<table>
<thead>
<tr>
<th>Title</th>
<th>Health promotion capacity mapping in low and middle income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Mahmood, Samir</td>
</tr>
<tr>
<td>Publication Date</td>
<td>2015-04-28</td>
</tr>
<tr>
<td>Item record</td>
<td><a href="http://hdl.handle.net/10379/5053">http://hdl.handle.net/10379/5053</a></td>
</tr>
</tbody>
</table>
Health Promotion Capacity Mapping in Low and Middle Income Countries

Thesis submitted for the Degree of Doctor of Philosophy

Samir Mahmood MBBS, MA

Supervised by Professor Margaret Barry

Discipline of Health Promotion

School of Health Sciences

National University of Ireland Galway

Submitted September 2014
# TABLE OF CONTENTS

- LIST OF FIGURES ............................................................................................................................... iv
- LIST OF TABLES ................................................................................................................................. v
- LIST OF APPENDICES ....................................................................................................................... vii
- LIST OF ABBREVIATIONS .................................................................................................................. viii
- ACKNOWLEDGEMENTS ...................................................................................................................... ix
- DEDICATION ....................................................................................................................................... x
- ABSTRACT .......................................................................................................................................... xi

1. Introduction ........................................................................................................................................ 1

2. Literature Review ............................................................................................................................... 8
   - 2.1 Background of the Study ........................................................................................................ 8
   - 2.2 Health Promotion Capacity Development and Mapping ................................................... 9
   - 2.3 Health Promotion capacity developments in LMICs ....................................................... 16
   - 2.4 Review of Capacity Mapping Frameworks and Tools ..................................................... 22
   - 2.5 Search Strategy and Analysis method .............................................................................. 25
     - 2.5.1 Objective 1: Development of a matrix of capacity domains ................................... 27
     - 2.5.2 Objective 2: Review of existing capacity mapping frameworks .......................... 28
   - 2.6 Discussion .......................................................................................................................... 52
   - 2.7 Conclusion: Health promotion capacity mapping framework for LMICs ....................... 57

3. Research Methodology ....................................................................................................................... 60
   - 3.1 Overall Study Design ....................................................................................................... 61
   - 3.2 Phase I: Delphi Consultation ............................................................................................ 63
     - 3.2.1 Sample .................................................................................................................... 64
     - 3.2.2 Response rates and Participants’ Profiles .................................................................. 66
     - 3.2.3 Online Questionnaire ............................................................................................ 70
     - 3.2.4 Procedure ............................................................................................................... 72
     - 3.2.5 Analysis .................................................................................................................. 73
   - 3.3 Phase II: Case Study ........................................................................................................ 75
     - 3.3.1 Case Study Design ................................................................................................. 75
     - 3.3.2 Selection of the Case ............................................................................................... 76
     - 3.3.3 Key Informants ........................................................................................................ 80
     - 3.3.4 Response rates and Participants’ Profiles ............................................................... 83
     - 3.3.5 Data Collection ...................................................................................................... 85

4. Phase I: Conceptual Framework and Tool ....................................................................................... 96
   - 4.1 Pilot .................................................................................................................................. 96
     - 4.1.1 Pilot study findings and analysis .............................................................................. 97
     - 4.1.2 Conclusion ............................................................................................................... 99
   - 4.2 Round 1 .......................................................................................................................... 100
     - 4.2.1 Data analysis ......................................................................................................... 100
<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Stages of capacity mapping tool design and implementation</td>
</tr>
<tr>
<td>2.2</td>
<td>Dimensions and components of the NSW Capacity Mapping Framework</td>
</tr>
<tr>
<td>2.3</td>
<td>National Health Promotion Capacity Wheel</td>
</tr>
<tr>
<td>2.4</td>
<td>Health promotion capacity mapping domains model</td>
</tr>
<tr>
<td>2.5</td>
<td>A three part tool design for national capacity mapping in the WHO WPR. Adapted from (Lin &amp; Fawkes, 2007)</td>
</tr>
<tr>
<td>2.6</td>
<td>Mapping contextual data (socio economic status and health insurance) adapted from the WHO (Nam et al., 2006)</td>
</tr>
<tr>
<td>2.7</td>
<td>Health Promotion Capacity and level of development adapted from (WHO SEARO, 2005)</td>
</tr>
<tr>
<td>2.8</td>
<td>The elements of health promotion capacity adapted from (S. McLean, Green, Moore, &amp; Williams, 2004)</td>
</tr>
<tr>
<td>2.9</td>
<td>Capacity mapping framework for LMICs</td>
</tr>
<tr>
<td>3.1</td>
<td>Study Design</td>
</tr>
<tr>
<td>3.2</td>
<td>Response Rates Round 1</td>
</tr>
<tr>
<td>3.3</td>
<td>Snapshot from the Round 1 questionnaire</td>
</tr>
<tr>
<td>3.4</td>
<td>Participants’ profile in the case study</td>
</tr>
<tr>
<td>4.1</td>
<td>Health Promotion Capacity Mapping Framework after Round 1 Analysis</td>
</tr>
<tr>
<td>4.2</td>
<td>Health Promotion Capacity Mapping Framework</td>
</tr>
<tr>
<td>5.1</td>
<td>Thailand and surrounding countries (Google Maps, 2013)</td>
</tr>
<tr>
<td>5.2</td>
<td>Population Pyramid Thailand 2010 adapted from (UN, 2012)</td>
</tr>
<tr>
<td>5.3</td>
<td>Health Promotion Networks in Thailand (Adapted from Buasai, Kanchanachitra, and Siwaraksa (2007))</td>
</tr>
<tr>
<td>5.4</td>
<td>Triangle that moves the mountain adapted from (Thai Health, 2009)</td>
</tr>
<tr>
<td>5.5</td>
<td>Agencies / Sectors partnering most frequently with others (Values have been rounded to the nearest decimal place and may not sum to 100%)</td>
</tr>
<tr>
<td>5.6</td>
<td>Agencies / Sectors partnering least frequently with others (Values have been rounded to the nearest decimal place and may not sum to 100%)</td>
</tr>
<tr>
<td>5.7</td>
<td>Percentage of participants who rated Policies &amp; Programmes as fully or partially implemented</td>
</tr>
<tr>
<td>5.8</td>
<td>Dedicated sources of funding for health promotion activities in Thailand (n=14)</td>
</tr>
<tr>
<td>7.1</td>
<td>Stages of the process of capacity mapping for LMICs</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 2.1 Definitions of capacity and capacity building................................................................. 11
Table 2.2 Evolution of concepts of health promotion capacity ........................................................... 12
Table 2.3 Definitions of ‘capacity’ and ‘capacity development’ in the development sector .......................................................................................................................... 20
Table 2.4 Health Promotion Capacity Mapping frameworks and tools reviewed ................................................................................................................................... 29
Table 3.1 Participants’ Profile................................................................................................................. 69
Table 3.2 Questionnaires developed in Phase I .................................................................................. 70
Table 3.3 Timeline of data collection Phase I ..................................................................................... 73
Table 3.4 Criteria for selection of LMIC ............................................................................................. 78
Table 3.5 List of Medium and Low Human Development Countries after applying the inclusion and exclusion criteria ................................................................................................. 79
Table 3.6 List of countries for final selection for Case Study submitted to the GRC .............................................................................................................................. 80
Table 3.7 Participants profile for Phase II interviews ......................................................................... 83
Table 3.8 Discussion Group Participants’ Profile ............................................................................... 84
Table 3.9 Interview Guide for Key Informant Interviews .................................................................. 88
Table 3.10 Types of questions used in the Case Study questionnaire .............................................. 89
Table 3.11 Timeline of data collection Phase II ................................................................................ 91
Table 3.12 Matrix sent to the key informants for the Telephone/ Skype interviews ................................................................................................................................... 92
Table 4.1 Changes made to the Mapping Framework in the Pilot Round ........................................ 99
Table 4.2 Delphi Study Round 1 ratings for suitability of inclusion of the health promotion capacity mapping domains and sub-domains .................................................................................. 101
Table 4.3 Percentage agreement levels on the proposed health promotion capacity domains in Round 1 of the Delphi consultation ................................................................. 102
Table 4.4 Number of questions under each capacity domain and sub-domains in Round 2 Questionnaire .................................................................................................................................. 117
Table 4.5 Quantitative Analysis of Round 2 Questionnaire ............................................................. 119
Table 5.1 Health promotion development milestones Thailand timeline ........................................ 144
Table 5.2 Matrix of themes for interview participants Phase II .......................................................... 164
Table 5.3 Internal consistency between rating scale questions ........................................ 189
Table 5.4 Response to the multiple-choice question on Institutional Capacity .......... 190
Table 5.5 Institutional Capacity for health promotion in Thailand (n=15) ....................... 191
Table 5.6 Health promotion leadership effectiveness in Thailand (n=14) ....................... 194
Table 5.7 Accountability for health promotion in Thailand ............................................ 197
Table 5.8 Transparency and accountability for health promotion in Thailand ............... 198
Table 5.9 Health promotion inclusion status in Thailand’s policies* (n=14), % ................................................................. 199
Table 5.10 Policymaking for health promotion in Thailand (n=14) ............................... 199
Table 5.11 Policy coherence for health promotion in Thailand (n=13) .......................... 202
Table 5.12 Health promotion delivery mechanisms in Thailand (n=14) ......................... 203
Table 5.13 Participants’ familiarity with the 5 action areas of Ottawa Charter............................. 204
Table 5.14 Health promotion Training and Education in Thailand * (n=15), % ....................................................................................................................................... 205
Table 5.15 Mean importance score for health promotion training and education for target audiences ........................................................................................................ 206
Table 5.16 Sustainable Financing for health promotion in Thailand (n=14) .................. 209
Table 5.17 Knowledge development and management for health promotion in Thailand (n=14) ........................................................................................................... 211
Table 5.18 Health promotion development landmarks in Thailand* (n=13), % ....................................................................................................................................... 212
Table 5.19 Assets of Thailand in health promotion capacity development .................... 212
Table 6.1 Summary of changes to mapping framework in Phase I ................................. 229
Table 6.2 Summary of findings of the Case Study on the basis of strengths and weaknesses in Thai health system to promote health promotion capacity ........... 232
Table 7.1 Strengths and weaknesses of health promotion capacity mapping frameworks and tools ................................................................. 245
LIST OF APPENDICES

APPENDIX A: Summary of tools reviewed in the Literature Review
APPENDIX B: Table of groups of capacity levels, domains and components
APPENDIX C: The WHO mapped regions/countries with HDI ranking
APPENDIX D: Criteria for developing the database of health promotion experts
APPENDIX E: List of Medium and Low Human Development Countries
APPENDIX F: Information for Delphi pilot participants
APPENDIX G: Delphi Pilot Questionnaire
APPENDIX H: Invitation email Delphi Round 1
APPENDIX I: Information for Delphi participants Round 1
APPENDIX J: Delphi Round 1 Questionnaire
APPENDIX K: Revised definitions of capacity domains
APPENDIX L: Email for Delphi participants Round 2
APPENDIX M: Health Promotion Capacity Mapping Tool
APPENDIX N: Health Promotion Capacity Mapping Tool for Thailand
APPENDIX O: Phase II findings online questionnaire
APPENDIX P: Item-wise internal consistency between rating scale questions
APPENDIX Q: Glossary
**LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR</td>
<td>Eastern Mediterranean Region</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HIAP</td>
<td>Health in All Policies</td>
</tr>
<tr>
<td>IUHPE</td>
<td>International Union for Health Promotion and Education</td>
</tr>
<tr>
<td>LMICs</td>
<td>Low and Middle Income Countries</td>
</tr>
<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-governmental Organisations</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>SEAR</td>
<td>South East Asian Region</td>
</tr>
<tr>
<td>Thai Health</td>
<td>Thai Health Promotion Foundation</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>WHA</td>
<td>World Health Assembly</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

In completing this study I have received support and encouragement from a great number of individuals. First of all I would like to express my gratitude to my supervisor, Prof. Margaret Barry, whose expertise, understanding and patience added considerably to my graduate experience. As my supervisor, a mentor and colleague, her guidance made this a thoughtful and rewarding journey.

I thank the members of my Graduate Research Committee, Dr. Lisa Purcell (NUI Galway), Dr. Su-ming Khoo (NUI Galway) and Dr Steve Thomas (Trinity College Dublin) for the assistance they provided at all levels of the research project as I moved from an idea to a completed study and helped enrich the experience.

I would also like to thank all my colleagues in the Health Promotion Research Centre at NUI Galway for fruitful discussions, and exchanges of knowledge and skills. I would like to acknowledge the College of Arts, Social Sciences, and Celtic Studies for providing financial support over the past four years.

A key challenge in the study was to find senior level health promotion experts and practitioners to respond to the mapping process in Thailand. In this regard, I particularly want to thank Dr Kwok Cho Tang (WHO Geneva), Marie-Claude Lamarre (Executive Director IUHPE), Dr Krissada Raungarreerat (CEO Thai Health), Mr Rungsun Munkong (Thai Health), and Barbara Battel-Kirk (BBK Consultancy) for facilitating and providing contact details of people involved in health promotion development in Thailand.

I am grateful to all the participants from Thailand who took part in the mapping study and responded to the mapping questionnaire, interviews and the group discussion at the 21st World Conference on Health Promotion in Pattaya, Thailand in August 2013. Without their involvement, the mapping would not be a success. My special thanks go to Dr. Narong Saiwongse (Director Health Promotion Bureau Office, Ministry of Public Health Thailand), Prof. Dr. Prakit Vathesatogkit (Executive Secretary of Action on Smoking and Health Foundation (ASH) Thailand), Dr Waranya Teokul (Director of Policy and Strategy Section Thai Health), Mrs. Kannikar Bunteongjit (Deputy Secretary General, National Health Commission Office (NHCO) Thailand).

