

NATIONAL HEALTH PROMOTION CAPACITY MAPPING IN THE WESTERN PACIFIC REGION

- Final Report -

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ABBREVIATIONS

FCTC	Framework Convention on Tobacco Control
LTU SPH	La Trobe University School of Public Health
MOH	Ministry of Health
NCD	Non-communicable diseases
WHO	World Health Organization
WHO-HQ	WHO Headquarters in Geneva
WPRO	Western Pacific Regional Office of WHO

1. ABSTRACT

Background: The ‘triple burden of disease’ now evident in the Western Pacific Region (WPR) – ie the co-existence of significant rates of non-communicable, communicable and emerging infectious diseases¹, presents a contemporary challenge for public health systems to develop health promotion as a core public health function. Health promotion should be a key area of investment for countries to control disease, reduce injury and achieve better standards of population health, regardless of their prevailing population health profile (eg whether infectious diseases are currently prominent compared with non-communicable diseases). Building up health promotion infrastructure and capacities in countries will require baseline assessments to be made in order to understand existing conditions and priorities, to pinpoint where financial and technical support is most needed to enhance the system and to evaluate changes over time.

Aim: The aim of this project was to produce point-in-time assessments of national health promotion capacity (as defined by the data collection tools) for selected countries in the WPR.

Methodology: Eight-domain questionnaires (short and extended versions) were completed in relation to 17 selected countries in the WPR during June and July 2005. The questionnaires were designed by a WHO HQ-based project team. They were usually completed by a known focal point in ministries of health or in the office of the WHO Representative. Data was also gathered from documents and key informants in WPRO that would be needed for the analysis and interpretation of questionnaires. Completed questionnaires were translated by WHO-HQ staff into health promotion capacity ‘wheels’, diagrammatic representations of responses across all eight-domains, for each country and the WPR overall.

Findings: Although methodological limitations were noted in relation to questionnaire design and construction, the time available for data to be collected for country-level capacity assessments and lack of availability of data in some domains (especially health promotion financing), the project identified strengths and weaknesses in health promotion capacity across the WPR and associations between capacity and specific variables. Across the WPR, capacity varies from medium to high in most domains but appears to be lower in relation to professional development to build a skilled health promotion workforce and appropriate and stable financing. While higher income countries (which includes those with higher expenditure on health care, higher levels of development and life expectancy) generally have more capacity across each of the eight domains investigated, all countries have exemplars of strong or growing capacity. Policy and planning capacity and cross-sectoral coordination within government were notably well advanced in most countries across the Region.

Conclusion: This project provided new information about and useful perspectives on the health promotion capacity of 17 countries in the WPR. There is significant potential for further mapping exercises of this type to inform country and regional level policy and planning for health promotion capacity, although further refinement, piloting and application of the methodology will be required.

¹ Presentation made by Dr Andrew Kiyu in technical workshop at the 6th Global Health Promotion Conference, Bangkok, Thailand, 7-11 August 2005

2. INTRODUCTION

Much emphasis has been placed on generating an evidence base for health promotion interventions over the last decade. This effort is a response to the need for evidence to be available about 'what works' in specific contexts as a guide for policy and investment decisions. An area that has received comparatively less attention is evidence concerning different types of capacity that need to be in place for health promotion to be effective.

A global project to map national health promotion capacity was initiated by WHO to re-dress gaps in available information about what infrastructure and capacity exist in countries.^{2 3} Project results informed discussions at the 6th Global Conference on Health Promotion (7-11 August 2005, Bangkok, Thailand).

The capacity mapping task for the WPR was undertaken between June and July 2005. The project presented a significant opportunity to initiate discussions with countries about what infrastructure and capacities exist and are needed for health promotion and how they are being secured and financed, although the timeframe and methodological issues precluded a more definitive documentation of health promotion infrastructure and capacity. While a range of data is routinely collected from countries in specific aspects relevant to this project, and previous mapping exercises (eg using the National Non-communicable Disease Programmes Baseline Questionnaire⁴) have investigated capacity in relation to specific themes, this project investigated *underlying* health promotion capacity in terms of a *whole system*. For the first time in the WPR, countries became involved in this study to consider the stage of development of eight interdependent capacity domains that together comprise national capacity for health promotion.

² Catford J. (2005) The Bangkok Conference: steering countries to build national capacity for health promotion. Health Promotion International, Vol 20 No 1: pp1-6

³ Mittelmark, M et al (2005) Mapping National Capacity to Engage in Health Promotion: Overview of Issues and Approaches. Technical paper, 6th Global Conference on Health Promotion, August 2005, Bangkok, Thailand

⁴ WHO WPRO. National NCD Programmes Baseline Questionnaire. 2005

3. METHODOLOGY

Data collection was undertaken by a project team at La Trobe University School of Public Health (LTU SPH). Two questionnaires developed by WHO HQ – a short and an extended version – were used for data collection, and eight domains were investigated using the questionnaires:

- | | |
|----------|---|
| Domain 1 | National policies and plans |
| Domain 2 | Core of expertise |
| Domain 3 | Collaborative mechanisms within government |
| Domain 4 | Program delivery |
| Domain 5 | Partnership among NGOs/civil societies, private sector and government |
| Domain 6 | Professional development |
| Domain 7 | Information systems |
| Domain 8 | Health promotion financing |

The questionnaires were completed to form a profile for each country and were usually completed by a known focal point in the Ministry of Health (MOH), or in the office of the WHO Representative. See: **Appendix 1 for the questionnaires.**

The approach for data collection was developed in association with WHO Western Pacific Regional Office (WPRO) in Manila (Philippines) and took account of other regions' approaches. The basis for inviting countries in the Region to take part in the project was primarily to reflect regional diversity - in terms of the stages of economic development, population health status and geographical location - as well as preparedness by countries to participate.

LTU SPH researchers visited WHO WPRO during June 2005 to meet with relevant WHO staff (See: **Appendix 2 for list of key informants to the project**) to review and gather preliminary information and data that would be needed for analysis and interpretation of questionnaire data. Materials located included mission reports from WHO staff and consultants and various WHO and country reports and reviews, across a wide range of health issues for which health promotion was relevant.

The questionnaires were then sent to the contact person for each country who worked out the approach to be taken to completing the questionnaires, taking account of local factors (eg availability of a senior health promotion officer or organisational norms for responding to questionnaires from international or intergovernmental bodies). Approaches ranged from a single individual in a position of authority in the MOH

completing the questionnaire through to more collaborative approaches involving discussion and deliberation.

The questionnaires were designed by a project team based at WHO-HQ.⁵ No amendments were made to the questionnaire for the WPR process, although country participants were entitled to contribute additional data (such as on specific policy areas) they thought was relevant to presenting a picture of national capacity for health promotion.

Country respondents sent their completed questionnaires directly to the LTU SPH team. Telephone contact was made with some country representatives as required to clarify their responses. These were then sent to Dr Gregoire Mercier, working with WHO HQ, who translated the data into health promotion capacity 'wheels', the diagrammatic representation of the eight-domain questionnaire. Wheels were produced for each country and also the Region overall. (See: **Appendix 3 for the health promotion capacity wheels**)

The LTU SPH team then made further observations based on the wheels and the information gleaned from written materials and interviews with both WHO regional advisors and technical officers and country focal points/contacts.

Due to time and logistical constraints, cleaning the data and checking for validity and reliability were not undertaken for this first effort in mapping capacity. However countries were encouraged to note which staff were consulted or documents reviewed to enable the questionnaires to be completed to enable follow up.

4. PROJECT LIMITATIONS

A number of limitations of the project deserve mentioning as a contribution to ongoing refinement of the process and tools used for the project. These limitations were identified by country respondents, as well as WHO WPRO colleagues and the researchers. They also need to be borne in mind in interpreting the findings reported in this report.

4.1 Question construction

Country respondents and key informants frequently noted that the form of some questions is problematic in terms of their construction and framing, use of terminology and the assumptions underpinning them.

