3. Collaboration between private sector and nongovernmental organizations for joint health promotion activities	A	B	B	A	B	F	A	C	A	B	F	E	F	E	E	C
6. Professional development																
6.1. Government support for health promotion education and training at the undergraduate level	F	A	E	B	C	E	B	F	A	F	E	D	E	E	A	B
6.2. Government support for health promotion education and training at university and graduate level	E	C	B	B	C	E	A	F	A	F	E	D	E	A	E	B
6.3. National professional association for health promotion to cater for the interest of health promoters	E	F	E	B	E	F	E	F	A	D	A	C	A	F	F	D
7. Information systems																
7.1. Mechanisms to report on behavioural risk factors	E	F	F	B	E	F	D	E	B	D	D	E	F	F	A	A
7.2. Mechanisms to report on social and environmental factors	F	C		C	E	F	C	E	B	F	C	E	A	F	F	B
7.3. Mechanisms to report on health promotional activities	F	C	B	A	E	F	A	D	A		B	C	F	E	F	C
8. Health promotion financing																
8.1. Separate budget for health promotion at the national level	B	A	F	E	E	B	B	F	A	B				F	F	F
8.2. Dedicated taxes or levies on tobacco, alcohol, gasoline, other products to fund health promotion activities	B	F	E	F	E	F	E	F	C	F	D	A	A	F	A	F
8.3. Separate budget line at provincial, district levels	F	B	F	F		F	E	F	A	F		B	A	F	F	F

	Pakistan	Syrian Arab Republic	Bahrain	Jordan	Afghanistan	Yemen	United Arab Emirates	Occupied Palestinian territory	Morocco	Lebanon	Egypt	Islamic Republic of Iran	Libyan Arab Jamahiriya	Sudan	Oman	Saudi Arabia
8.3a. Percentage of total government expenditures and donor grants spent on health promotion activities in 2003	B	B	E	D	A	B	E	B	C	D	C	B	D	B	F	D
8.3b. Trend of government expenditures and donor grants on health promotion activities since 2000	B	B		A	A	B	D	D	A			B	C	E	C	