In the end I would like to thank my friends and colleagues who were there to proofread, advise and provide material and emotional support: Gary O’Toole, Brid Gavin O’Connell, Eric Van Lente, Dr Umer Farooq Afridi, Dr Khadi Shah Afridi and Dr Imran Dotani. I owe them my deepest gratitude.
We cannot build or develop capacity as we think we do, or wish to – by constructing, implementing, inputting in order to achieve an outcome. We can prepare ourselves, in disciplined fashion, through practices informed by a finely held intentionality, but that which lifts us comes towards us from the vast beyond, enters into our minds, is received as though our brains and our hearts were antennae, feelers sensitised to an intelligence which lives in the world itself. We become capable of perceiving, of receiving, of seeing, of understanding (different from producing). A reversal takes place; at some point the process turns and we find that we are not building anything, but being developed. We do not develop ourselves, or others. We can develop faculties with which to perceive, or receive, but this implies that there is an equal and opposite movement necessary, a letting go, an opening up, which alone will allow something greater to enter.

Allan Kaplan
Towards a Larger Integrity: Shining a different light on the elusive notion of capacity development, 2010
The present study is concerned with mapping health promotion capacity in LMIC contexts and seeks to develop a capacity mapping conceptual model and data collection process that will address these factors. The overall aim of the study is to develop and test a flexible and sensitive conceptual framework and data collection process to map health promotion capacity with specific reference to LMIC contexts.

A phased, multi-method approach was employed to develop and test a capacity mapping framework and assessment process in an LMIC context. A comprehensive review of the international literature on conceptual frameworks and methodologies for health promotion capacity mapping helped to identify a conceptual model and a set of core capacity domains appropriate for use in an LMIC context. To determine the suitability of the capacity mapping framework in an LMIC context, a layered online consensus building process was undertaken in Phase I of the study involving experts in global health promotion with experience of working in LMICs. The first round of the Delphi consultation examined the appropriateness of the conceptual framework and core capacity domains and was completed by 104 global experts from 53 countries. Based on the agreed capacity domains from Round 1, 65 of the original respondents went on to complete Round 2 of the Delphi, which explored their views on the capacity mapping survey tool.

In Phase II, a case study method was employed to test the revised capacity mapping framework and assessment process in a selected LMIC, Thailand. The mapping assessment process comprised the following data collection methods; a desk review of key policy and related documents, an online questionnaire and semi-structured telephone interviews conducted with 28 health promotion leaders and key informants at the country level, and a face-to-face discussion group with 9 senior level policymakers, academics and practitioners.
The consultation process resulted in development of a conceptual framework comprised of four core domains; country-specific context, governance, policy environment, and infrastructure; and 10 sub-domains. In Phase II of the study, the mapping framework and the assessment process were tested in Thailand. The findings highlighted the country’s unique features in terms of Thai context including the cultural characteristics, bottom-up approach through community health promotion development and political buy-in. The presence of Thai Health Promotion Foundation has given the country high rating in health promotion developments within LMICs. Practical and methodological challenges highlighted in the study included the need for the mapping process to take a participatory approach that will engage a wide range of key stakeholders and that will result in reliable and valid information. The study findings highlight the complexity of assessing country level capacity in an LMIC context and calls for further testing of the capacity mapping framework and data collection process in other LMIC settings. Capacity mapping is an important process in supporting health promotion capacity development and its effective use is dependent on the availability of assessment methods that are meaningful, valid and sensitive to country specific contexts.
Health promotion is increasingly being adopted globally to improve population health and address health inequalities and the social determinants of health (CSDH, 2008; WHO, 2009a). The Ottawa Charter for Health Promotion states that ‘Health promotion is the process of enabling people to increase control over, and to improve, their health’ (WHO, 1986). The Charter highlights the need to develop holistic thinking, political will, and ecological action to address health inequities. Global health promotion experts from both High Income Countries (HICs) and Low and Middle Income Countries (LMICs) recognise that the health potential of nations can be improved through their ability to refocus health systems to include the promotion of health (WHO, 2009g).

Many countries have health promotion goals and processes embedded in national policies or have stand-alone health promotion policies. However, progress is uneven and a number of countries are lagging behind. There are wide differences in the understanding of key concepts of health promotion and a lack of functional health promotion infrastructure in many countries around the globe. Closing the health promotion capacity gap and mainstreaming health promotion in health systems is a global health development challenge, especially in LMICs (Battel-Kirk & Barry, 2010; Sparks, 2007).

Developing national capacity for health promotion strengthens health systems in supporting, protecting and improving population health, especially the health of disadvantaged populations. Building sustainable health promotion infrastructure and capacity, including the development of knowledge, skills, commitment, structures, systems, and leadership, is critical to mainstreaming health promotion and closing the implementation gap. A key principle of capacity development is that it should build on existing capacities and resources in order to develop well-planned and
integrated strategies that will respond to the local context. Capacity mapping is a critical aspect of this process as it involves the systematic assessment of existing capacities, based on a conceptual framework, in order to inform capacity development (Aluttis, Krafft, & Brand, 2014). A capacity map is a representation of the status of capacity in a system or organisation, and the mapping process is performed to identify which capacities already exist, how well they are developed, and how well they link together as a system.

This study defines health promotion capacity mapping for LMICs as ‘a strategy to assess a country’s existing knowledge, skills, commitment, structures, systems and leadership to develop Health Promotion capacity for strengthening national health system.’ The concepts of ‘capacity’, ‘capacity building’ and ‘capacity development’ were originally used by the United Nations in terms of ‘institutional building/development’ (UNCED, 1992). These initiatives were specifically focused on traditional technical trainings at organisational level in less developed countries but later evolved into complex thinking on the overall system and environmental development of institutions (Lusthaus, Adrien, & Perstinger, 1999). Therefore, in the context of LMICs, it is important to take into consideration how global and national development sectors perceive the issue of capacity in addition to how it is portrayed in the health promotion and public health literature.

This study on ‘Health Promotion Capacity Mapping in LMICs’ was undertaken to understand capacity development and mapping capacity at country level in LMIC contexts. The literature from HICs specify that the objectives of capacity mapping comprise of identifying the extent to which essential policies, institutions, programmes and practices are in place, and to guide recommendations about what remedial measures are desirable (Mittelmark et al., 2006). There is a paucity of similar research on capacity development and mapping capacity in the case of LMICs. While some studies point to the need for the development of health promotion

---

1 The definition is an adaptation of a WHO Glossary definition of Health Promotion Infrastructure (Smith, Tang, & Nutbeam, 2006).
capacity and infrastructure in LMICs (Battel-Kirk & Barry, 2010; Catford, 2005; Sparks, 2007) the literature is not clear on what are the specific needs of health promotion capacity development in LMICs.

There is a paucity of research on the capacity development needs of LMICs. In LMICs, the capacity mapping needs to address the particular challenges faced by the LMICs, by taking into consideration the specific country level contextual factors that shape the development of health promotion policies and programmes. These factors include poorly developed health systems, poor financing, dependency on external aid, lack of infrastructure, fragmentation of systems and absence of leadership. Capacity mapping can help to address these issues and provide information on the country’s existing assets which can then be used to inform future capacity development. Health promotion capacity mapping is an activity carried out by the WHO at regional level since 2005. This study builds on previous work in this area, including the WHO studies on the assessment of regional and national capacity in health promotion (Catford, 2005; Lin & Fawkes, 2005; Mittelmark, Fosse, Jones, Davies, & Davies, 2005; WHO, 2010e). This study sought to add to the existing evidence on capacity mapping at country level in LMICs by illustrating how a capacity mapping process can be undertaken that is sensitive to the specific factors encountered in LMICs and produce valuable data at a country level of those specific factors need to be addressed in order to bring health promotion to the forefront of development process in LMIC contexts.

The present study aims to explore the specific contextual factors that may influence country level health promotion capacity in LMICs and to develop a capacity mapping conceptual model and data collection process that addresses these factors.
1. Introduction

The study has the following objectives:

- To review the international literature concerning conceptual frameworks and methodologies for health promotion capacity mapping in order to identify a conceptual model and set of core domains suitable for mapping health promotion capacity in LMIC contexts.
- To achieve consensus among a panel of global health promotion experts regarding a conceptual framework and a proposed set of core capacity domains for mapping health promotion capacity in LMIC contexts.
- To develop a capacity mapping process and data collection tools, based on a consensus building process, suitable for use in an LMIC context.
- To test the mapping framework and data collection tools within an LMIC context.
- To make recommendations for research and practice based on the study findings, regarding the development and implementation of health promotion capacity mapping in LMIC settings.

This thesis commences with a review of the literature (Chapter 2) concerning current concepts of health promotion capacity development and mapping. The chapter outlines relevant key issues and definitions, current policies and practices in place for health promotion capacity development and mapping at global and country levels. An overview is provided of the history and evolution of the concepts of ‘capacity’, ‘capacity building / development’ and ‘capacity mapping’ in health promotion, public health and development sectors, highlighting their role in both global and country level development. The chapter explores the key health promotion capacity development and capacity mapping issues that arise in the context of LMICs, and current developments in the area, especially by the WHO and IUHPE, are reviewed. A comprehensive review of the international literature on conceptual frameworks and methodologies for health promotion capacity mapping is undertaken in order to identify a conceptual model and a set of core capacity domains and sub-domains appropriate for use in a LMIC context.
1. Introduction

Chapter 3 outlines the overall methodology of the study across both Phase I and II. It provides details on the study design, sampling, the data collection procedures, and how the data were analysed. A phased, multi-method approach is employed to develop and test a capacity mapping framework and assessment process for use in an LMIC context. To determine the suitability of the capacity mapping framework, a consensus building process is undertaken in Phase I of the study involving experts in global health promotion with experience of working in LMICs. Purposive sampling is used to recruit participants, who are drawn primarily from contact lists made available by the International Union for Health Promotion and Education (IUHPE) and the World Health Organization (WHO). A number of related international agencies and NGOs were also contacted to participate. Phase I of the study is comprised of a layered online consultation process utilising two rounds of the Delphi technique. In Phase II, a case study method is employed to test the revised capacity mapping framework and assessment process in a selected LMIC context. Thailand is chosen for the case study, based on its LMIC status, Human Development Index, health promotion development and study feasibility.

The results from this study are divided into three chapters. Chapter 4 presents the findings from the Delphi consultation involving experts in global health promotion with experience of working in LMICs. The first round of the Delphi consultation examines the appropriateness of the conceptual framework and core capacity domains and sub-domains. Based on the agreed capacity domains from Round 1, the respondents go on to complete Round 2 of the Delphi, which explores their views on the capacity mapping survey tool. The capacity mapping conceptual framework and data collection tool is refined based on the findings. After three rounds of re-drafting, a final mapping framework and a data collection tool are produced consisting of four core domains and 10 sub-domains.
Chapter 5 presents the main findings from the case study conducted in Thailand, which included the pilot implementation of the mapping framework. A capacity mapping assessment process was undertaken comprising of the following data collection methods; a desk review of key policy and related documents, an online questionnaire and semi-structured telephone interviews conducted with health promotion leaders and key informants at the country level, and a face-to-face discussion group with senior level policymakers, academics and practitioners. Key stakeholders and key informants were recruited following consultation with the Thai Health Promotion Foundation (Thai Health). The multiple sources of data are triangulated in order to obtain reliable information concerning country level capacity development for health promotion in Thailand and insight into the factors which led to its current state of development. The findings are presented as a country case study of health promotion capacity mapping in an LMIC context.

Chapter 6 considers the integration of the key findings from both Phase I and II studies: the Delphi study on development of the conceptual mapping framework and tool, and the case study which piloted the implementation of the framework and tool in a specific LMIC country context. The chapter summarises the key findings from both phases. It presents the changes the mapping framework goes through during its development stages, how effective it was in mapping capacity, and how various mapping methods used were successful in capturing different dimensions of health promotion capacity in Thailand.

Chapter 7 considers the study findings in the context of the existing literature and practices regarding health promotion capacity mapping. This chapter examines the findings from the development and implementation of the capacity mapping framework and data collection process, and discusses the strengths and weaknesses of the approach used, and its perceived usefulness, with particular reference to an LMIC context. The chapter
1. Introduction

considers the main differences between the proposed framework and mapping strategy from existing tools and approaches, with particular reference to their application in LMIC contexts. These include the new framework being developed with an explicit focus on its relevance for the LMIC context employing a mixed methods consensus-based approach, supported by evidence and informed by theory. The inclusion of country specific contextual factors in the mapping process is also discussed supported by use of participative and dialogue-based processes involving a wide spectrum of stakeholders. The chapter discusses how the capacity domains common to the existing frameworks (policy and infrastructure) were modified to better address the needs of LMICs. In addition, the new proposed domains of Country Specific Contexts (historical, political, social, cultural and economic environments), and the sub-domains Transparency and Accountability (Domain Governance) and Policy Coherence (Domain Policy Environment) were added in order to improve the relevance of the domains in the capacity mapping framework for use in LMIC contexts. The chapter concludes with an acknowledgement of the study’s limitations and a discussion of the practice and policy implications of the findings together with recommendations for future research.
2. Literature Review

2.1 Background of the Study

Mapping health promotion capacity in low and middle-income countries’ (LMICs) context is a multifaceted and complex area. LMICs have different, as well as overlapping, priority health issues from high income countries (HICs). These issues are deeply linked with existing social, political, economic and cultural environments. Health challenges, like growth of non-communicable diseases, re-emergence of infectious diseases and threat of pandemics, rapid urbanization, and climate change pose immense challenges for all countries across the globe. Health promotion can help attain good health and health equity through its comprehensive approach which empowers individuals and communities, fosters leadership for public health, and promotes intersectoral action to build healthy public policies and create sustainable health systems (WHO, 2009g).