⁵ The project was led by Drs K. C. Tang, Desmond O'Byrne and Robert Beaglehole of the Department of Chronic Diseases and Health Promotion, WHO HQ.

Example (1) It is not possible for some respondents to provide a single score assessment for Q1.1, when the question refers to three policy areas that are likely to differ in their stage of development (tobacco, nutrition and physical activity). While a country might have legal restrictions about smoke-free environments, sale of tobacco and warnings on cigarette packets – ie a reasonably comprehensive approach to tobacco control – it might have very poor legislative measures associated with obesigenic environments or taxes on fat.⁶ Similarly, Q1.1.2 is presented as a compound question and was difficult to answer for a number of respondents: “legislation and legal measures aimed at promoting health by addressing socio-economic determinants such as increased access to clean and safe environment, universal health services, universal education and employment opportunities”.

Example (2) There is potential for confusion in relation to Q3.1 and Q3.2 in introducing terminology of ‘public health sector’, as this represents a shift in terminology from health promotion and could be interpreted as the publicly funded part of a health sector.⁷

Example (3) The framing of a number of questions is quite complex and made answering them difficult for some country respondents. For instance, Q4.3 asks for an assessment of the ‘use of combinations of intervention strategies in different settings across different age groups for delivery of HP activities (intervention strategies include empowerment, development of conducive environment, reorientation of services and advocacy for health).

Example (4) Some questions seem to be based on assumptions about infrastructure and capacity in countries. For instance, Q4.1 seems to assume that centralised planning and decentralised program delivery is needed for health promotion. This arrangement would be relevant to countries in which a hierarchical structure is in place designing and delivering *health education* programs, but the more complex structures required to plan, implement and evaluate *health promotion* programs might not involve ‘mechanisms branching out nationwide to regions for delivery of health promotion activities’ but network-like structures.

Example (5) There are some issues with correlating the short and expanded questionnaires. For example, Q7 in the short version refers to a ‘national research and evaluation resource’ while the expanded version implies more about surveillance.

4.2 Language and concepts

The terminology used in the questionnaires posed difficulties for some respondents. This is not a marginal matter of semantics or understanding of the English language

⁶ Written comments provided by country respondent for New Zealand. July 2005

⁷ Personal communication, Colin Sindall, Senior Adviser, Strategic Planning Branch, Population Health Division, Australian Department of Health and Ageing, 17 June 2005

but a real issue that has implications for assessing and boosting health promotion capacity. In some countries, the infrastructure underpinning activities of a health promotion nature is known as ‘public health’ infrastructure, leading to a need for clarification.

A frequent problem was that the term ‘health promotion’ was found to carry multiple meanings.

- In some countries, health promotion is equated with health education. As a consequence, responses by such countries to questions about ‘health promotion’ capacity will reflect this more limited understanding of what is required to improve population health: government focal points might have as their main responsibility the delivery of health education products and programs; the workforce will tend to be skilled in information/ communication/ education strategies (rather than advocacy for instance); where they exist, partnerships might be primarily engaged around product and program development and delivery (rather than healthy public policy for instance).
- In countries where health promotion is understood in terms of the Ottawa Charter for Health Promotion, different capacities are being, or will have been, developed, but often outside the health sector. At the same time, health promotion resources may be relatively limited within the health sector. In these circumstances, capacity profile may reflect general social and economic policy climate which may or may not be attributable to action by those identified as health promoters. In these circumstances, health promotion capacity may appear to be over-estimated.
- The concept of health promotion is used in some countries to refer to a particular stratum of health professionals. The point was made by one respondent that in her country, health promotion is regarded as a ‘sub-set’ of public health activity, and is therefore positioned as a low level, local activity that might involve workers such as health education officers.
- The concepts and practice of health promotion might be embedded in policy and plans but named using language more familiar to health bureaucrats than that set out in the Ottawa Charter (eg ‘supportive environments’). In such circumstances, health promotion capacity would be less visible leading to possible underestimation of health promotion capacity assessments.

The implication of this issue is how countries understand health promotion needs to be determined early in the process of capacity mapping to aid the interpretation of questionnaire responses.

4.3 Availability of and access to information

Availability of, and access to, accurate information about matters such as public sector arrangements and resources for health promotion was needed to complete the questionnaire. However, some information was not readily available or not collected, such as assessments of partnerships and collaborations. Access to information was a particular issue when answering questions that required knowledge about private sector engagement (Domain 5).

Also in some countries, health promotion is not organised in a way that specific components of infrastructure and capacity can be easily distinguished and quantified or evaluated. This was an issue when answering questions about workforce and also, in particular, for questions of financing (Domain 8). Health promotion is not typically ‘fenced off’ as a budget area in national accounts and to make appropriate assessments, of trends in expenditure on health promotion for instance, would entail considerable additional investigation. Specific activities (perhaps along the lines of the Australian public health expenditure assessment ⁸) would need to be pursued to locate this information.

Access to some types of information was also problematic for a number of country respondents. In general, access to information of this type is contingent on respondents having the authority and means to locate and use information. It is likely that where there was an existing focal point for health promotion (such as a director of health promotion in the MOH) information of the right type, amount and quality was easier to access in order to complete questionnaires. The diversity of questions (from policy to programs) meant that the best ‘stocktake’ of capacity would involve contributions from multiple officers in government. More often than not, however, questionnaires were completed by one or a small number of colleagues who sit in quite specific areas of government.

As well as countries experiencing problems with the availability of and access to information, remarks were also made by some key informants that there is further potential for health promotion to be a shared area of interest, activity and possibly collaboration across WPRO program areas (which are generally ‘vertical’ in their focus and specific to prevailing diseases – eg HIV/AIDS, emerging diseases – eg Avian Influenza, or topics – eg nutrition). Work with countries in capacity building for health promotion could be made more effective if linkages to consider infrastructure and capacity were also made within WHO WPRO.

4.4 Validation of data

⁸ Australian Institute of Health and Welfare. National Public Health Expenditure Report 2000-2001. Health and Welfare Expenditure Series No 18. AIHW: Canberra. June 2004

Cleaning of data and checking for validity and reliability were not undertaken due to time constraints. As with any project of this type, additional time to undertake further analysis and discussion would improve the quality of project outcomes.

4.5 Analysis

The relatively short timeframe for this project limited the extent to which:

- System performance and resilience could be understood. While infrastructure and capacity for health promotion were investigated, the dynamic relationship of these to the performance of a system and whether the system could remain capable of performing its functions over time were not explored
- Trade-offs between different dimensions could be investigated. For instance, where the level of government financing of health promotion was relatively low, resources for health promotion might be generated through partnerships between government and other types of organisations
- Analytical reports by country could be prepared
- Questions could be posed to countries to illuminate contextual issues and trends and boost the depth of analysis
- Databases that shed light on areas of health promotion capacity such as workforce (eg those prepared by UNICEF, World Bank, UNDP and other bodies) could be analysed for additional data and interpretations.

Further work on this project will require methodological refinement to ensure validity and reliability and additional key areas of analysis to be included. In-country discussions occurred on a limited basis in this project, but are likely to play a particularly useful role in improving accuracy of data collected as well as refining data analysis.

5. RESULTS

5.1 Respondents

Questionnaires were completed in relation to seventeen (17) countries. They were:

Australia	(Republic of) Korea	Philippines
Brunei Darussalam	Lao PDR	(Western) Samoa
China	Malaysia	Singapore
Cook Islands	Mongolia	Tonga
Fiji	New Zealand	Viet Nam.
Japan	Papua New Guinea	

5.2 Overview of results in eight health promotion capacity domains

Health promotion capacity wheels for each participating country are in **Appendix 3**.