Successive World Health Organisation (WHO) conferences on health promotion have focused on health promotion capacity development. The Fifth Global Conference on Health Promotion in Mexico City in 2000 called for the development of countrywide plans which strengthen existing capacity for implementing strategies (WHO, 2000). The Sixth Global Conference on Health Promotion in Bangkok, Thailand in 2005 included reports and discussion on mapping capacity for Health Promotion at a global level (WHO, 2005a). The Seventh Global Conference on Health Promotion in Nairobi, Kenya, in 2009 emphasised developing knowledge and skills for intersectoral collaboration and effective delivery, as a means of achieving a critical mass of capacity for Health Promotion globally (WHO, 2009m).

The recently held Eighth Global Conference on Health Promotion in Helsinki, Finland, in 2013 called on governments to build capacity of Ministries of Health to engage other sectors of government to achieve improved health outcomes (WHO, 2013). In light of emerging evidence both LMICs and HICs need to address health issues by adopting health in all
policies, social determinants of health and other health promoting approaches (CSDH, 2008). There is insufficient literature which addresses health promotion capacity issues at country level especially in the LMIC context, something that is ‘central to the country’s development agenda’ (WHO, 2005c).

This study explores existing frameworks and activities for health promotion capacity development at country level in LMICs, what influences these developments and how these can be assessed or mapped in LMICs. This mapping process can then pave the way to further develop health promotion capacity in LMICs. Literature review discusses what health promotion capacity and capacity mapping is, key issues relating to health promotion in LMICs from human, international and health development perspectives. It also and presents a thematic analysis of existing health promotion capacity mapping frameworks, methodologies and data collection tools being utilised worldwide. The thematic analysis is later utilised to develop a capacity mapping framework and data collection tools to map capacity in LMICs.

2.2 Health Promotion Capacity Development and Mapping
In the health sector, CIDA describes the capacity development approach as ‘the process by which individuals, groups, organizations and societies enhance their abilities to identify and meet development challenges in a sustainable manner’ (Lavergne & Saxby, 2001). CIDA further explains this approach as:

……..what distinguishes a capacity development perspective is enhanced concern for the intangible dimensions of development. Capacity development is about increased ability to use and increase existing resources, in an efficient, effective, relevant and sustainable way. Usually emphasizing “core” capabilities, the capacity development approach recognizes the primacy of learning by doing, takes a holistic approach that recognizes the interdependence of actors and systems, and seeks to balance the need for short term results in satisfying social needs with the need for long-term improvements in capacity (Lavergne & Saxby, 2001).
In the field of health, ‘capacity of a health professional, a team, an organisation or a health system is an ability to perform the defined functions effectively, efficiently and sustainably and so that the functions contribute to the mission, policies and strategic objectives of the team, organisation and the health system’ (Milèn, 2001). The literature describes some of the characteristics of capacity in the health sector as follows:

- both a (continuous) process and an outcome (LaFond, Brown, & Macintyre, 2002)
- dynamic, multidimensional and influenced by the external environment (LaFond et al., 2002)
- required at different levels and within different entities – health system, organisations, health personnel and individuals (LaFond et al., 2002)
- should lead to an improvement in performance (poor performance indicate capacity gaps (Milèn, 2001))
- contributor to the sustainability of the health system, health related organisations, and health personnel and individual/community behaviour (LaFond et al., 2002)
- reflecting the development process as a whole in the broadest sense (LaFond et al., 2002)
- the ability to carry out stated objectives (Goodman et al., 1998)
- a collection of attributes and processes and implies a transformational ability (Bagley & Lin, 2009)

Strategies and actions to build or develop capacity depend on how capacity is defined. The terms ‘capacity building’ and ‘capacity development’ have been defined in numerous ways which can be broadly categorised into, capacity referred to as ability (skills set), an approach, a process or an objective. Many definitions fall in between these perspectives. In the development context it is referred to as assistance provided to institutions in the developing countries which have a need to develop a certain skill or competence, or for general upgrading of performance ability.
Table 2.1 provides a list of definitions of capacity and capacity building commonly found in the health promotion and public health literature, with sources. These definitions also explain the level of their application like organisation, community, regional, etc. Most definitions are not developed or suitable for country level use.

Table 2.1 Definitions of capacity and capacity building

<table>
<thead>
<tr>
<th>Capacity is defined as:</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>ability to carry out stated objectives</td>
<td>(Goodman et al., 1998)</td>
</tr>
<tr>
<td>underlying foundation that supports the planning, delivery, and evaluation of all public health activities and practices (capacity as public health infrastructure – PHI)</td>
<td>(Centers for Disease Control and Prevention (CDC), 2001)</td>
</tr>
<tr>
<td>(capacity of a health professional, a team, an organisation or a health system is an) ability to perform the defined functions effectively, efficiently and sustainably and so that the functions contribute to the mission, policies and strategic objectives of the team, organisation and the health system</td>
<td>(UNCED, 1992)</td>
</tr>
<tr>
<td>actual knowledge, skill sets, participation, leadership and resources required by community groups to effectively address local issues and concerns'</td>
<td>(The Ontario Prevention Clearinghouse, 2002)</td>
</tr>
<tr>
<td>extent to which organizations within communities use and build upon their knowledge, skills, resources and abilities to take action on heart health promotion</td>
<td>Heart Health Nova Scotia (HHNS) (Joffres et al., 2004)</td>
</tr>
<tr>
<td>(capacities are the) elements necessary for a public health system to function</td>
<td>(PAHO/WHO, 2007)</td>
</tr>
<tr>
<td>(capacities are the) systems, competencies, relationships and resources that enable performance of public health’s core functions and essential services in every community</td>
<td>(Turnock, 2009)</td>
</tr>
<tr>
<td>Capacity building is:</td>
<td>WHO: (Smith et al., 2006)</td>
</tr>
<tr>
<td>development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion.</td>
<td>WHO: (UNCED, 1992)</td>
</tr>
<tr>
<td>continuing process of strengthening of abilities to perform core functions, solve problems, define and achieve objectives and understand and deal with development needs</td>
<td>(Hawe, Noort, King, &amp; Jordens, 1997)</td>
</tr>
<tr>
<td>approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over</td>
<td>(Goodman et al., 1998)</td>
</tr>
<tr>
<td>cultivation and use of transferable knowledge, skill, systems and resources that affect community and individual level changes consistent with public health-related goals and objectives</td>
<td>(Hawe, King, Noort, Jordens, &amp; Lloyd, 2000)</td>
</tr>
<tr>
<td>building sustainable skills, resources and commitments to health promotion in health care settings, community settings and in other sectors (in order to) prolong and multiply health gains many times over</td>
<td>(Zonta &amp; Wilson, 2000)</td>
</tr>
<tr>
<td>deliberate effort to create, support or strengthen capacity</td>
<td></td>
</tr>
</tbody>
</table>
approach to development that seeks to enhance the potential that programs will be sustainable or that the experience of working on a program will give people and organisations a greater ability to address new challenges (Leeder, 2000)

increase in community groups’ abilities to define, assess, analyse and act on health (or any other) concerns of importance to their members (Gibbon, Labonte, & Laverack, 2002)

Process that improves the ability of a person, group, organisation or system to meet its objectives or to perform better (LaFond et al., 2002)

System-wide increases in capacity to meet stated objectives whether through increased skills, improvements in information flow or through increases in resource acquisition (LaFond et al., 2002)

process by which people gain knowledge, skills and confidence to improve their own lives (Rifkin, 2003)

The extent to which organizations within communities use and build upon their knowledge, skills, resources and abilities to take action on heart health promotion (Joffres et al., 2004)

Health promotion capacity development is a progressive and evolving area in health systems in the HICs. Joffres et al. (2004) describe how the meaning and definition of capacity building has evolved with time especially throughout the 1990s (Table 2.2). It has become a key strategy to achieving improved and sustained health status (LaFond et al., 2002). There is a developing trend in public health sectors employing health promotion capacity development strategies to strengthen public health systems (Aluttis, 2010; Bagley & Lin, 2009; PAHO/WHO, 2007; Zonta & Wilson, 2000).

Table 2.2 Evolution of concepts of health promotion capacity adopted from (Joffres et al., 2004)

<table>
<thead>
<tr>
<th>Years</th>
<th>Focus of capacity building</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992-93</td>
<td>Infrastructure building (staff, skills, resources, structures)</td>
<td>(Meisnner, Bergner, &amp; Marconi, 1992; Roper, Baker, Dyal, &amp; Nicola, 1992; Schwartz et al., 1993)</td>
</tr>
<tr>
<td>1994-95</td>
<td>Programme sustainability</td>
<td>(Bracht et al., 1994; Rissel, Finnegan, &amp; Bracht, 1995)</td>
</tr>
<tr>
<td>1997-2000</td>
<td>Problem solving skills to address health and other development issues</td>
<td>(Crisp, Swerissen, &amp; Duckett, 2000; Eade, 1997; Hawe et al., 1997)</td>
</tr>
</tbody>
</table>

Capacity development in relation to health promotion has been defined as ‘the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills
among practitioners; the expansion of support and infrastructure for health promotion in organisations, and; the development of cohesiveness and partnerships for health in communities’ (Milèn, 2001).

The word ‘mapping’ is derived from the metaphor cartography which is explained as ‘the drawing of images meant to represent the world around us’. Broadly, cartography refers to understanding the needs, planning, collecting information and agreeing on unsure or disputed borders, terms, topography, features and forms.

Mapping health promotion capacity was initiated in response to the need for a set of indicators and checklists for planning and evaluation of capacity building or development (Hawe et al., 2000; Hawe et al., 1997). Various attempts to assess and conceptualise health promotion capacities followed. In 2005, Catford (2005), developed and proposed the ‘National Health Promotion Capacity Wheel’ in preparation for the Global Health Promotion Conference in Bangkok which resulted in an assessment of health promotion capacity in different WHO regions (Catford, 2005). For at least the past decade, national capacity for health promotion has been the subject of conferences, scholarly dialogue and political debate (Wise & Signal, 2000). At the Fifth Global Conference on Health Promotion in Mexico City in June 2000, national investment for health and the need to build infrastructure for health promotion were dominant themes (Moodie, Borthwick, Phongphit, Galbally, & Hsu-Hage, 2000; Ziglio, Hagard, & Griffiths, 2000).

From a health promotion perspective, Mittelmark, Wise, Nam et al. (2006) argue that "having the capacity to perform a task is an essential but not sufficient condition for good performance". A capacity mapping process does not provide answers about the ‘performance’ of a system but contains an evaluation of the ‘system’s ability to fulfil its specific functions within a set of given resource constraints’ (Mittelmark et al., 2006). The issue of achievement of objectives of the health system are considered as the subject of conventional health system performance assessments.
Nevertheless a number of authors have suggested further investigation into the nature of the relationship between capacity and performance (Bagley & Lin, 2009; LaFond et al., 2002). Bagley & Lin (2009) also highlight the utility of capacity mapping as a useful part of a quality improvement system.

With regards to assessment of professional competencies, ‘strengthening’ competencies for public health or health promotion are concerned with identifying and describing the knowledge and skills required of health professionals to guide professional training. Health promotion capacity mapping includes identification of existing strategies in a country to develop professional competencies as a way of strengthening health promotion capacity and hence covers broader issues than competencies.

LaFond et al. (2002) refer to a capacity map as a representation of the current status of capacity in a system or organisation, in an individual or a community, independent of, or prior to any specific capacity building intervention. This prior analysis is performed to identify which capacities already exist, how well they are developed, and how well they link together as a system (Aluttis, Van den Broucke, Chiotan, Costongs, & Price, 2010). The capacity mapping activity should be considered in the design phase of capacity development (LaFond et al., 2002). It should include assessment of the ability to build on pre-existing capacities and identify potential for additional required capacities to plan integrated strategies to respond to capacity needs.

The process of mapping capacity is seen as an important step in strengthening health systems and their ability to deliver on core functions (Bagley & Lin, 2009). This process is not different from developing strategies in any other well planned programme and involves an evaluation of the system’s ability to fulfil its specific functions within a set of resource constraints. Capacity mapping is also described as "a strategy to find untapped and unrecognized resources" (Dato, Potter, Fertman, & Pistella, 2002).
2. Literature Review

Issues in capacity mapping

Mittelmark et al. (2006) in their review of capacity building initiatives at a national level in the past decade describes some important lessons learnt as summarised below:

- Use of one single mapping protocol for all health promotion capacity mapping exercises is not possible.
- The capacity needs in a given country may be different from that in another country.
- There are differences in what constitutes capacity among countries arising from addressing different health issues.

Mittelmark et al. (2006) stated a number of general problems which capacity mappers might confront in developing a capacity mapping tool for policy management. These are defining infrastructure (what to map?), difficulty in separating health promotion policy, infrastructure and programmes in health budgets, health professionals doing health promoting work (who to count?), hidden health promotion workforce (parents, teachers, politicians, etc.), national contexts and country comparisons and inaccessible data (e.g. private institutions).

Lin & Fawkes (2007) identified additional issues to consider during technical analysis which are: relationship between level of economic development and stage of development of health promotion infrastructure, role of pre-existing public health infrastructure, history of health promotion in the country concerned, relationship between organisational and professional cultures associated with policy making and development of specific capacities, etc.

The issues identified by Lin & Fawkes (2007) overlap with the development framework for LMICs recommended by (Lethbridge, 2001). The health promotion development strategies of poverty elimination, recognising social and economic rights, social justice and environment form the broader
2. Literature Review

framework for understanding how health promotion is part of the development process for any country.

2.3 Health Promotion capacity developments in LMICs
Lack of evidence of health promotion capacity in the LMICs is often reported where public health is still a major strategy to address health issues. This mixed picture of capacity development in HICs pose a challenge in defining capacity issues in LMICs where international development initiatives have already created complex situations especially regarding implementing strategies to deal with health issues. Making an accurate and useful assessment of existing capacity to measure the effectiveness of capacity building interventions is a vital requirement for donors involved in the effective implementation of capacity development strategies in LMICs (LaFond et al., 2002).

At a WHO/IUHPE Joint Planning Meeting held in Vancouver Canada in 2007 a group of global health promotion leaders identified a need to develop a report on the health promotion capacity building needs for low income countries (Sparks, 2007). Many participants felt that the best practice for capacity building in any country is to begin with an assessment of the gaps and the relevant existing assets. In 2010 Battel-Kirk & Barry (2010) carried out a scoping study on health promotion workforce capacity and education and training needs in LMICs (Battel-Kirk & Barry, 2010). Although the study focused on health promotion education and training needs, it was also successful in mapping some key capacity needs, assets and gaps at the country level in LMICs which are vital for future capacity development initiatives.

In another study a conceptual framework proposed by a health policy expert in 2001, for the IUHPE, describe four main determinants of health within the development process: poverty, social and economic rights, social justice and environment (Lethbridge, 2001). The author proposes four underpinning activities to address health promotion issues related to these determinants which are: research and policy formulation, working with
communities, institutional structures and governance, and information and communication. Identifying health promotion’s role in public sector reform or poverty elimination and income redistribution bring health promotion in the centre of development.

In the context of research and policy, for example, the author states that the LMICs lack research capacity which acts as barrier to programme planning, restricting the ability to participate in national and international policy development, and thus contributing to increasing health inequity between countries (Sitthi-amorn & Somrongthong, 2000).

In the context of governance and to strengthen institutional structures, the author quotes Bloom (2000), a development studies expert, who stated that LMICs need tools for decision-makers to ‘make explicit the trade-off between interests of specific groups so that they can manage inequalities better’ (Bloom, 2000). Other governance related issues mentioned in the literature relevant to LMICs are: conceptualising health improvements within governance, use of government powers, decentralisation, health promotion governance skills and expertise, safeguarding health, rights and social justice as ‘public goods’, etc.

There is a need for development of skills and expertise at institutional level to argue for health needs for deprived populations in LMICs (Cardelle, 1998; Lethbridge, 2001). Private stakeholders like the non-governmental organisations need to play a more active role in international health policy formulation so that the needs of LMICs can be advocated in international agencies and networks (Cardelle, 1998).

Another challenge in mapping health promotion capacity in LMICs is the wide range of disciplines and competencies, some not yet associated with health promotion. For example in the case of governance, some key components like a country’s capacity to develop coalitions and alliances with different sectors, disciplines, professions and groups which are essential to share knowledge and develop new skills.
A good capacity mapping tool would need to encompass all these related issues in order to enable health promotion development as a contributory force for the country’s development.

A key area which is often missed by the health promotion experts involved in capacity development is the international development sector and human development organisations. Development agencies in collaboration with governments have a dominant role in shaping policies and programmes for various social sectors in the LMICs. In these countries the development aims are intermixed with national priorities and programme objectives.

The term ‘capacity building’ was first used in the 1970s in the United Nations Conference on Environment and Development (UNCED) synonymous with ‘institutional building/development’ by the United Nations systems to offer guidance to its staff and member governments. In 1992 ‘capacity building’ became a central concept in Agenda 21 (UNCED, 1992) and other UNCED agreements as well as a major priority of global conventions and international communities. The terms ‘capacity building’ and ‘capacity development’ have been used interchangeably and subsumed concepts like organizational development, community development, integrated rural development and sustainable development under the wider concept of capacity development (Lusthaus et al., 1999; P. Morgan, 1998).

Various development agencies have defined and modified the terms ‘capacity’ and ‘capacity building/development’ in accordance with the organisations’ aims. Within the development agencies’ culture, the meanings of the terms have evolved from a traditional technical training focus at organisational level to a broader and more complex thinking on the overall system and environmental development of institutions. Capacity development emerged as a development theme and replaced the term ‘institutional building’ in the late 1990s (Lusthaus et al., 1999). In the development literature, it is expressed as an interest of the development agencies to reduce inequalities, maximize donor aid and to make the work of non-government organizations (NGOs) more effective (Bagley & Lin,
2. Literature Review

2009). In the context of LMICs it is important to take into consideration how global and national development sectors perceive the issue of capacity in addition to the perceptions portrayed in the health promotion and public health disciplines.

Over time the concept of capacity has become complex as a wide range of previous approaches merged and became absorbed into the general concept. CIDA (2001) quotes various approaches researched by Lusthaus et al., (1999) as:

- **organizational approach** - building capacity at the level of individual organizations;
- **institutional approach** - processes and rules that govern socio-economic and political organization in society at large;
- **systems approach** - emphasizes the interdependencies among social actors and the need to promote capacity building in a holistic way; and
- **participatory process approach** - emphasizes ownership and participation as fundamental elements of CD.

The Table 2.3 below provides an overview of how capacity and capacity development have been defined in the development context in the last two decades.
The organisations like United Nations Development Programme (UNDP) and the Organisation for Economic Co-operation and Development (OECD) differentiate between capacity development and capacity building. The United Nations (UN) says that ‘while both are processes which are involved in creating and building capacities, the former is driven from the inside and starts from existing capacity assets, whereas the latter supports only the initial stages of building or creating capacities and is based on an assumption that there are no existing capacities to start from’ (UNDP,
2. Literature Review

2009). The OECD uses the phrase capacity development purposefully in preference to the traditional capacity building as ‘the “building” metaphor suggests step by step erection of a new structure starting with a plain surface, based on a preconceived design’ and therefore does not contribute towards enhancing capacity (OECD, 2006).

The World Bank considers capacity development and capacity building as having the same meaning but differentiates between ‘capacity development’ and ‘capacity for development’. According to the World Bank an operational definition for ‘capacity for development’ is ‘the availability of resources and the efficiency and effectiveness with which societies deploy those resources to identify and pursue their development goals on a sustainable basis’ (Driedger et al., 2007). It further provides subsidiary definitions of the terms ‘availability of resources’, ‘effectiveness and efficiency’ and ‘sustainability’.

A prominent feature of capacity development is its scope which goes beyond the institutional limits and addresses capacity issues at systems levels and the environmental context within which individuals, organisations and societies operate and interact. This is further highlighted by Qualman and Morgan (1996) who state that capacity development encompasses institutional development ‘but goes beyond individual organizations and institutions to broader systems, groups of organizations and inter-organizational networks’ which addresses complex, multi-faceted problems requiring the participation of various actors, organizations and institutions’ (Qualman & Morgan, 1996). From a development perspective, the UNDP does not endorse the idea of interchangeable use of the terms ‘capacity development’ and ‘capacity building’ (Milèn, 2001). According to the UNDP the concept of capacity development is broader than organisational development since it includes an emphasis on the overall system, environment or context within which individuals, organisations and societies operate and interact (and not simply a single organisation). The UNDP recommends for development planners and in situations where there
are limited resources to build on what exists and utilize and strengthen existing national capacity assets, rather than to start from scratch (UNDP, 2009).

2.4 Review of Capacity Mapping Frameworks and Tools
The earlier works in health promotion capacity mapping (Ebbesen, Heath, Naylor, & Anderson, 2004; Hawe, King, Noort, Gifford, & Lloyd, 1998; Hawe et al., 1997) describe in detail the concept of ‘capacity’ and identify the need for further research in developing indicators to assess capacity, although many of these studies are focused on capacity development interventions at the community/local level. The focus of this thesis is mapping the capacity at country/national level. An analysis of existing health promotion capacity mapping tools with related conceptual frameworks is presented below. These frameworks and tools were identified in the health promotion research publications and grey literature. Each tool description includes the related framework, scope of the tool, methodology, strengths, weaknesses and commonalities.

Conceptual framework: A conceptual framework is a set of coherent ideas or concepts organized in a manner that makes them easy to communicate to others. Health promotion capacity frameworks based on single or multiple interventions, apply interlinked theoretical approaches to understand changes at several levels related to the planning, development, implementation, and/or evaluation of the initiative. This includes identification of an intervention’s conceptual and operational elements, and its intended outcomes.

Capacity mapping tools: Assessment tools are the materials, instruments and procedures to gather and interpret evidence of competence using the chosen assessment method (DET Australia, 2008). A capacity mapping

---

2 Health promotion capacity building interventions are usually multiple intervention programmes involving a complex process of implementing and maintaining diverse strategies across levels. These strategies focus on building health promotion capacity to address interdependencies among socioeconomic, cultural, political, environmental, psychological, and biological determinants of health and illness including individual behaviour.
process ideally involves a systematic, objective assessment of existing capacities using a pre-defined set of *indicators* based on a conceptual framework. Building on the frameworks, tools can be developed to collect data and assess and measure the existing status of capacity for mapping.

Definition/aims for national health promotion capacity mapping as depicted in various studies are:

- To help policy and decision makers build the necessary financial and technical support within their countries and spheres of influence for the implementation of effective health promotion (Catford, 2005).
- At national level, the objective is usually to learn the extent to which essential policies, institutions, programmes and practices are in place, to guide recommendations about what remedial measures are desirable (Mittelmark et al., 2005).
- To produce point-in-time assessments of national health promotion capacity (as defined by the data collection tools) for selected countries (Lin & Fawkes, 2005).
- To identify which types of capacity already exist, how well developed they are and how well they link together as a system to improve performance and achieve results (Fawkes & Lin, 2007).
- A collective approach used to assess existing capacity in health promotion planning, programme implementation, financing and cross-sectoral collaboration in different countries (WHO, 2010e).

According to LaFond et al. (2002), ‘(mapping) frameworks could provide a starting point for determining critical gaps in capacity at the design phase of a project or activity, and for choosing appropriate capacity building interventions to fill these gaps. They could be used to guide planners in developing a strategy for evaluating the effect of capacity building interventions (defining appropriate indicators, selecting data gathering tools and developing a viable timeframe)’ (LaFond et al., 2002). Figure 2.1 uses a general schema to depict where health promotion capacity mapping fits in
the broader health planning structure and phases of capacity mapping tool
designing.

Figure 2.1 Stages of capacity mapping tool design and implementation

The concept of ‘capacity’ seems to vary in different countries and cultures
and for different types of organisations and levels; there is no agreed model
or framework for health promotion capacity (Ebbesen et al., 2004; LaFond
et al., 2002; Mittelmark et al., 2006). From a public health perspective,
Ebbesen et al. (2004) points out a lack of a ‘gold standard’ due to the
evolving nature of public health capacity. Aluttis et al. (2014) suggest that
while such a gold standard is difficult to achieve, a more systematic review
of existing capacity frameworks can provide a basis for integration.

From a development perspective, health promotion capacity mapping has
largely been focused in HICs and more efforts are required to address
capacity issues in LMICs (Catford, 2005; Mittelmark et al., 2006). Some of
the key questions regarding health promotion capacity mapping in LMICs
which emerge at this stage are:
• Is it possible to use capacity mapping protocols commonly used in HICs for LMICs?
• Does health promotion capacity have different meanings in LMICs and is it more politically defined?
• Are the capacity requirements in LMICs for effective health promotion different from other countries because of differing cultural, social, economic and political conditions?
• Apart from existing commonality in what constitutes capacity among countries, are there differences arising from addressing different health issues in LAMICs?

2.5 Search Strategy and Analysis method
The literature review aimed to identify existing health promotion conceptual frameworks for capacity development, and capacity domains for LMICs. This required that a focused literature review be performed employing a thematic approach. The literature review fulfilled two objectives:

1. Development of a matrix of capacity domains (core and sub-domains) based on commonalities.
2. A review of existing capacity mapping frameworks derived from health promotion literature.

The review involved a search of the electronic journal databases in James Hardiman Library at the National University of Ireland Galway. The main databases selected were subject data bases - EBSCO, PubMed and Web of Science (Global Health), multidisciplinary database - ScienceDirect, scholarly archive - JSTOR, and Google and Google Scholar for grey literature, etc. As the subject matter of the thesis was diverse and not common, both subject and multidisciplinary databases were searched. The search also included policy documents, books, newspaper articles, and relevant reports from international and national organisations (WHO, IUHPE, UN, USAID, etc.) due to relevance of topic to a variety of areas. This step was planned to identify relevant frameworks in the international
development discipline as most of the health development work in LMICs is carried out by international health agencies. The range of selected databases were considered appropriate for conducting the review as they constituted wide-ranging sources of information for health promotion, public health and health system related research.