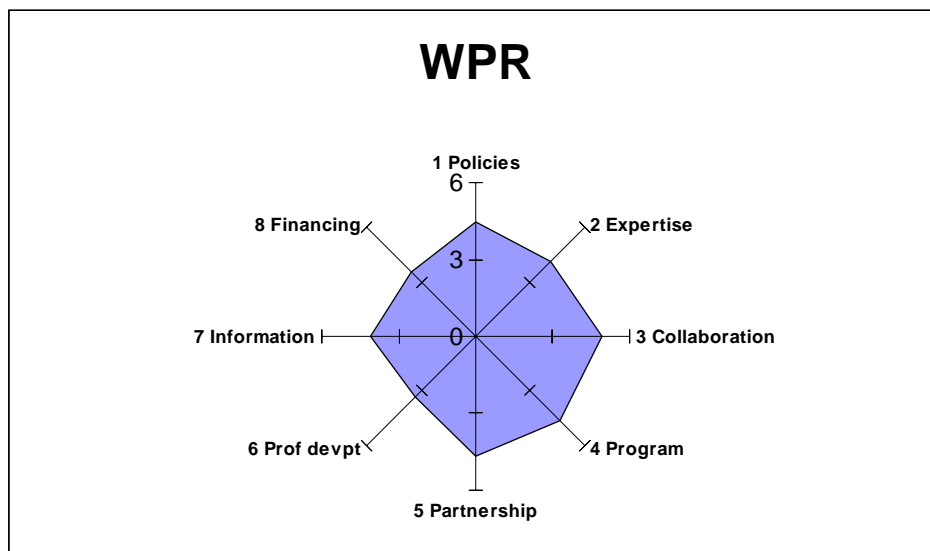
All items had a possible maximum score of 6. Given the small number of countries involved, and the possibility of distortion by outliers, the range for each item is presented as being more indicative of the WPR picture than the average score.

5.2.1 Analysis of overall scores by domain

“Making healthy choices easy, early, exciting and everywhere” is the principle that guides health promotion in the Western Pacific Region while the Regional Framework for Health Promotion 2002-2005⁹ sets out strategic directions for the promotion of health.

This section provides a perspective on capacity in the WPR as a whole and summarises the stage of achievement countries have reached in relation to each of the domains. Given the methodological issues plus the diversity across the region (in terms of the size of countries, the level of economic development, the nature of political systems, and the organisation and financing of health systems) it would not be possible to make more general conclusions about the region. Nonetheless, some summary observations are offered.

The capacity wheel for the WPR as a whole is as follows:



⁹ WHO Regional Office for the Western Pacific. Regional Framework for Health Promotion 2002-2005. WHO WPRO: Manila

Each capacity domain was present in eight countries. Overall, the results produced a remarkably balanced pattern of capacity in place in the WPR (as seen in the wheel) however it is likely that outliers (such as Republic of Korea on financing and Japan on professional development) distort the WPR picture. Thus, it would be inappropriate to draw conclusion about the region as a whole, and further analysis is required to work through these statistical patterns.

Stage of achievement: *Fully or partially implemented*

While no domains were fully implemented in the Region, some countries did score their capacity in some domains as fully implemented.

Stage of achievement: *Partially implemented or starting to be implemented*

The majority of domains in the WPR were partially implemented or starting to be implemented.

Domain:	WPR Average:	WPR Range:
National policies and plans	4.5	3.2-6.0
Core of expertise	4.1	2.7-6.0
Collaborative mechanisms within government	4.9	3.3-6.0
Program delivery	4.7	2.7-6
Partnerships among NGOs/civil societies, private sector and government	4.7	2.7-6.0
Information systems	4.1	1.0-6.0

Stage of achievement: *Already being put into action or under development*

Two domains were being put into action or were under development

Domain:	WPR Average:	WPR Range:
Professional development	3.3	1.0-6.0
Financing	3.6	1.0-6.0

Stage of achievement: *Being considered and starting to be developed*

From the WPR perspective, and based on data provided in this project, there were no domains which were still just starting to be developed.

In summary, no country in the WPR had all eight capacity domains assessed as at the highest stage of development, although the majority of domains have been partially implemented or are starting to be implemented.

5.2.2 Analysis of variation in domains across the WPR

Analysing responses on the basis of how much variation there is in the WPR for specific domains provides an indication of whether the region as a whole is developing specific health promotion capacities or whether development is contained to certain countries. Variation was calculated by subtracting the maximum WPR average score for a domain from the minimum WPR average score for the same domain.

Small differences were found in the following areas, indicating there are areas that most countries have been working on:

Domain:	Variation:
Policies and plans	2.8
Collaborative mechanisms within government	2.7

Large differences were found in the following areas, pointing to divergence in the amount of attention paid to these issues by countries:

Domain:	Variation:
Professional development	5.0
Information system	5.0
Health promotion financing	5.0

5.2.3 Analysis of domains

An analysis by country for each domain is useful for highlighting issues that result in cross-regional variation. Variations from country to country can illustrate where there has been an international push in certain fields but an uneven capacity to respond, indicating where further technical or financial support is required.

For example, many countries in the WPR have developed and implemented policies and plans for tobacco control as a result of process leading up to and then becoming signatories to the Framework Convention on Tobacco Control (FCTC)¹⁰; considerable effort has also been made to support countries to develop national nutrition plans of action. Progress in relation to these two issues is not even across the WPR however.

Variations can also indicate differences between countries in terms of their national priority setting strategies, epidemiological trends (prevalence of communicable

¹⁰ WHO (2003). WHO Framework Convention on Tobacco Control. Geneva: WHO; WHO WPRO (2000). Tobacco Free Initiative Regional Action Plan. 2005-2008. Manila: WHO WPRO

compared to non-communicable diseases for instance) or history of support by major donors to respond to particular health priorities.

Domain 1- Policies and plans

[Range: 3.2-6.0; WPR score: 4.5]

Respondents for all participating countries stated that they had legal and legislative measures aimed at promoting health and national plans for health promotion priorities. All countries were assessed as having actioned, partially implemented or fully implemented such policies.

Legislation:

Across the WPR, legislation has been developed to improve health by controlling access to products (eg tobacco, alcohol, drugs, defective products, high sugar beverages, infant formula), encouraging the use of services (eg preventive healthcare, screening), influencing behaviour (using seat belts and helmets; health and safety practices at work and school; breastfeeding) and increasing exposure to health protective factors (fluoride, clean and safe environments). WHO is exploring the use of legislation to prevent obesity¹¹ through changing environments. Legislation in the area of tobacco control is stronger than for many other issues, and this is likely to be related in part by increased population understanding of these issues along with the FCTC.

Legislation has been developed in some areas that are health-related (such as road safety, urban design or environmental pollution), possibly with little involvement from health promotion personnel. These have generally been developed in response to issues other than population health.

National policies and plans (policy statements, rules and regulations and guidelines):

A wide range of national policies and associated plans has been developed by countries in the WPR to guide action on improving population health and wellbeing. A number of these apply the Ottawa Charter for Health Promotion principles in framing multi-level and multi-strategy preventive and health promotion action to address issues.¹² Intersectoral cooperation has been central to formulation of a number of these policies and is also needed for successful implementation.

Country respondents and key informants reported that national policies, and associated plans, that have health promotion as their goal are increasingly being developed across the WPR, and to date have been formulated in relation to specific

¹¹ Eg WHO WPRO (2003). Using domestic law in the fight against obesity: An introductory guide for the Pacific. WHO Manila: WPRO.

¹² Eg Papua New Guinea Department of Health (2003). National policy on health promotion.

health topics including: nutrition¹³, tobacco control¹⁴, physical activity, alcohol control¹⁵, infant feeding, reproductive health, maternal and child health, road safety, mental health and HIV/AIDS. Areas such as mental health are less commonly a focus for health promotion.

In response to the limitations of vertical programs focussing on specific diseases or risk factors and the need to take account of contextual factors, integrated planning for health promotion is being encouraged in different ways.