The search terms were selected under four main concepts: capacity (capacity building, capacity development, capacity mapping, capacity framework, capacity tool), health (health promotion, public health, global health), development (global, international, health), and low and middle-income countries (developing countries, third world countries, low resource countries, poor countries, LMICs). These search terms were used in various combinations to acquire a comprehensive overview of the contemporary literature on the issue. As a result of the search, more than 100 primary and secondary literature publications were retrieved. Reference lists of the identified articles were checked for additional publications, and personal contacts were used as additional information sources to identify further publications.

Relevant publications for this review were selected on the basis of the abstracts or summaries, using the following inclusion criteria:

i) the document should describe one or more framework(s) for health promotion capacity at the national or regional level (to exclude models and concepts that were only vaguely related to the issue, or that described capacities of individual organizations or local health agencies).

ii) the outcome of the framework should be health promotion capacity distinct from health system performance or competencies

iii) the document should be published or otherwise made publicly available after 1995 to exclude work that has become out-dated or has been revised.
iv) the documents should be published in English (only as a practical consideration acknowledging that the limitation to published studies available in English may have led to the potential exclusion of frameworks in other languages).

2.5.1 Objective 1: Development of a matrix of capacity domains
The literature search was unable to identify a health promotion capacity mapping framework focused on mapping health promotion capacity in LMIC contexts. A total of 19 publications were found after applying the inclusion criteria. These publications were further content analysed to identify the dimensions relevant to health promotion capacity represented in the existing conceptual frameworks (Appendix B). The matrix of capacity domains took into consideration frameworks and capacity domains from health promotion, public health and international health development literature. These frameworks were found to be categorised into (i) national and global level conceptual frameworks for public health and health promotion capacity, (ii) capacity in specific areas of health promotion and public health, (iii) assessment tools for health promotion and public health capacity, and (iv) country level assessment tools from international health agencies (Spence K. Health Communication /Promotion Capacity Mapping Questionnaire for the UNICEF CEE/CIS Region; UNICEF. 2007, and MEASURE Evaluation Project USAID).

A thematic analysis approach was employed as the guiding methodology for the synthesis of the findings into a matrix in which prominent themes were identified and capacity dimensions from various identified frameworks were retrieved, summarized, and compared with each other to identify recurring dimensions across frameworks. The dimensions from the different models bearing the same content were clustered under a set of thematic areas and were then used to construct a framework for health promotion capacities that describes the main dimensions at the country-level. The developed framework was presented to a panel of international experts in the next stage of the study and the panel members were asked to rate the set of proposed capacity domains for their suitability to health promotion capacity.
mapping based on their experience. Any feedback and comments from the panel members was documented and the framework was adjusted based on the statements provided.

The outline of the matrix System Governance, Inputs, Outputs, Impact and Outcome was adopted from the Health Promotion Capacity Mapping Domains Model (Lin et al., 2009). Under each ‘level’ main themes were identified as Governance, Policy Environment, System Infrastructure and Resources, and Framework of Programs and Services. These were considered as core domains in the mapping framework. The sub-domains with similar meanings were grouped under the core domains. For example common dimensions like vision, leadership, institutional links, etc. were grouped under the core domain Governance as noted in various frameworks (Appendix B). Key issues faced in developing and arranging these capacity domains in a framework were how these were defined by various authors, how these related to other dimensions and the overall objectives of particular frameworks from where the dimensions came from. The framework and set of capacity domains developed from the literature review is illustrated in section

2.5.2 Objective 2: Review of existing capacity mapping frameworks

The review of the existing frameworks aimed to identify methodological limitations and strengths of current initiatives. A total of six frameworks with accompanying tools were identified (Table 2.4). Along with the strengths and weaknesses, for each framework and tool, the review identified the key mapping domains, issues regarding process implementation and challenges faced by the assessors from LMICs perspective. At the end of the review the findings were summarised and discussed in detail.
Table 2.4 Health Promotion Capacity Mapping frameworks and tools reviewed

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of Mapping Tool</th>
<th>Type</th>
<th>Authors (year)</th>
<th>Published by</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Indicators to help with capacity building in health promotion, New South Wales, Department of Health</td>
<td>Report</td>
<td>Hawe, King, Noort, Jordens &amp; Lloyd (2000)</td>
<td>Department of Health, New South Wales</td>
</tr>
<tr>
<td>B</td>
<td>National capacity mapping by the World Health Organisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B2</td>
<td>National Health Promotion Capacity Mapping in the Western Pacific Region</td>
<td>Report</td>
<td>Fawkes &amp; Lin (2005)</td>
<td>La Trobe University, Australia</td>
</tr>
<tr>
<td>B3</td>
<td>Mapping European Capacity to Engage in Health Promotion at the National Level: HP-Source.net</td>
<td>Journal article</td>
<td>Mittelmark, Fosse, Jones, Davies, &amp; Davies (2005)</td>
<td>Sage Journals</td>
</tr>
<tr>
<td>C</td>
<td>Health Promotion Capacity Checklists: A Workbook for Individual, Organizational, and Environmental Assessment</td>
<td>Workbook</td>
<td>Prairie region health promotion research centre (2004)</td>
<td>University of Saskatchewan, Canada</td>
</tr>
</tbody>
</table>

**A. Indicators to help with capacity building in health promotion, New South Wales, Department of Health**

Hawe et al. (2000) researched and developed the capacity mapping tool ‘Indicators to help with capacity building in health promotion’ (Hawe et al., 2000). Along with a capacity building framework (NSW, 2001), it constitutes the New South Wales (NSW) Health Department, Australia’s response to regional capacity building strategies. This response builds up on the work of Hawe et al (1997) to build health promotion capacity ‘to improve health and as an approach to development that builds independence’ (NSW, 2001).
Hawe et al. (1998) conducted a study on perceptions of health workers on capacity building work which brings about ‘invaluable health gains’ but is ‘invisible’ (Hawe et al., 1998). The workers contributing to this work were found ‘unrecognised and undervalued’ as capacity development was not a national health priority area but seen as ‘diversion to the purpose/funds of the program’.

Framework: Hawe et al. (2000) defines capacity building as ‘being (at least) three activities: (1) building infrastructure to deliver health promotion programs, (2) building partnerships and organisational environments so that programs are sustained – and health gains are sustained; and (3) building problem-solving capability’ (Hawe et al., 2000; Hawe et al., 1997). According to Hawe et al. (2000) health promotion capacity is developed in ‘levels’ understood as processes and outcomes underlying different sets of activities:

**Level 1: Health infrastructure or service development**
Capacity to deliver particular programme responses to particular health problems (structures, organisation, skills and resources in health sector)

**Activities:** Community organisation, needs assessment, data gathering, priority setting, comprehensive and integrated interventions and program monitoring and evaluation

**Level 2: Programme maintenance and sustainability**
Capacity to continue to deliver a particular programme through a network of agencies, in addition to, or instead of, the agency which initiated the programme

**Activities:** (1) Tracking over time the ‘natural history’ of the incorporation of programs into other agencies to determine how well data gathered in the early years predict uptake in later years (programme’s capacity to deliver multiple health gains (2) Degree of program ‘institutionalisation’ assessed by
2. Literature Review

how embedded a program becomes in an organisation’s operations

**Level 3:** *Problem solving capability of organisations and communities*

Capacity of a more generic kind to identify health issues and develop appropriate mechanisms to address them

**Activities:**
1. Programme specific context: network size, relationships between agencies, prior commitment of resources
2. Collaborative problem solving: pressure strategies (garnering support for initiating action on a problem), cooperative strategies (working together of participating agencies in planning action, maintaining communication and recruiting others to join them), and, maintenance strategies (organisations maintaining their own interests while collaborating with other organisations)
3. Key qualities profile of communities
4. Capacity building to create a learning organisation as a superior option

With the third level being ‘crucial’, these levels were defined as assisting in developing indicators or markers of progress in building services or infrastructure, promoting sustainability and enhancing problem-solving capacity. From levels 1 to 3, the capacity of an organisation develops from being able to address a specific health issue to a generic capacity to tackle new health issues. Hawe’s et al. (2000) model depicts capacity as:

- A ‘*means to an end*’ - where purpose is for others to take on programs
- An ‘*end*’ in itself - where individuals and government departments attain capacity to work together to solve problems
- A ‘*process*’ - where capacity building strategies form important elements of effective practice

Building on the work of Hawe et al. (2000), the NSW Department of Health, Australia (NSW, 2001), linked five key action areas to the three
levels of capacity building identified by Hawe et al. (2000) as follows (Figure 2.2):

a. Organisational development: processes that ensure that the structures, systems, policies, procedures and practices of an organization reflect its values and objectives and ensure that change is managed effectively.

b. Workforce development: processes to ensure that the people working within a community or system have the abilities and commitment to contribute to organizational and community goals.

c. Resource allocation: includes the people, physical space, administrative support, tools, and finances needed to support a program.

d. Leadership: about future orientated systems thinkers, who critically analyse their work and search out opportunities to grow and experiment, set examples, and engage, mobilize, and inspire others to make things happen.

e. Partnership: capacity to establish strategic collaborations where systems engage with systems, or community partnerships that focus on people.
Figure 2.2 Dimensions and components of the NSW Capacity Mapping Framework adopted from (NSW, 2001)

Tool format: The tool to assess health promotion capacity in NSW, *Indicators to help with capacity building in health promotion*, is a set of theory-informed indicators which collect data to assess the three dimensions of health promotion capacity identified by Hawe and colleagues (Hawe et al., 2000), within nine scenarios or checklists having a total of 130 items: strength of a coalition (24 items), opportunities to promote incidental learning among other health workers (five items), opportunities to promote informal learning among health workers (seven items), programme sustainability (14 items), learning environment (for team/project group) (20 items), capacity for organisational learning (11 items), capacity to tackle
health issues (13 items), quality of programme planning (24 items) and community capacity to address community issues (12 items).

The indicators were field tested, face validated, inter-rater reliability and internal consistency tested and gave a satisfactory performance when applied to 130 health promotion projects across NSW (Hawe et al., 2000).

Methodology: The tool was developed through a process of literature review, focus groups with health promotion workers, consultations and workshops, document analysis (review of planning and policy materials) and field testing of indicators and reliability testing.

The tool itself is implemented by experienced health promotion practitioners within an organisation and/or community and collects data through dissemination of quantitative questionnaire (checklists) among health workers.

Strengths

- Theory based indicators which bring in the quality
- Top down and bottom up approach
- Very comprehensive for assessing one-to-one, group, organisation, inter-organisation/coalition and community capacity
- Good emphasis on problem solving through learning
- Tested for validity and reliability

Weaknesses

- Does not address capacity issues at regional/national policy levels (essentially it is settings- or situations-based within an organisation/community)
- Only addresses workforce capacity and not health promotion capacity infrastructure
- Only to be used by experienced health promotion practitioners
- Project still in development (lack of literature on evaluation)
2. Literature Review

B. National capacity mapping by the World Health Organisation

In preparation for the 6th Global Conference on Health Promotion (7-11 August 2005, Bangkok, Thailand), the WHO initiated a global project to map national health promotion capacity through its network of regional offices for Africa (AFR), the Americas (AMR-PAHO), South-East Asia (SEAR), Europe (EUR), Eastern Mediterranean (EMR) and Western Pacific (WPR). The following accounts present how mapping was carried out in various WHO regions and the tools employed. Currently reports are only available for the WPR, EUR and EMR and results for the SEAR.

The baseline framework utilised in the WHO regions for mapping health promotion capacity at national and regional levels is the National Health Promotion Capacity Wheel proposed by Catford (2005) prior to the 6th Global Conference on Health Promotion.

B1. National Health Promotion Capacity Wheel

Catford (2005) developed a mapping framework for the WHO to map national health promotion capacity at regional and country levels. Catford observed that there is an uncertainty and lack of information about the extent of the global and national health promotion capacity (Catford, 2005). Catford identified three areas requiring attention to fill the gaps in capacity improvements in HICs versus LMICs:

- an agreement on the scope and definitions of what to measure
- a valid global system to collect the data consistently
- a mechanism to present the information in a way that compels a policy response

Building on Hawe et al., (2000) and the NSW’s work on health promotion capacity, Catford (2005) developed an eight ‘health issue free’ domains framework which the author describes as compatible with situations in LAMICs, avoiding imposition of developed countries’ perspectives on the
findings (Figure 1.2). Key domains identified by Catford (2005) which need to be included in the mapping process are:

a. **National policies and plans**: national government policies and plans for health promotion priorities, which embrace the underlying concepts of the five Ottawa Charter strategies.

b. **National leadership**: core of expertise and leadership within the national Ministry of Health for health promotion development, coordination and partnerships.

c. **Joined up government**: coordinating mechanisms within the Ministry of Health and across national government for policy development and plan implementation for health promotion priorities.

d. **Programme delivery**: delivery structures and mechanisms for health promotion priorities at national and/or subnational levels, including support for inter-sectoral partnerships.

e. **National partnerships**: national partnerships among NGOs, civil society, private sector and government for health promotion priorities.

f. **Professional development**: national-level advanced education and training programmes, and a professional association for health promotion practitioners, policy makers and researchers.

g. **Performance monitoring**: national-level research and evaluation, and information systems to track and report on health indicators relevant to health promotion policy, priorities and programmes.

h. **Sustainable financing**: transparent and sustainable source of public financing for health promotion priorities at national or subnational levels.

**Methodology**: The data is collected through questionnaires based on these domains. The information collected is plotted in the form of an eight-spoked steering wheel (a spider-gram) and analysed to assess the country’s health promotion capacity status (Figure 2.3). The size and shape of the wheel
(plot) indicate the various stages of the developing capacity in a country. The domains falling between the four quadrants according to the two continuums of Inside/Outside Government and Policy/Partnership Focus provide a deeper understanding of the existing capacity in terms of national policy and partnerships.