- In line with the Western Pacific Regional Committee's resolution in 2000 on the prevention and control of NCDs¹⁶ and other related policy statements¹⁷ national NCD policies and plans are being developed by an increasing number of countries. The resolution calls for Member States to: adopt multi-sectoral public policies and legislation in the areas of eg tobacco control, food and agriculture, trade and promotion of physical activity in particular; set up coordination mechanisms for action; develop national strategies and capacity for planning, implementing, monitoring and evaluating community-based, integrated NCD prevention and control programs. NCD control policies and plans have been developed in several countries¹⁸ and programs have been implemented in countries including China, the Philippines, Tonga and Samoa.
- An area of strength in both developed and developing countries in the WPR is the preparation of national and sub-national policies and plans for health promoting settings. Such policies and plans require the identification of determinants of health associated with specific types of settings and engagement of parties with the ability to influence these determinants in favour of population health. Guidelines for the WPR have been produced in relation to elemental settings (schools, markets¹⁹, workplaces²⁰) and important contextual settings (cities, islands²¹, villages). Many countries have,

¹³ National Plans of Action on Nutrition are under development in countries across the WPR. See http://www.wpro.who.int/health_topics/nutrition/data.htm

¹⁴ Tobacco control activities have been catalysed by the WPRO Tobacco-Free Initiative and the FCTC

¹⁵ SPC/WHO First meeting on www.spc.org.nc/health/docs/Countryreports.doc; WHO (2004); Global status report. Alcohol policy. Geneva: WHO

¹⁶ WHO WPRO. Prevention and Control of Noncommunicable Diseases. Resolution WPR/RC51.R5. 22 September 2000. Available from www.wpro.who.int/rcm/en/archives/rc51/rc_resolutions/wpr_rc51_r05.htm. Accessed 2 July 2005

¹⁷ Eg Pacific Islands Countries' 'Call for Action' (for prevention and control of obesity), 2000; Pacific Health Ministers Meeting formulated Madang Commitment on a regional intervention on diabetes in Pacific Island countries, 2001; Western Pacific Declaration on Diabetes, 2000

¹⁸ Eg Fiji Ministry of Health. National NCD Strategic Plan 2004-2008; Samoa Ministry of Health. National NCD Strategy and Plan of Action 2004-2008 for the primary prevention of non-communicable diseases. Draft 27 February 2005

¹⁹ WHO WPRO (2004). Healthy marketplaces in the Western Pacific. Guiding future action. Manila: WHO WPRO

²⁰ WHO WPRO (1999). Healthy settings Document Series No 1.. Regional guidelines for the development of healthy workplaces. Manila: WHO WPRO

²¹ WHO WPRO. The vision of healthy islands for the 21st century. Regional implementation guidelines. Manila: WHO WPRO

in turn, produced national policies and plans for settings that have country significance.

At this stage, national policies and plans related to communicable diseases tend to be weak in terms of their use of health promotion as a strategy for prevention, despite the potential value of healthy settings approaches: such plans are, at this stage, more concerned with surveillance and how to respond to an outbreak.

Domain 2 - Core of expertise

[Range: 2.7-6.0; WPR score: 4.1]

All countries represented were assessed as having or developing a core of expertise in health promotion, though there was some variation in the stage of development of this domain.

Some countries bring together health promotion expertise in a multi-disciplinary committee structure to drive health promotion strategy, programs and capacity building (eg Brunei's National Committee on Health Promotion). Singapore has a governmental organisation, the Health Promotion Board²², that undertakes research and implements initiatives such as social marketing campaigns in a range of priority health areas (eg mental health, workplace health promotion, communicable diseases education, smoking control). Designated centres such as national centres for health promotion in Cambodia and Fiji and the National Health Promotion Branch in Papua New Guinea draw together expertise to undertake various roles including research, professional development and coordination of social marketing strategies. In other countries, expertise is more dispersed, reflecting the nature of the health system and of public administration. For example, Australia has a federalist system and health promotion expertise is distributed through state and territory governments, as well as NGOs, statutory authorities and public sector organisations at national, state and local levels. In China, health promotion responsibilities exist in several departments within the MOH (eg Department of Disease Control and Primary Health Care/Maternal and Child Health) as well as with the national Centre for Disease Control, the national Health Education Institute, and their provincial counterparts. In general, most countries appear to be moving to put suitable structures in place that have a policy development and coordination function and which are led by professionals with some training and experience in health promotion.

Skilled people are essential for effective planning, implementation and evaluation of health promotion programs. Across the WPR some obvious deficits were reported in the quantity and proportion of health personnel employed throughout the system who are trained to be health promotion specialists, and also other professionals who are

²² See <http://hpb.gov.sg>

trained to contribute to health promotion though it is not their primary role (eg nurses, teachers, youth workers, pharmacists). That health promotion skills and concepts should be integrated into all health worker training courses at all levels is appreciated in the region as an important way to build overall health promotion capacity.²³ The trend for enhancing the core of expertise appears to be in the right direction in the WPR.

The concepts of leadership and leadership development were not assessed in this project, yet leadership can play a catalysing role in making health promotion 'work' even in resource constrained environments. Six countries in the WPR participated in the pilot program of Prolead - a leadership development program in 2004/2005 (China, Fiji, Malaysia, Mongolia, Philippines, Tonga) and there will continue to be Regional participation in Prolead II (from Japan, Korea and Vietnam) and future programs.

Domain 3 - Collaborative mechanisms within government

[Range: 3.3-6.0; WPR score: 4.9]

All countries represented were assessed as having collaborative mechanisms within government (within and between ministries of health). All countries were assessed as having actioned, partially implemented or fully implemented such structures.

This domain scored highest out of all domains (Regional average was 4.9) and had a relatively narrow range. This is likely to be because it is central to the operation of government that collaborative mechanisms exist vertically (from local to provincial to national level) and horizontally (between public health sector and curative services sector and between ministries within the national government eg health, education, transport).

The Western Pacific Regional Committee's resolution in 2000 on the prevention and control of NCDs specifically called for multi-sectoral coordinating mechanisms to advocate regional, national and local commitment and action, so it is reasonable to assume that collaborative mechanisms within government will continue to form and strengthen in the WPR.

Domain 4 - Program delivery

[Range: 2.7-6.0; WPR score: 4.7]

All countries represented were assessed as having the means to deliver programs through an organised approach. All countries were assessed as having actioned, partially implemented or fully implemented this domain.

²³ Eg Papua New Guinea Department of Health (2003). National policy on health promotion.

A number of issues were raised by this question:

- Having particular mechanisms in place - 'branching out nationwide', does not necessarily indicate whether a country has the capacity (eg skills, knowledge, resources, linkages) to deliver programs
- While health promotion might operate through a vertical system in some countries, this is not the case for others, which might have programs operating horizontally across the health care system (from referral hospitals to community health services)
- Even with infrastructure in place (eg staff), implementation of policy innovations can still fail at the point of program delivery when there is not adequate capacity (eg skills, resources) to adapt to new approaches for health promotion
- Sustainability of program delivery is a key issue in contexts where donor support is critical for getting things done.

Domain 5 - Partnership among NGOs, private sector and government

[Range: 2.7-6.0]

All countries represented stated that they had partnerships operating between NGOs, private sector and government. All countries were assessed as having actioned, partially implemented or fully implemented this domain.

In the WPR, there is abundant evidence that many successful partnerships exist between NGOs, private sector and government in all countries and for many purposes. The notion of partnerships can be problematic²⁴ and their sustainability can be at risk on a number of fronts, however they are a common feature of health promotion programs in WPR countries. In addressing heart health or cancers for example, partnerships that form typically include government, businesses related to food and sports and NGOs that focus on risk factors (eg anti-smoking bodies) or health promotion strategies such as social marketing. The work of partnerships can be influential. For example, in the context of the Global Diet and Physical Activity Strategy, the Philippine Coalition for the Prevention of NCDs worked with the MOH to pressure fast food producers to reformulate menus and develop affordable, healthy and nutritious food options.²⁵

An important issue for health promotion capacity in countries is the nature of the NGOs that exist and the extent to which they mobilise civil society in efforts to influence health determinants. NGOs operate in all countries in the WPR, but they

²⁴ The literature suggests that not all working relationships between organizations are 'partnerships' and that 'partnerships' and 'collaborations' are different. Interpreting responses to this question needs to take this into account.