![Diagram of National Health Promotion Capacity Wheel adapted from Catford, 2005](image)

Figure 2.3 National Health Promotion Capacity Wheel adapted from (Catford, 2005)

To further improve the use of this tool, the author suggests developing a set of consistent measurement criteria at global and country levels to monitor change over time and conduct inter-regional or inter-country comparisons.

The following section examines how the tool was adapted in combination with other methods to map capacity in various WHO Regions. Based on the eight domains presented by Catford (2005), the WHO developed a capacity mapping tool to be utilised in the global initiative to map health promotion capacity in the WHO regions, which had three versions (short, short
expanded and long). Each region was directed to use the version most suited to local conditions (Lin & Fawkes, 2005; WHO, 2010e). The strengths and weaknesses of the WHO mapping strategy are discussed in Appendix A.

B2. National Health Promotion Capacity Mapping in the Western Pacific Region

Lin and Fawkes (2005) were involved in health promotion capacity building in the Western Pacific region since 2005 as part of the WHO’s global project to map national health promotion capacity in various regions (Catford, 2005; Lin & Fawkes, 2005). The project was underpinned by the Regional Agenda for Capacity Building in Health Promotion (2002-2005) (Lin & Fawkes, 2005).

Lin and colleagues used the WHO tool based on Catford’s National Health Promotion Capacity Wheel in 2005 to map capacity in 17 WHO member states (Australia, Brunei Darussalam, China, Cook Islands, Fiji, Japan, (Republic of) Korea, Lao PDR, Malaysia, Mongolia, New Zealand, Papua New Guinea, Philippines, Western Samoa, Singapore, Tonga and Vietnam) (Lin & Fawkes, 2005). The tool was re-trialled in 2006 with modifications in the methodology in Philippines, Papua New Guinea and Brunei (Fawkes & Lin, 2007).

Framework: Lin and colleagues (2005) presented the final version of their capacity mapping framework in a working document for the 7th Global Conference for Health Promotion, Nairobi, 2009 (Lin, Fawkes, Lee, Engelhardt, & Mercado, 2009). The document describes a systems perspective for health promotion where capacity evolves, and is developed through a reflective learning and action systems approach (RELEASE). The systems perspective renders capacity building interventions as not only addressing the individual building blocks (finance, workforce, resources, information systems, organisational and intersectoral teams and partnerships) but ultimately how well the system functions as a whole.
Lin’s framework requires that capacity building efforts should have learning embedded into organisational processes for which concepts and terms, *reflective practice*, *learning organisations* and continuous *quality improvement* need to be used. Lin and colleagues suggest that capacity mapping should be repeated to maintain continuous quality improvement. Health promotion capacity mapping is taken as an application of the RELEASE model. The proposed framework for capacity mapping is given in the Figure 2.4.
Methodology: The tool comprised of three parts, each serving a different purpose for mapping health promotion capacity in a country: context; infrastructure and capacity across four domains; and system resilience. Contextual information was gathered by focal points in a process undertaken prior to completing the capacity assessment questionnaire.
Catford’s eight capacity domains were distilled into four broader domains and a new section was added which aimed to prompt in-country discussion about the *dynamics* of the health promotion system, with regard to allocative and technical efficiency, adaptability and sustainability.

<table>
<thead>
<tr>
<th>Part A Country profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socioeconomic</td>
</tr>
<tr>
<td>Demographic</td>
</tr>
<tr>
<td>Population health status</td>
</tr>
<tr>
<td>Health sector infrastructure and financing</td>
</tr>
<tr>
<td>Health promotion infrastructure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part B: Questionnaire Four domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Governance</td>
</tr>
<tr>
<td>2. Policy environment</td>
</tr>
<tr>
<td>3. System infrastructure and resources</td>
</tr>
<tr>
<td>4. Framework of programs and services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part C Discussion prompts about HP system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocative efficiency</td>
</tr>
<tr>
<td>Technical efficiency</td>
</tr>
<tr>
<td>Adaptive capacity</td>
</tr>
<tr>
<td>Autonomy</td>
</tr>
</tbody>
</table>

Figure 2.5 A three part tool design for national capacity mapping in the WHO WPR. Adapted from (Lin & Fawkes, 2007)

The 2006 capacity mapping was based on the experiences and results of the mapping conducted in 2005. Though the mapping carried out in 2005 brought significant results, further modification to the tool were done in agreement with the WHO and tool re-trialled in three countries in 2006.

In the 2005 mapping, eight-domain email questionnaires (short and extended versions, developed in the WHO-HQ) were completed by known focal points in the ministries of health or offices of the WHO Representative to form profiles of 17 selected countries, designed by a WHO HQ-based project team. Data was also gathered from background documents and interviews of the key informants in the WPR for the analysis and interpretation of questionnaires. Some follow-up was done by telephone and email. Completed questionnaires were translated by the WHO-HQ staff into diagrammatic representations of responses across all eight domains, for each
country and the WPR overall and an analytical report was produced (Lin & Fawkes, 2005).

The methodology was reviewed and modified in 2006 and findings were presented in 2007 at the Global Forum for Health Research, China (Fawkes & Lin, 2007). The modified tool included a review of international literature on capacity mapping by organisations such as the United Nations Development Program (UNDP) at the regional level and capacity mapping undertaken by other WHO regions. This was in comparison to the 2005 mapping where only local data was analysed.

The methodology applied a dialogue-based process through a one-day workshop to bring together key national stakeholders in health promotion who worked in small groups to discuss, debate and work towards agreement about assessments of capacity. These key stakeholders were:

- Ministry of Health staff from different levels and areas
  - policy and planning
  - finance
  - information and knowledge management systems
  - director and senior staff of the divisions of health promotion and community health/community development
  - local level health agencies
- Individuals from other ministries
  - Education
  - Sport and recreation
  - local government
  - national level non-government and community organisations
  - academic institutions
  - people from non-health sectors
- Officers of the prime minister and treasury
- Senior policy officers from other sectors
- Individuals from the private sector and donor bodies participated in some pilots
The authors consider the most important attributes of the methodology to be stakeholders’ engagement in the capacity debate, as well as joint assessment of strengths and deficits in health promotion infrastructure and capacity which also facilitates consensus about strategic direction for health promotion capacity building.

The tool was finalised based on results from the trial and targeted consultation with key informants including WHO WPRO.

B3. WHO EUR/IUHPE: HP-Source.net

Capacity mapping has been undertaken in Europe at the national level by the WHO for more than a decade now. The two large scale health promotion capacity mapping initiatives are:

1. Country audit approach of the WHO’s Investment for Health initiative (WHO, 2002)

2. HP-Source.net: a researcher / practitioner collaboration developed to meet data collection needs of the WHO country audit exercises (Mittelmark et al., 2005)

The HP-Source.net was founded by Spencer Hagard, former president of the IUHPE in response to the personnel employed and time consumed by the WHO country audit approach (Mittelmark et al., 2005). As a health promotion network, HP-Source.net deals with the challenge of developing health promotion capacity to move from evidence to practice. Initially funded by the European Commission the HP-Source.net is meant to ‘evolve into a voluntary, global collaboration of researchers, practitioners and policy makers towards developing a uniform system for collecting information on health promotion policies, infrastructures and practices, creating and analysing databases and disseminating this information and knowledge through of publications, seminars, conferences, briefings and other means’.
As an applied research tool, HP-Source.net is a mixed method approach (triangulation methodology) to produce country profiles. It is stated to capture the complexity of policy, infrastructure and key programmes which no single capacity mapping method can reveal (Fosse, Mittelmark, & Skogli, 2005).

*Framework:* The HP-Source.net utilises nine capacity domains similar to the ones used in Catford’s National Health Promotion Capacity Wheel to assess capacity at the country level. The approach addresses national level capacity with foci on policy, infrastructure and programmes. The nine capacity domains addressed are: politics, policies and priorities, evaluation, monitoring and/or surveillance, knowledge development, implementation, information dissemination for healthcare professionals, programmes and strategies, professional workforce and funding.

*Methodology:* The WHO country appraisals are qualitative, and conducted by a visiting team who study, before their visits, documents related to geography, political system and laws, economic situation, demographic, social health and sickness profiles, and structures and institutions of the particular country. The team conducts interviews, semi-structured discussions and a workshop in the country visited. Based on the information garnered from documents and meetings, the team composes a report with two elements: an assessment of strengths, weaknesses and opportunities for investment in health; and investment for health strategy.

The HP-Source.net (Mittelmark et al., 2005) is an Internet-based capacity mapping system (www.hpsource). It provides a portal for researchers, practitioners and policymakers to maximise the efficiency and effectiveness of health promotion by:
2. Literature Review

- Developing a uniform system for collecting information on health promotion policies, infrastructures and practices;
- Creating databases and an access strategy so that information can be accessed at inter-country, country and intra-country levels, by policy makers, international public health organisations and researchers;
- Analysing the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice;
- Actively imparting this information and knowledge, and actively advocating the adoption of models of proven effectiveness and efficiency, by means of publications, seminars, conferences and briefings, among other means.

Data is entered into the database online by using country-based named researchers from a variety of country sources. This mix of methods adopted for mapping health promotion capacity in health promotion is known as a triangulation approach, a multi-method way or a cross examination to double or triple check results. The data is also plotted on a spidergram.

The European mapping made use of the information collected on various occasions by activities like national appraisals, analysis of social and economic trends, WHO Capacity Mapping Initiative (2005) and HP-Source.net (Mittelmark et al., 2006).

**HP-Source.net application in Asia**

In 2004 Nam and colleagues conducted a study which compared health promotion policies between Korea and Japan which included the categories of data collection developed by HP-Source.net (Nam, Hasegawa, Davies, & Ikeda, 2006). The socio-economic status and health insurance data were sourced from the WHO while other data was collected through HP-Source.net on the domains mentioned above (Figure 2.6).

**Methodology:** Qualitative and quantitative data from published and unpublished literature and from the internet websites of relevant official
agencies were collected and inserted into comparative tables. The data from each country was described item by item for comparison.

<table>
<thead>
<tr>
<th></th>
<th>Korea</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousand, 2003)*</td>
<td>47,700</td>
<td>127,854</td>
</tr>
<tr>
<td>GDP per capita (Intl $, 2002)*</td>
<td>19,523</td>
<td>26,860</td>
</tr>
<tr>
<td>Life expectancy at birth (male/female, years, 2003)*</td>
<td>73.0/80.0</td>
<td>78.0/85.0</td>
</tr>
<tr>
<td>Total health expenditure per capita (Intl $, 2002)*</td>
<td>982</td>
<td>2,133</td>
</tr>
<tr>
<td>Total health expenditure as % of GDP (2002)*</td>
<td>5.0</td>
<td>7.9</td>
</tr>
<tr>
<td>Type of health insurance</td>
<td>NHI</td>
<td>NHI</td>
</tr>
<tr>
<td>Coverage of health insurance (%)</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 2.6 Mapping contextual data (socio economic status and health insurance) adapted from the WHO (Nam et al., 2006)

The same findings are also described in a case study on Korea alone, focused on the capacity mapping through HP-Source.net and Health Promotion Capacity Profile (Catford, 2005; Nam & Engelhardt, 2007).

Methodology: National and sub-national level data were obtained from: published and unpublished documents, reports, reliable Internet sites of relevant official agencies and through informal interviews with government officials from the Ministry of Health and Welfare (MOHW) and with public health experts.

B4. Capacity mapping for health promotion (WHO EMRO, 2010)

The capacity mapping in the WHO EMR adopted a collective approach to assess capacity in health promotion planning, programme implementation, financing and cross-sectoral collaboration (WHO, 2010e). The EMR office adopted the short expanded version in English and French and sent this tool to 22 countries to illicit information. The exercise took nine months. In addition, separate individual narrative reports were also prepared, based either on information provided by countries or on a hired consultant’s visit. The researcher utilised a modified version of this tool to map health promotion capacity in Pakistan in 2009 (S. Mahmood, 2009). The mapping
framework consisted of modified eight capacity domains framework as suggested by Catford (2005).

*Health Promotion Capacity Mapping - The SEARO Experience: *The mapping done by the WHO SEAR office shows a consolidated spidergram of health promotion capacity of the whole region. The mapping has employed Catford’s eight domains to map the region’s capacity - a level higher than national capacity mapping and towards global capacity mapping. The findings include the stage of development of each domain and uniformity of responses across SEARO countries. Also shown in the analysis are the differences in capacity according to level of development showing association between capacity, life expectancy and development index (Figure 2.7). There is no accompanying report regarding the study conducted in SEAR.