²⁵ WHO WPRO. (2004) The Work of WHO in the Western Pacific Region. WHO WPRO: Manila; MarketNewZealand.com Available from MarketNewZealand.com/mnz/News/Story/13572/12723.aspx. Accessed 10 July 2005

vary in ways that determine their role and influence: their health focus, primary mission, history, association with international NGOs, composition, engagement with civil society and independence in relation to government. Some involve citizens while others comprise professionals and operate as professional associations. Similar bodies to NGOs are set up by government and might be considered as quasi-governmental organisations (or GONGOs).

As well as taking stock of the type and number of partnerships, future health promotion capacity assessments could examine certain types of programs to assess whether they can only be in operation if partnerships are in place. For example, a WHO colleague noted in discussions that if a country has 'healthy settings' initiatives (especially contextual settings – cities, islands) they will *by definition* have cross-sectoral and cross-organisational structures in place and have mobilised support among a variety of partners.

Domain 6 - Professional development

[Range: 1.0-6.0]

There was significant variation across the WPR in the domain of professional development, with approximately one-third of countries having not currently actioned this domain or currently considering it.

Across the WPR, responsibilities and the means for funding, developing and delivering professional development vary, with education and training programs organised and delivered by professional associations (eg nursing), training institutes such as schools of public health (or their equivalent) or country ministries of health. In terms of assessing a country's health promotion capacity, the different approaches to providing undergraduate, postgraduate and continuing professional development programs could be explored further as they have important implications for who is trained, the numbers of people who can be trained, credentialing, possibilities for further education, the skillbase developed and its portability across settings.

To produce a skilled health promotion workforce through professional development initiatives requires substantial and ongoing investments by countries, linked to a long term strategy. Hence countries' stage of development in this domain may be associated with the nature of their tertiary education infrastructure for public health, their economic status and their relationship to donors that fund participation in professional development programs (such as AusAID). A number of countries take part in third-party funded schemes that enable their eligible workers to be trained in, for instance, masters of public health degrees and more specialised areas such as research. These have an important place in capacity building in countries, but the extent to which these activities are part of a clear long term strategy was not explored.

It was noted in some country-based discussions about major donor programs (such as in HIV/AIDS and emerging diseases) that there is potential for ongoing professional development in health promotion to be boosted, by negotiating the leverage of funds from a variety of sources such as donor grants.

Domain 7 - Information systems

[Range: 1.0-6.0]

Most respondents reported that countries had mechanisms for tracking and reporting risk factors and health promotion activities. In two countries this domain was not currently actioned or being considered.

In a number of countries, health promotion information systems are an infrastructure component of the public health system, providing data needed for planning, monitoring and evaluation. Depending on the information and data that are handled, information systems for public health can be important for health promotion (such as those that monitor social and environmental risk factors). Information systems in other sectors, such as social, economic, environment and infrastructure development sectors, are also useful for planning, monitoring and evaluation of programs although these need to be harmonised with information systems in health systems to be most useful.²⁶ It is not clear whether respondents took into account the information systems located in various ministries when answering questions in this domain, or those that are produced by offices of national social statistics. It is also not clear the extent to which information systems play a role in policy development and health promotion program evaluation.

Domain 8 - Health Promotion Financing

[Range: 1.0-6.0]

There was significant variation in the Region in relation to financing, with country results suggesting there is a continuum from not having actioned a system of financing for health promotion to having a fully implemented system. This domain appeared as one of the areas that has the potential to limit health promotion activity, with some countries (mainly developing countries) assessing their capacity as very low to low.

Questions concerning financing were not straightforward for most respondents to answer because of difficulties in accessing the necessary statistics. General impressions of trends were easier to identify than quantitative data about percentage of National Health Accounts being directed to health promotion. Difficulties in isolating money that is invested in health promotion were related to the incorporation

²⁶ Macfarlane SB (2005). Harmonising health information systems with information systems in other social and economic sectors. Bulletin of the World Health Organisation. Vol 83, No 8, pp561-640.

of health promotion into public health programs, such as in New Zealand. Analyses that have attempted to capture investments in health promotion in the context of wider public health programs, such as the Australian public health expenditure studies, demonstrate that quantifying health promotion investments can be feasible and provide useful information.

Some respondents noted that if they were to complete the questions in the financing domain as they appear, it would look as though no funds were directed to health promotion in a country even though significant sums might be invested annually. For most countries, their approach to financing health promotion does not include collecting dedicated taxes and there is not a separate budget line for health promotion.

In some countries, taxes on specified products (alcohol, tobacco, high sugar content beverages) provide financing for health promotion infrastructure and/or programs.²⁷ Korea [1995] and most recently Mongolia [2005] have enacted legislation at a national level for taxes to fund organisational structures to administer funds for health promotion. In Australia, legislation has been enacted at the sub-national level (state and territory) level to fund health promotion foundations.²⁸ There is a proposal in place for a health promotion foundation in Malaysia. In the Philippines, new 'sin taxes' will provide funding for disease prevention programs. These developments are likely to strengthen the funding of tobacco control programs, provision of infrastructure for health promotion, development of health promotion strategies for national, provincial and local levels of government and provision of advocacy for health promotion.

5.3 Correlations between country scores and specific indices

Relationships between country scores and specific indices were graphed to gain insight into the possible associations between health promotion capacity and specific factors.

5.3.1 Relationship between health promotion capacity and expenditure on health as a percentage of GDP

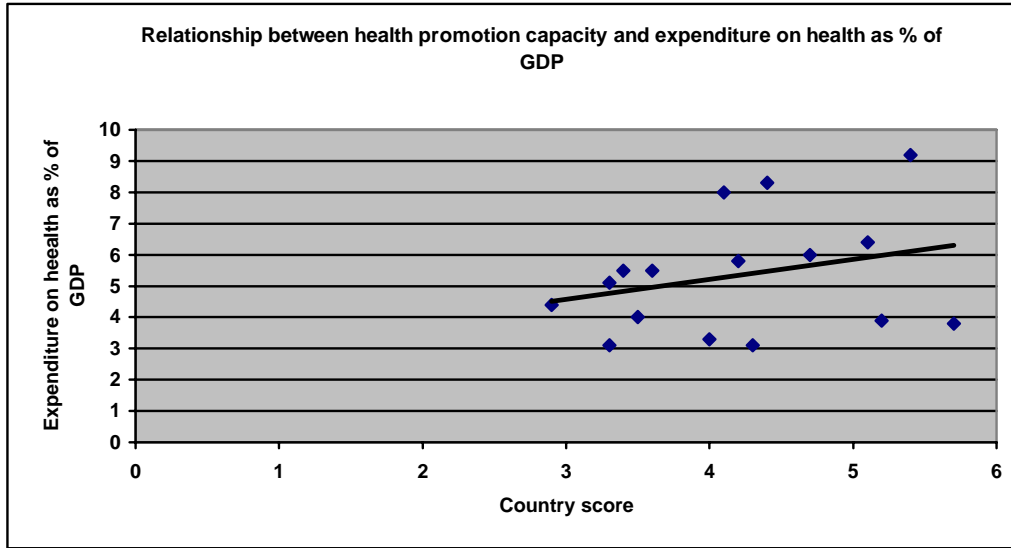
Health promotion capacity appears to increase slightly as expenditure on health²⁹ as a percentage of GDP increases³⁰, although that relationship is not very strong.

²⁷ WHO WPRO (2004). The establishment and use of dedicated taxes for health. Manila: WHO WPRO

²⁸ Since a 1997 ruling by the High Court of Australia that collecting tobacco taxes from states is unconstitutional, funding for health promotion foundations have been from consolidated revenue

²⁹ Health expenditure usually equates to expenditure on health and medical care including diagnostic investigations and pharmaceuticals.