![Figure 2.7 Health Promotion Capacity and level of development adapted from (WHO SEARO, 2005)](image)

*Strengths and weaknesses of the WHO capacity mapping*

The following are strengths and weaknesses of overall WHO approach to regional and national health promotion capacity mapping derived from the
frameworks discussed above. These are not representative of all regions but are features from mapping done in various regions:

**Strengths**

- Structured approach to health promotion capacity assessment (‘a systems approach, engaging people operating at multiple levels in scoping capacity strengths and weaknesses to help shape system development agendas, which might not be the case in some countries where these voices are not heard routinely’ (Fawkes & Lin, 2007)).
- Mix of qualitative and quantitative methods undertaken for capacity assessment of the region and countries in the region.
- Multi-sectoral and participative methodology
- Involves stakeholders’ consensus building (enhances reliability) through application of a dialogue based process
- Some reports on mapping describe various methodological limitations with regards to question construction, language and concepts, availability of and access to information and issues in analysis of data.
- Considers a systems approach to a country’s health promotion system
- National capacity is analysed with comparison to human development: expenditure on health as a percentage of Gross Domestic Product (GDP), Human Development Index (HDI) and Life Expectancy Index.
- Japan and Korea are good examples of application of a European methodology in Asia that identify vital issues surrounding application of a tool developed for a ‘western audience’ utilised in Asia though more ‘fine-tuned’ tools are needed (Nam & Engelhardt, 2007)
- Country profiling (WHO, 2010e)

**Weaknesses**

- The WHO tools are in the development stage therefore a considerable amount of focus is on tool development rather than what capacity needs are being met through the use of tool.
2. Literature Review

- There were concerns about time constraints during the dialogue based approach (one-day workshops), the time to become familiar with others’ experiences and expertise, to achieve a trusting rapport, to encourage the sharing and questioning of opinions and experiences and to debate and negotiate assessments.

- Misunderstandings and conceptual misinterpretations of health promotion due to cultural and language barriers in the case of Japan and Korea (Nam & Engelhardt, 2007) where tools were unable to identify the country’s health promotion capacity as expected.

- Some methodological limitations identified by authors: 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)

- Flexibility of methodology exists for use at regional levels but country level contextual factors are not well reflected in the questionnaires or other methods employed

- No indication of cost of implementation

Appendix C shows a table of global regions and countries where health promotion capacity mapping was conducted by the WHO categorised into tool used, year of mapping, and the countries’ human development index ranking in 2010.

C. Health Promotion Capacity Checklists: A Workbook for Individual, Organizational and Environmental Assessment (McLean, Green, Moore, & Williams, 2004)

The Health Promotion Capacity Checklists workbook was developed by the University of Saskatchewan, Canada in conjunction with the Saskatchewan Heart Health Program supported by the National Health Research and Development Program/Canadian Institutes of Health, Saskatchewan Health, and the Saskatchewan Heart and Stroke Foundation. Though focusing on the specific issue of health promotion capacity building in heart health (Saskatchewan Heart Health Program (SHHP) Canada), the workbook aims
to act as a guide for assessment, reflection and improvement of the population health promotion practices of practitioners, managers and decision-makers. The authors argue that the tool should be useful for those engaged in, or supporting, population health promotion practices in many other contexts.

Although the tool has a specific focus and addresses practice based health promotion capacity issues, it is included to establish comparison among frameworks and capacity domains from different sources rather than only comparing the ones within the dominant WHO capacity mapping profile. Similar mapping frameworks and tools found in the literature are: Spence K. Health Communication/Promotion Capacity Mapping Questionnaire for the UNICEF CEE/CIS Region, and MEASURE Evaluation Project USAID.

Framework: The tool defines ‘capacity for health promotion’ as ‘having the knowledge, skills, commitment, and resources at the individual and organizational levels and in the wider environment to conduct effective health promotion’. Based on the socio-environmental model of health (Labonté, 1993), the framework describes how the macro environment of political, public, social and economic factors have an impact on effective practice (Figure 2.8).

Methodology: The authors employed multiple processes of inquiry and application to develop a model of the elements of health promotion capacity with items and domains (Figure 2.8). In addition to repeated surveys, other methods utilised were semi-structured interviews with practitioners and managers as well as innovative research approaches such as a historical timeline to get at the temporal aspects of health promotion development in districts.

There are 3 surveys in all (3 checklists – individuals, organisation, and environment). Each item in a domain of a survey collects response to a Likert rating scale question, evidence, comments and open ended questions on reflection. Each section on a domain ends with a list of resources referred
2. Literature Review

to for that domain. The responses from each checklist are plotted on a spidergram.

![Spidergram](image_url)

Figure 2.8 The elements of health promotion capacity adapted from (S. McLean, Green, Moore, & Williams, 2004)

**Strengths**
- Theory-based
- Well-structured survey
- ‘Road tested’ for face validity and acceptability with practitioners and managers

**Weaknesses**
- Practice focused
2. Literature Review

- Has not been subject to user satisfaction ratings, inter-rater reliability testing or internal consistency scores.

A thematic analysis was carried out to explore and identify the common capacity domains and sub-domains in the existing mapping frameworks and tools. Differences and similarities in the methodologies and strengths and weaknesses with regards to country level mapping are presented. The table in Appendix A presents the key findings.

Various capacity components like financing, workforce, etc. were grouped under capacity levels (system governance, inputs, outputs, impact and outcomes) and core capacity domains (governance, policy environment, system infrastructure and resources, and framework of programs and services). These groups are presented in Appendix B.

2.6 Discussion

The review of the existing frameworks and tools was carried out to gain a deeper understanding of the health promotion capacity mapping needs of the LMICs. There is no evidence that suggests implementation of these frameworks in an LMIC context and their use in developing national capacity based on the results of mapping. A major gap noted was the absence of addressing the contextual factors in which the mapping takes place. In this case it was the low and middle-income status of the country which gives LMICs unique characteristics in terms of policy formulation, its implementation and infrastructure development. This by itself was considered an ample argument for developing a framework and tool dedicated to the health promotion capacity mapping needs of LMICs.

The New South Wales mapping tool ‘Indicators to help with capacity building in health promotion’ is a quality focused tool based on theory based indicators. The tool employs a top down and bottom up approach with a comprehensive coverage for assessing multi-level workforce capacity. The tool emphasises problem solving through learning but lacks qualitative methodology. While it has been tested for validity and reliability, the project is still in development stages and there is lack of literature on evaluation.
The tool does not address capacity issues at national level especially health promotion capacity infrastructure assessment. The assessment process requires experienced health promotion practitioners to execute the process.

The WHO approach to mapping health promotion capacity is a structured approach employing quantitative and qualitative methods. The mapping process includes dialogue based multi-sectoral and participative strategies involving stakeholders’ consensus building which enhances reliability. The tool takes a systems perspective to assess health promotion capacity and in some regions capacity of a country is compared to human development indicators. While there is evidence of the use of this tool in other countries, various regional reports describe methodological limitations which include: personnel and time required to map, cultural and language barriers, lack of availability of data in some domains (especially health promotion financing), country contextual factors not well reflected in the methodologies, and no indication of cost of implementation.

The ‘Health Promotion Capacity Checklists: A Workbook for Individual, Organizational, and Environmental Assessment’ tool from the University of Saskatchewan, Canada employs a theory-based approach with a well-structured survey. The tool has been tested for face validity showing acceptability with practitioners and managers. Nevertheless, the tool is quite practice focused, with less of an emphasis on policy development and further reliability and consistency tests have not been conducted.

This review suggests that national health promotion capacity mapping initiatives are undergoing a development process. The frameworks and tools are still at a development stage and authors often suggest areas for further improvements. Most of the initiatives undertaken by the WHO to map regional and national health promotion capacity in the last decade require further research in refining the process of mapping and developing concrete tool and indicators which can measure and evaluate capacity, generate
2. Literature Review

evidence and be a regular and consistent feature in health promotion capacity building initiatives (Hawe et al., 1997; Lin & Fawkes, 2005; Mittelmark et al., 2006).

Almost all capacity frameworks identify information and monitoring systems, skilled workforce, capacity for research and development, sufficient resources and infrastructures, collaboration between various actors, adequate policy, planning and management systems as key capacities, but differ in the terminologies used and the conceptual and operational definitions. The examples of existing capacity mapping tools found in the literature vary considerably with regard to scope, size and format. In terms of scope, some instruments are a combination or adaptation of existing tools and measures, e.g. (Hawe et al., 2000; Lin & Fawkes, 2005), whereas others are specifically developed for the purpose of measuring health promotion capacities. With regard to the format, though most instruments are of the survey type, structured or semi-structured interviews, workshops and checklists are also found to be part of the mapping process. The data collection method may also involve individual responses, and focus groups. In terms of length, the instruments vary between 42 and 184 items.

However despite these differences there are many similarities. For instance, most of the assessment tools require the items relating to the health promotion capacity dimensions to be assessed using rating scales corresponding to the stage of development for capacity (e.g., not developed to fully developed). Some also provide a possibility for the respondent to further elaborate on the rating by giving additional information in an open format. Some tools encourage the provision of additional data by including open questions and the option to consult relevant data, reports and publications. While these tools provide a straightforward way to assess the capacities for health promotion as given in the models, very little information is provided regarding the validity of the scales, and most
2. Literature Review

sources provide no information about the time necessary to collect data and complete the tool.

An important feature in the capacity mapping which seems to be missing is the uniformity in the mapping process, capacity domains addressed and levels of implementation mapping is intended for (regional, national, organisational, community/local). The WHO regional offices, where most of the studies came from, have used the same questionnaires (short, expanded and long versions) but employed additional and different methods to collect data.

But, how uniform can a national capacity mapping tool be in the global setting? With an overall agreement on use of mixed method approach, there are still issues like, developing a tool for a specific level (regional, national, organisational, community and local) and agreement on baseline capacity domains. The Korean example discusses the importance of drawing from the experience of community level mapping (capacity components, assessment methods) for the assessment of national capacity for health promotion (Nam & Engelhardt, 2007).

The capacity related terminology is also diverse and creates confusion. For example capacity domains derived from capacity frameworks are often expressed as dimensions, levels, components, domains, scenarios, etc. In this study the researcher will use the terms ‘domains’ and ‘sub-domains’.

Almost all tools lack a capacity evaluation element, this need to be more pronounced. Though Lin and colleagues suggest impact and outcome mapping (Lin et al., 2009), evaluation capacity can be incorporated as a capacity component in a framework.

Questions posed in the Mittelmark and colleagues’ study on national health promotion capacity mapping (Mittelmark et al., 2006) along with some new questions in light of health promotion capacity development in LMICs are again quoted here in light of the findings of the review of frameworks and tools:
2. Literature Review

- Are the capacity requirements in LMICs for effective health promotion different from other countries because of differing cultural, social, economic and political conditions? Apart from existing commonality in what constitutes capacity among countries, are there differences arising from addressing different health issues in LMICs? Data on capacity cannot be understood without reference to the national context. Users of capacity maps that include the possibility of country comparisons need to be aware that the ‘look, feel, smell and taste’ of health promotion may be very different even in two geographically adjacent countries.

- Is it possible to use capacity mapping protocols commonly used in high income countries for LMICs? (Examples from Korea, Japan, South Africa).

- What constitutes health promotion infrastructure for capacity development in LMICs? Is it Systems, Money, Manpower, Activities, Plans, Intentions, Hopes and aspirations? Does capacity have different meanings in LMICs and is it more politically defined?

- Health promotion policy, infrastructure and programmes may be hard to separate and identify in the formal public or private investments in health promotion from other health budgets (broad as well as narrow definitions raise objections and generate controversy)

- Who is a health promoter? If a country has an established specialist force, its work will surely be counted, but if many other health professionals are doing health promoting work, their contributions will be hard to document.

- How to map the extent of health promoting work of the hidden workforce (individuals themselves, or of parents, teachers, or politicians)?

- Not all data is accessible or dependable. Private institutions consider data as business information and are often reluctant to share it. Public data may be tainted by political considerations.

- How is health promotion capacity mapped in countries where health promotion needs have not been identified?
2.7 Conclusion: Health promotion capacity mapping framework for LMICs

In light of the analysis of the existing mapping frameworks and tools, a mapping framework was developed for LMICs comprising of a set of four capacity domains and 15 sub-domains. This is presented in Figure 2.9. The core domains were the Country Specific Context, Governance, Policy Environment and Infrastructure.

![Figure 2.9 Capacity mapping framework for LMICs](image)

The capacity domains identified in the literature were grouped under the broad dimensions for capacity mapping proposed by Lin and Fawkes (2005)
namely System Governance, System Inputs, System Outputs, Impact and Outcome (Appendix B). Themes were identified and grouped under each broad domain: System Governance (Governance, Policy Environment), System Inputs (Infrastructure, Resources) and System Outputs (Programmes, Services). These were labelled as ‘domains’. Under these domains the capacity ‘sub-domains’ were grouped together which later became the sub-domains in the mapping framework. The broad capacity domains (System Governance, System Inputs, System Outputs, Impact and Outcome) were omitted to avoid making the framework complex. The capacity domain names were simplified as Country Specific Context, Governance, Policy Environment, and Infrastructure. The capacity sub-domains grouped under the domains were the commonly occurring capacity areas in various frameworks termed differently by various authors. The most common were selected and termed as presented in Figure 2.9. A Glossary was prepared which defined and explained the selected capacity domains and sub-domains.

The review of the literature on health promotion capacity issues in LMICs, and the existing six mapping frameworks and tools, highlighted the need for mapping framework, tool and mapping methodology in LMICs context. The review of the existing frameworks and mapping tools also provided insight to the process of mapping and identified issues related to implementation of the frameworks and tools. The main lessons learnt were:

1. The framework and tool for LMICs need to be supported by evidence and theory informed
2. The mapping process should be based on a mixed methods approach
3. Country contextual factors need to be well reflected in the methodology including language and cultural barriers
4. The mapping process should be participative and include dialogue-based processes involving a wide spectrum of stakeholders
5. The mapping tool should be reliable and valid
2. Literature Review

The mapping process in LMICs with different cultural, social, economic and political conditions should address these differences and how these impact policies and infrastructure. The country specific context of health promotion capacity development in LMICs is the core domain which addresses the historical, political, sociocultural and economic conditions which influence health promotion capacity development and could help define the differences in health promotion development from HICs. While the capacity domains like Governance, Policy Environment and Infrastructure are common in various existing mapping frameworks and tools it is elements in their sub-domains like Ownership, Policy Coherence, etc. that will address health promotion capacity issues that are unique to LMICs. The mapping framework and tool have to be sensitive to address LMICs development issues highlighting the role of country level factors that influence health promotion capacity development including rights-based approaches to health and human development criteria.