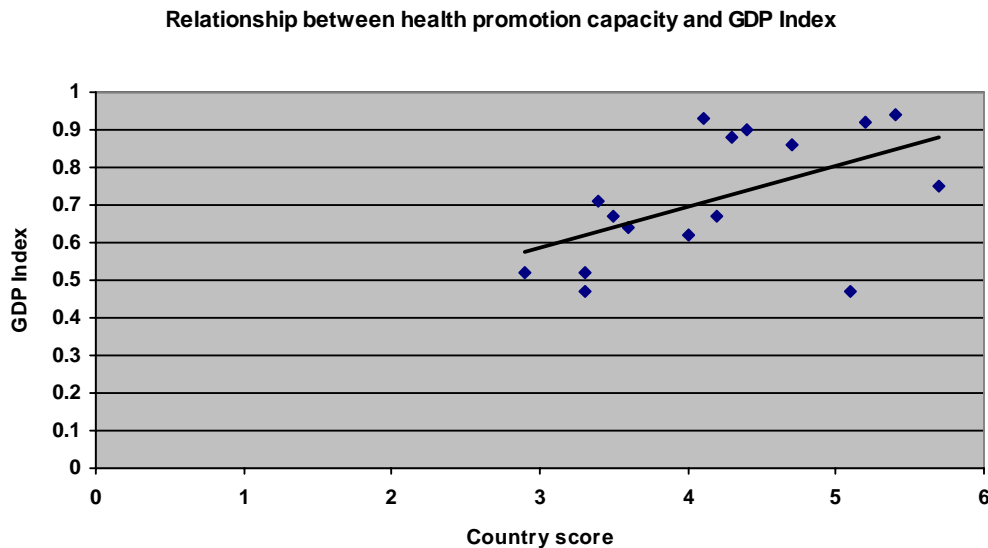
³⁰ WHO. World Health Report 2004. Geneva: WHO



It would appear that different approaches within the health sector to allocation and counting of health promotion funding may contribute to the lack of a strong relationship between health promotion capacity and health expenditure. The fact that health promotion capacity is measured across government and society, rather than be restricted to programs within the health sector, may also contribute to this finding.

5.3.2 Relationship between health promotion capacity and GDP

Health promotion capacity tends to increase with the GDP of a country (as indicated by the GDP Index ³¹).



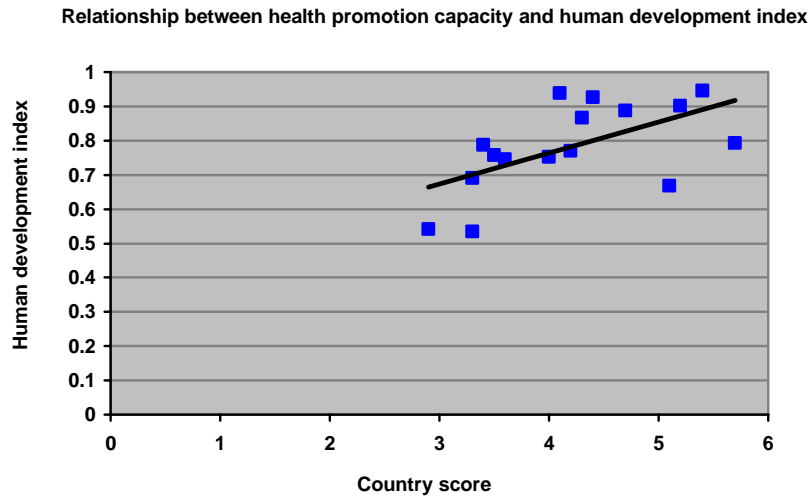
This trend is generally predictable: as GDP increases there is more potential for funds to be available to establish and sustain health promotion capacity. Bearing in mind

³¹ UNDP (2004). Human Development Report 2004. Cultural liberty in today's diverse world. Human Development Indicators, pp139-142 New York: UNDP

that health is promoted through the efforts of a variety of sectors (eg sectors concerned with education, environment, roads and transport, agriculture), health promotion capacity is likely to be higher as a result of more generalised capacity across sectors.

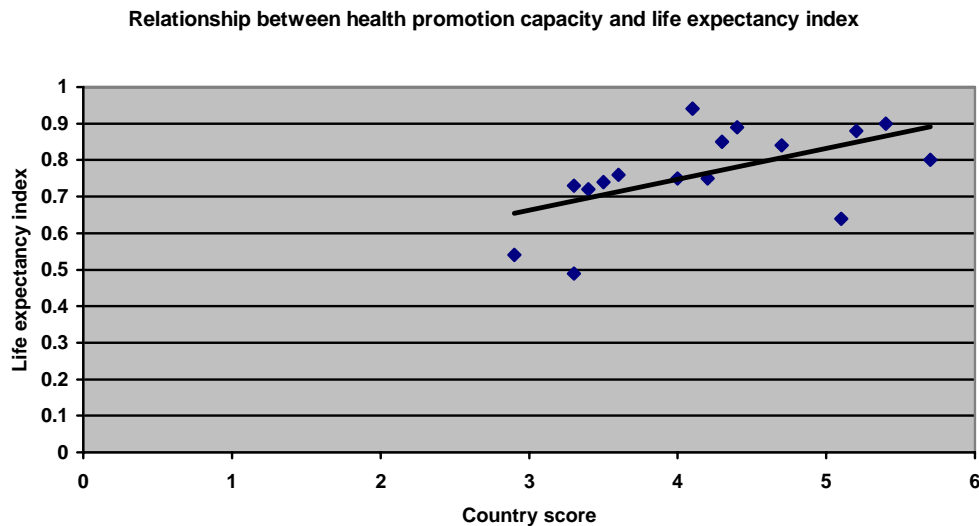
5.3.3 Relationship between health promotion capacity and human development

Health promotion capacity tends to be higher in countries with higher levels of development (as indicated by the Human Development Index ³²).



5.3.4 Relationship between health promotion capacity and life expectancy

Health promotion capacity tends to be higher in countries with higher life expectancy (as indicated by the Life Expectancy Index ³³).



³² ibid

³³ ibid

6. DISCUSSION

6.1 Project intent

The National Health Promotion Capacity Mapping project was generally viewed by colleagues in WPR countries as valuable. Country respondents appreciated the intent of the project and most welcomed the opportunity to look at national infrastructure for health promotion. The discussions and debates within countries prompted by the project were regarded, by those who offered comments about the process, as useful in initiating a focussed reflection on country infrastructure and capacity (rather than programs for example). Some concerns were expressed about the use of the project results beyond the conference deliberations. While the results are useful for provoking discussion, scientific interpretations of statistical information would be inappropriate because of methodological limitations and because the reliability and validity of data could not be confirmed.

6.2 Methodological issues

6.2.1 Data collection tools - Short and Expanded questionnaires:

Many colleagues offered comments about the data collection instrument. The intent of those who designed the instrument was generally recognised: to find a way of measuring and presenting information that would compel a policy response to strengthen key areas of capacity. However, as indicated in Section 4 of this report, it was frequently noted that some revisions of the questions could improve ease of completion, relevance to countries, comprehensiveness, reliability and validity of data.

Suggestions were made that would improve understanding of the country context for health promotion: for example, the questionnaire could begin with an invitation to country respondents to outline their current efforts in promoting health and preventing disease and injury, including the policy environment, organisational infrastructure and indicative programs.³⁴ This would then provide an opportunity for countries to state, for example, the relationship of health promotion to both the health care system and public health system, and ensure that capacities supporting health promotion that are considered part of public health (such as information systems) are captured. Some gaps in data resulted from the construction of questions, with both under-reporting and over-reporting of capacities likely.

³⁴ Personal communication, Colin Sindall, Senior Advisor, Strategic Planning Branch, Population Health Division, Australian Department of Health and Ageing, 17 June 2005

While health promotion ‘is happening’ in many countries, the questionnaire does not necessarily capture the type and extent of activity and the capacities associated with many of these activities. For example, work undertaken by ministries other than health (eg education, agriculture or industrial/labour relations) will require infrastructure and capacity that is unlikely to be accounted for in the questionnaire but which might make a substantial contribution to the infrastructure and capacity for health promotion *as a whole* in the country. Much capacity for health promotion is hidden. Further qualitative research is needed to explore these questions.

For some respondents, answering the questions required a shift in thinking from issues (such as nutrition, tobacco or occupational health and safety) and infrastructure and capacity associated with them to the infrastructure and capacity underpinning the *system as a whole*. This was a challenging task and one that some people identified as useful and necessary but difficult to do.

6.2 Interpreting the data and other observations

Interpreting the data must be undertaken with caution because of the methodological limitations.

While a snapshot of infrastructure and capacity was able to be gleaned from participating countries, the questionnaires do not provide for an assessment of some of the important contextual factors that would enrich our understanding such as the barriers and facilitators in countries to developing infrastructure and capacity. These are more complex issues requiring qualitative research but are important areas for assessment. Understanding what inhibits or facilitates the development of each of the capacity domains would add context and meaning to the data and boost potential cross-country learning. Three countries in the Region have reported elsewhere on their experience of capacity mapping, showing the value of looking beyond the ‘stocktake’ approach to case studies.³⁵

Explanations for patterns emerging from the data will depend on further analysis and discussion with countries. Some questions that might assist the development of more sophisticated explanations include:

- What relationship is there between level of economic development and stage of development of health promotion infrastructure, and what factors explain this relationship?
- What role does pre-existing public health infrastructure play in the development of health promotion infrastructure (eg information systems set up

³⁵ Brief case studies of capacity mapping Japan, Republic of Korea and Australia appear in Mittelmark et al (2005) Mapping National Capacity to Engage in Health Promotion: Overview of Issues and Approaches. Technical paper, 6th Global Conference on Health Promotion, August 2005, Bangkok, Thailand

to record mortality and morbidity incidence, training and education of professionals other than those in the health promotion workforce, cross-portfolio partnerships established for other public health activities)?

- What is the history of health promotion in the country concerned? For instance, what drivers brought about increases in health promotion infrastructure and programs (eg introduction of healthy settings initiatives such as Healthy Islands might have promoted increased collaborative mechanisms; responding to a population health crisis such as HIV/AIDS might have led to more extensive information systems being developed)?
- What relationship might there be between organisational and professional cultures associated with policy-making and the development of specific capacities (eg information systems)? If there is a prevailing culture that emphasises evidence-based policy-making, might that be associated with stronger investments in information systems?
- What associations might there be between health promotion infrastructure and capacity and the presence of schools of public health in countries? Countries in the WPR with academic profiles in public health (even if they don't have schools of public health *per se*) are indicated through the membership list of the Asia-Pacific Academic Consortium Schools of Public Health.³⁶ They are: Australia, China, Hong Kong, Japan, Republic of Korea, Lao PDR, Malaysia, Mongolia, Philippines, Singapore and Viet Nam.
- What relationships could there be between the preparedness and capacity of civil society to participate in health promotion programs and the overall national level of activity and impact of health promotion? Similarly, what relationships could there be between the preparedness and capacity of the private sector to finance and/or participate in health promotion programs and the overall national level of activity and impact of health promotion?
- A country whose health promotion capacity 'wheel' is 'perfectly balanced' and has fully and effectively implemented action in all eight domains has - in theory - an optimal policy focus within and outside of government and an optimal partnership focus within and outside of government that favour health promotion. To which extent does this situation 'guarantee' that population health will be at its highest standard possible? Are there any other factors likely to be at play in a country that might influence its capability to promote health?

The concept of relational issues between capacity domains is inherent in the project, reflected in the choice of a 'wheel' to diagrammatically represent country capacity for health promotion: if the wheel is balanced it will spin; if it is distorted in any

³⁶ Asia-Pacific Academic Consortium Schools of Public Health. Available at <http://www.apacph.org/member.asp>
Accessed 2 August 2005

direction/s, it will fail to spin. A broad set of questions arises from this. For example, what is the effect on levels of health promotion activity in a country if there are well-developed policies on non-communicable diseases but a weak workforce for allocation to NCD health promotion programs? What level of financing – and which sources of financing – would support an effective health promotion infrastructure? What trade-offs exist between domains for example the value of well developed partnerships in a resource-constrained environment?

7. CONCLUSIONS AND NEXT STEPS

7.1 Conclusions

7.1.1 Importance of capacity building in the WPR

In the decade since the 4th Global Conference on Health Promotion held in Jakarta, strong policy frameworks for health promotion plus technical support have been in place across the WPR, healthy settings and capacity building have been firmly established as central to the regional health promotion agenda. High level support for health promotion has been mobilised across most countries.

As a consequence, healthy settings and capacity building have been invested in by countries and have generated practical results; achievements in the WPR in terms of health promotion policies, plans and national and local programs can be associated with these efforts. For example, healthy cities and islands have been consolidating in a number of countries over the last decade, demonstrated by the formation of the regional Alliance for Healthy Cities. Health promoting settings (eg schools, marketplaces, hospitals, workplaces) are expanding and have shown how concepts can be adapted to country contexts and brought to life by local health systems, communities and settings. Partnerships that involve different sectors and professional disciplines have prospered through projects at national and sub-national levels. Inter-regional activities that have health as their focus have been spawned through the actions of ASEAN and other inter-governmental agencies. All of these initiatives have required a practical approach and the availability of health promotion capacity.

7.1.2 Regional strengths and weaknesses

The project has identified that there are strengths and weaknesses in health promotion capacity across the WPR. While higher income countries generally have more capacity across each of the eight domains investigated, all countries have exemplars of strong capacity and how this can be achieved.

The major strengths in the region, suggested by the data, were in legislation, policies and plans; collaborative mechanisms within the health portfolio and between health

and other government sectors; program delivery; and partnerships among NGOs, private sector and government. Some discussions indicated that while some good information systems existed in countries, how well they were used for health promotion was a matter for further consideration.

The major weaknesses, suggested by the data, are in professional development and financing. This conclusion needs considerably more analysis as it was common that countries found it difficult to locate or interpret this information from existing national and other accounting systems.

Overall the project signalled the need for investment in capacity related to all domains, but particularly professional development to build a skilled health promotion workforce and appropriate and stable financing. These are important 'performance-limiting' factors that if under-developed, can undermine the application of good capacity in other domains.

Across the WPR, in lower income countries and transitional economies as well as high income countries, good examples can be located of policy, legislation, workforce capacity and professional development, program delivery, collaborative mechanisms within the health portfolio and between health and other sectors, information systems and financing. These specific examples are important to identify so that existing experience and accomplishments can be shared and built on in the future.

This project represents a point-in-time assessment of national health promotion capacity as defined by the data collection tools. It does not indicate trends in either direction (except for financing) or security of existing infrastructure and capacity. These are also important issues to examine.

7.1.3 The need for health promotion capacity building in the region

It is clear from the data that higher investment in health promotion is a key area for attention in all countries in the region, in order to ensure that existing activities can be scaled up and their effects expanded and become sustainable. Furthermore, increased financing is required so that new initiatives can be generated, to meet the diverse health challenges which exist for each country, whether infectious diseases are currently prominent compared with non-communicable diseases. Although health promotion activities are generally well identified with promoting optimal health and wellbeing and preventing non-communicable diseases and conditions such as cardiovascular diseases and some cancers, it should also be regarded as an essential public health function and also relevant to the control of communicable diseases and emerging infectious diseases such as EV 71, SARS and avian influenza. Health promotion capacity – at the level of governments, communities and key partners –

needs to be built as a matter of urgency with the support of citizens, governments, donors and the business sector.

7.1.4 Prospects for future health promotion capacity mapping exercises

As indicated, the intent of the project was generally appreciated and valued by respondents. A number of country respondents and key informants expressed the view that it would be valuable if:

- The current project could be completed with further checking/cleaning of existing data, further validation of data by countries and more robust collection of data where needed
- The results were formally fed back to countries for in-country use
- In-country discussions were integral to future mapping because of their value in contextualising data and encouraging participation
- Regional capacity building strategies be worked on by WHO in association with countries (and perhaps bodies such as ASEAN)
- Country contextual information could be prepared to give depth and meaning to the questionnaire responses.

A number of respondents, having completed the questionnaire, and despite the limitations of the tool, remarked that the exercise would be useful as a more regular activity, with potential for it to drive policy reforms in countries and across the Western Pacific Region.

7.2 Next steps

The project has drawn attention to the need for national health promotion capacity to be developed in all countries so that effective responses can be made to the ‘triple burden of disease’. In particular, the health promotion capacity of health systems needs to be strengthened to bring about leadership and substantive programs in analysis, advocacy and action for improving population health and preventing disease in countries.

In order for this mapping exercise to be useful, an expanded project is required to provide information and stimulate debate about further capacity building priorities and mechanisms in countries. This mapping project should be based on a revision and piloting of project methodology, including the design of data collection tools, so that data quality and usefulness is enhanced. An expanded range of WPR countries should be engaged in piloting this revised methodology and mapping capacity to enable a richer analysis of capacity and mobilisation of interest and support for building capacity across the WPR. Applying this methodology in countries would benefit from engaging a suitable cross-section of senior officers in an interactive process that

builds consensus about responses to questions, and in itself contributes to capacity building.

Appendices

Appendix 1 WHO National Health Promotion Capacity Questionnaires:

Short Version

Expanded Version

Appendix 2 - Health Promotion Capacity Profile (Short version) (Revised draft)

The letters A-E in the column on right stand for the following stages.

A - fully implemented, B - partially implemented, C - Actioned, D - Underdevelopment, E - being considered, F - Not currently actioned

	Key requirements for effective health promotion at national level	Stage achieved during year 200__					
		A	B	C	D	E	F
1.	Policies and plans						
	National government policies and/or plans for health promotion priorities, which embrace the following action areas: develop healthy public policies, create supportive environment, re-orient health system, strengthen community action and develop personal skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Core of expertise						
	Core of expertise within the national and provincial Ministry of Health for health promotion development and coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Collaborative mechanisms within government						
	Partnering mechanism(s) (e.g. inter-divisional and/or inter-departmental and/or inter-ministerial committees) within the national government for policy development and plan implementation for health promotion priorities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Program delivery						
	Delivery structures and mechanisms for integrated health promotion nation wide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Partnership among NGOs/civil societies, private sector and government						
	Formal mechanisms for multi-sectoral actions among NGOs/civil societies, private sector and government for health promotion priorities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Professional development						
	Advanced education and training for health promotion at the national and provincial levels, and a professional association for practitioners of health promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Information systems						
	A national research and evaluation resource with capacity to track and report on health information relevant to health promotion and/or on health promotion activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Health promotion financing						
	Sustainable sources of public financing for health promotion priorities at national and provincial levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 3 - Health Promotion Capacity Profile (Expanded version)

The letters A-F in the column on right stand for the following stages (see the detailed explanation on page 3)
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
4.	Policies and plans						
1.1	Legal and legislative measures aimed at promoting health in the following areas						
1.1.1	Promote healthy lifestyles such as reduced consumption of tobacco products and fatty, sugary or salty food and increased physical activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.2	Address socio-economic determinants such as increased access to clean and safe environment, universal health services, universal education and employment opportunities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.3	Reduce consumption of alcohol among teenagers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.4	Reduce environmental risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.5	Reduce sexual and reproductive health risky behaviours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.1.6	Promote occupational health and safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>(Further additions/deletions could be made for the above list).</i>						
1.2	National plans (e.g. policy statements, rules and regulations & guidelines) on						
1.2.1	National tobacco control plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.2	Mental health promotion plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.3	National plans for a priority infectious disease <i>(an appropriate priority disease for each country will be named)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.4	Settings based HP such as schools and workplaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.5	National traffic injury prevention plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2.6	Rapid response plans for health crisis management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>(Further additions/deletions could be made for the above list).</i>						
1.3	Recent (within last 5 years) guidelines for staff members to plan, implement and evaluate HP activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Core of expertise						
2.1	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.2	Local HP intervention studies have been published in professional journals at the national, regional or international levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.3	Many national HP experts have been recruited to provide technical support to other countries on a regular basis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Collaborative mechanisms within government						

	Key requirements for effective health promotion	Stage of development for year 2003-2004					
		A	B	C	D	E	F
3.1	Evidence of collaboration within the public health sector within the Ministry of Health for coordinating joint HP activities at the national and provincial levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.2	Evidence of collaboration between the public health sector and curative service sector within the Ministry of Health for joint HP activities at the national and provincial levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.3	Evidence of collaboration between ministries within the national government for coordinating joint HP activities at the national and provincial levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Program delivery						
4.1	One or more mechanisms branching out nation wide to regions for delivery of health promotion activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.2	Staff are required by their supervisor to give priority to adopt evidence based health promotion in their day to day practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.3	Use of combinations of intervention strategies in different settings across different age groups for delivery of HP activities (intervention strategies include empowerment, development of conducive environment, reorientation of services and advocacy for health)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Partnership among NGOs, private sector and government						
5.1	Evidence of collaboration between NGOs/civil societies and national government for joint HP activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.2	Evidence of collaboration between private sector establishments and national government for joint HP activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3	Evidence of collaboration between private sector establishments and NGOs/civil societies for joint HP activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Professional development						
6.1	Government support in cash and/or in kind for HP education and training at the undergraduate level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.2	Government support in cash and/or in kind for HP education and training at the postgraduate level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.3	A national professional association for health promoters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Information systems						
7.1	One or more mechanisms to track and report on behavioral risk factors at the national or provincial level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.2	One or more mechanisms to track and report on social and environmental risk factors at the national or provincial level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Key requirements for effective health promotion	Stage of development for year 2003-2004					
		A	B	C	D	E	F
7.3	One or more mechanisms to track and report on health promotion activities at the national or provincial level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Health promotion financing						
8.1	A separate budget line for Health Promotion at the national or provincial government level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.2	Funding for Health Promotion at the national or provincial government level from dedicated taxes or levies on tobacco, alcohol, gasoline, or other products and services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Government expenditure			Aid organizations grants & loans		
8.3a	Using National Health Account if available or based on your best estimate, 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	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	<input type="checkbox"/> increased significantly <input type="checkbox"/> increased slightly <input type="checkbox"/> no change <input type="checkbox"/> decreased slightly <input type="checkbox"/> decreased significantly <input type="checkbox"/> fluctuated			<input type="checkbox"/> increased significantly <input type="checkbox"/> increased slightly <input type="checkbox"/> no change <input type="checkbox"/> decreased slightly <input type="checkbox"/> decreased significantly <input type="checkbox"/> fluctuated		

Scale

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.

Appendix 2 Key informants to the project from WHO WPRO

Key Informant	Position
Linda Milan	Director, Building Healthy Communities and Populations
Dato' Dr Ah Sian Tee	Director, Combating Communicable Diseases
Dong Il Ahn	Regional Advisor in Stop TB and Leprosy Elimination
Dorjsuren Bayarsaikhan	Regional Advisor, Health Care Financing
Tommaso Cavelli-Sforza	Regional Advisor, Nutrition and Food Safety
Yok Ching Chong	Regional Advisor, Health Information
Bernard Fabre-Teste	Regional Advisor, Sexually Transmitted Infections including HIV/AIDs
Ezekiel Nukuro	Regional Advisor, Human resources development
Hisashi Ogawa	Regional Advisor, Healthy settings and Environment
Hitoshi Oshitani	Regional Advisor, Communicable disease surveillance and response
Kevin Palmer	Regional Advisor, Malaria Vector borne and other Parasitic Diseases
Ruyan Pang	Regional Advisor, Reproductive health
Ponnudurai Doraisingam	(Acting) Regional Advisor, Health Promotion
Jonathan Santos	Technical Officer, Tobacco Free Initiative
Xiangdong Wang	Regional Advisor, Mental health and substance abuse

**Appendix 3 Health promotion capacity wheels for the Western Pacific
Region**