The mapping framework was sent to a group of global health promotion experts, accompanied by a Glossary, for their comments and feedback to pilot test in an LMIC. This process is described in Chapter 4.
3. Research Methodology

The overall aim of the study is to develop and test a conceptual mapping framework and data collection process to map health promotion capacity with specific reference to LMIC contexts. Chapter 2 provided a comprehensive review of the international literature concerning conceptual frameworks and methodologies for health promotion capacity mapping. Based on the review of existing studies, a conceptual model and set of core capacity domains and sub-domains were identified as being suitable for mapping health promotion capacity in LMICs. The core capacity domains included the four domains of Governance, Policy Environment, Infrastructure and Country Specific Context, and ten sub-domains. This chapter describes the two phased research methodology employed to fine-tune and test implement the mapping process and tools in a LMIC. The findings of the Phase I and II studies will be presented in the next chapter. The study adopted a phased approach and focused on the following objectives:

Phase I – Delphi Consultation
- To achieve consensus among a panel of global health promotion experts regarding a conceptual framework and a proposed set of core capacity domains for mapping health promotion capacity in LMIC contexts.
- To develop a capacity mapping process and data collection tools based on a consensus building process, suitable for use in an LMIC context.

Phase II – Case Study
- To test the mapping framework and data collection tools within an LMIC context.
- To explore the country specific factors that needs to be taken into account when mapping health promotion capacity development at the country level.
- To make recommendations for further development.
3. Research Methodology

3.1 Overall Study Design
The study consisted of two phases and employed a mixed methods approach. As a research method, a mixed methods approach has been defined as: “collecting, analysing, and mixing both quantitative and qualitative data in a single study, or series of studies. Its central premise is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone’ (Creswell & Clark, 2011).

A mixed methods approach is used when one methodology does not provide all the information required. When used in combination, quantitative and qualitative methods complement each other and allow for more complete analysis (Creswell, Fetters, & Ivankova, 2004; Tashakkori & Teddlie, 2010) answering the research question from a number of perspectives. In a mixed research both deductive and inductive methods are used to obtain quantitative and qualitative data ensuring that there are no ‘gaps’ to the information / data collected. The mixed research also ensures that pre-existing assumptions from the researcher are less likely. The data is corroborated to complement findings therefore taking a balanced approach to research. The mixed methods approach was found specifically appropriate for this study as it involved exploring the complexity of health promotion capacity mapping from the perspective of a number of key stakeholders at both a global and country-specific level.

The study was conducted in two phases (Figure 3.1). To determine the suitability of the capacity mapping framework in an LMIC context a consensus building process was undertaken in Phase I of the study, involving experts in global health promotion with experience of working in LMICs. Purposive sampling was used to recruit participants which were drawn primarily from contact lists made available by the IUHPE and the WHO. A number of related international agencies and NGOs were also contacted to participate. A layered online consultation process utilising two rounds of the Delphi consultation was employed. The first round of the
3. Research Methodology

Delphi consultation examined the appropriateness of the conceptual framework and core capacity domains and was completed by 104 global experts from 53 countries. Based on the agreed capacity domains from Round 1, 65 of the original respondents went on to complete Round 2 of the Delphi consultation which explored their views on the capacity mapping survey tool. Based on the findings, the capacity mapping conceptual framework and data collection tool was refined.

In Phase two, a case study method was employed to test the revised capacity mapping framework and assessment process in a selected LMIC context. Thailand was chosen for the case study, based on its LMIC status, Human Development Index (HDI), health promotion development and study feasibility. A mapping assessment process was undertaken in 2013, which comprised of the following data collection methods; a desk review of key policy and related documents, an online questionnaire and semi-structured telephone interviews conducted with 28 health promotion leaders and key informants at the country level, and a face-to-face discussion group with 9 senior level policymakers, academics and practitioners.

![Figure 3.1 Study Design](image-url)
Figure 3.1 illustrates multiple methods utilised to capture views concerning what capacity mapping is, and how best can it be carried out in LMIC contexts. This involved eliciting the perspectives of various stakeholders and key informants at both the global and country-specific level. A key issue identified in the literature review (Chapter 2) was the absence of focus on country-specific contextual factors in existing mapping processes. While quantitative research can be used in understanding the LMIC context for health promotion capacity development, qualitative research can provide a deeper insight into the perspectives of key informants, bringing stakeholders’ voices to the forefront (Creswell & Clark, 2011). Using both methods helped to combine the strengths of one approach to make up for the weaknesses of the other.

This mapping study connected the two phases of developing the mapping framework and testing of the framework and assessment process to reach the overall study aim. The two study phases gathered both quantitative and qualitative data and presented the findings by combining the results of both phases.

3.2 Phase I: Delphi Consultation

The aim of Phase I was to achieve a consensus among a panel of global health promotion experts regarding a conceptual framework and propose a set of core capacity domains for mapping health promotion capacity in LMIC contexts.

The Delphi method is commonly used in consensus building processes (Adler & Ziglio, 1996; Hsu & Sandford, 2007) and facilitates inclusion and participation of a large number of respondents across wide geographical areas (P. Howze & Dalrymple, 2004; Jairath & Weinstein, 1994; Thomson et al., 2009). The Delphi process aims to guide group opinion towards a final decision and to answer questions through triangulation of subjective group judgments, analytical techniques and the experience of the researcher. The method used in the study is similar to the Policy Delphi Method which
3. Research Methodology

aims to identify divergence of opinions and facilitate consensus among stakeholders (Dunn, 2003; Rayens & Hahn, 2000; Strauss & Zeigler, 1975).

The Delphi method used in the study enabled consultation with the experts in a systematic and multi-stage process in which questions were posed, the results analysed and findings reported back to the participants. There is no agreement in the literature on the optimal number of rounds to be used in the Delphi method (Critcher & Gladstone, 1998), with variables such as the time available and how the consensus process begins (i.e. with a broad question which requires refinement or with a list of specific questions) influencing the decision (Keeney, Hasson, & McKenna, 2006). As time was limited and the Delphi method posed specific questions based on draft documents, two rounds were considered sufficient for this development process.

A Delphi method is both a qualitative and quantitative instrument of inquiry (Skulmoski, Hartman, & Krahn, 2007). An e-Delphi approach (modified Delphi technique) was chosen for the present study as it enabled a web-based consultation with the larger geographically dispersed and multi-professional group. A method called ‘Real Time Delphi’ may have been more suitable for the study but was not found feasible due to resource constraints (Gordon, 2008, 2009; Gordon & Pease, 2006).

3.2.1 Sample

The sample was intended to include health promotion experts across the globe. An ‘expert’ was defined in the study as ‘anyone with noteworthy contribution in health promotion capacity development in LMICs. This contribution could be in health promotion research, academics, policymaking or a global or national level programme management in health promotion or public health with focus on health promotion’. Collectively the experts who agreed to participate in the consensus building were referred to as the Delphi Panel of Experts. A geographically expansive group of experts coming from a variety of countries, organisations and
networks were also expected to represent a wide range of opinions and enrich the consensus building process by capturing the breadth of contextual factors specific to health promotion capacity in LMICs through a wide range of opinions.

While a typical policy Delphi sample size could range from 10 to 30 participants (Dunn, 2003), the sample size in this study was desired to be larger in order to represent a wide range of geographical areas, job descriptions and health promotion expertise areas, with varying degrees of influence, and as well as being affiliated with different groups.

A purposive sampling technique was employed to identify the Delphi Panel of Experts to provide in-depth information about capacity mapping, proposed capacity areas and items in the mapping tool (Creswell & Clark, 2007). Initially the participants were selected by identifying contacts through requesting the thesis supervisor, colleagues and from personal contacts. The WHO and the IUHPE (International Union for Health Promotion and Education) were requested for permission to invite their personnel to be members of the Experts’ Panel such as regional WHO health promotion focal persons and IUHPE Regional Vice Presidents.

The participating experts came from a mix of experts working in high income countries (HICs) and LMICs. The experts from the HICs were selected based on their experience of work in LMICs. In light of the evidence of low health promotion capacity in LMICs (Battel-Kirk & Barry, 2010) consensus and feedback was sought from experts from both HICs and LMICs. This provided the experts an opportunity to reflect upon and share their experiences of health promotion capacity development in LMICs. A number of the World Health Organisation’s focal persons for health promotion in various regions were contacted for participation for which permission was sought from the WHO headquarters in Geneva, Switzerland.
In addition participants were also identified from the internet searches and contact authorships of research publications. An extensive internet search was conducted to identify relevant organisations and individuals on the internet. The search strategy was kept intensive and systematic so as not to miss potential participants who would be of benefit to the Delphi process. The experts were also allowed to snowball the questionnaire to other suitable colleagues in the field employing peer-to-peer nomination within the Delphi rounds to generate subsequent participants of the Delphi panel (Skulmoski et al., 2007). Snowball sampling is especially useful when trying to reach ‘inaccessible or hard to reach’ populations (Trochim & Donnelly, 2006) which in the case of this study were the health promotion experts worldwide, especially in LMICs. The database of experts also included lists of experts from previous studies (Battel-Kirk & Barry, 2010; M. Mahmood & Barry, 2010). A process of online recruitment was also used to add participants to the sample population via a web-based advertisement of the Delphi consultation using an online form. The link to the form was posted on popular and relevant forums and social networking platforms along with relevant details about the aim of the study.

A database of health promotion experts from across the globe was developed based on the criteria given in Appendix D. The difficulties faced in this type of sampling at an international level were in identifying the experts due to lack of data availability. Most countries lack suitable expertise, or job descriptions are not well defined. In addition the organisations do not make the information about their personnel easily accessible, especially the intergovernmental organisations (the UN, WHO, etc.) and other international development organisations.

3.2.2. Response rates and Participants’ Profiles

3.2.2.1 Pilot

The pilot questionnaire (Appendix G) was administered to 16 experts in global and national health promotion, coming from a range of backgrounds.
An online survey software, SurveyMonkey (www.surveymonkey.com), was employed. Six participants out of the 16 started the survey and five completed it. The participants’ expertise included policy (1), academia (3), research (1) and practice (1). Four participants worked in public organisations, while the remaining two came from the private sector and an inter-governmental organisation (IGO). Out of the six participants, five worked in High Income Countries (HICs), while one worked in a LMIC.

3.2.2.2 Round 1

A total of 781 email invitations were sent, out of which 723 were delivered to the potential respondents and organisations. 120 emails were not delivered and bounced back with error message ‘undeliverable’. The invitees also forwarded or ‘snowballed’ 62 email invitations to relevant colleagues or employees.

The response rate in terms of the respondents who completed the survey was n=96 (13%). A reminder was sent to the participants who did not respond to the questionnaire within one month of the deadline. Details of the response rate calculation are presented as a flow chart in Figure 3.2. Thirty experts enrolled themselves through an online web form out of which 23% (n=7) responded to the survey.
The participants who took part in Round 1 of the Delphi process responded from 53 countries across the globe. Details of the participants’ job description (academia, research, policy, practice), organisational affiliation (public, private, NGO, INGO, IGO), scope of work (national, international) and country they worked in (HIC or LMIC) were recorded to profile participants. A majority of participants worked as practitioners (42%), public organisations (44%) and at a national level (62%). 58% of respondents were based in HICs as compared to 41% who were resident in LMICs. Table 3.1 gives the detailed break down of participants in terms of their job, organisations, scope of work and their country of work.
3. Research Methodology

Table 3.1 Participants’ Profile

<table>
<thead>
<tr>
<th>Job description</th>
<th>% of responses (n=104)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>6</td>
</tr>
<tr>
<td>Academia</td>
<td>37</td>
</tr>
<tr>
<td>Research</td>
<td>15</td>
</tr>
<tr>
<td>Practice</td>
<td>42</td>
</tr>
<tr>
<td>Organisation</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>44</td>
</tr>
<tr>
<td>Private</td>
<td>14</td>
</tr>
<tr>
<td>MOH*</td>
<td>5</td>
</tr>
<tr>
<td>NGO</td>
<td>12</td>
</tr>
<tr>
<td>INGO</td>
<td>14</td>
</tr>
<tr>
<td>IGO</td>
<td>11</td>
</tr>
<tr>
<td>Scope of work</td>
<td></td>
</tr>
<tr>
<td>International</td>
<td>38</td>
</tr>
<tr>
<td>National</td>
<td>62</td>
</tr>
<tr>
<td>Countries (n=53)**</td>
<td></td>
</tr>
<tr>
<td>HICs</td>
<td>58</td>
</tr>
<tr>
<td>LMICs</td>
<td>41</td>
</tr>
</tbody>
</table>

*Abbreviations used: MOH=Ministry of health, NGO=Non-governmental organisation, INGO=International non-governmental organisation, IGO=International governmental organisation, HICs=High Income Countries, LMICs=Low and Middle Income Countries

**Based on United Nations Development Programme’s Human Development Index criteria, HICs are the ones ranked ‘very high human development’ and ‘high human development’. LMICs are the ones ranked ‘medium human development’ and ‘low human development’.

There were 27 refusals in total who communicated to inform of their inability to participate for various reasons. Out of these, 25 were individual experts and two came from international non-governmental organisations who were asked to forward the survey to suitable employees within the organisation. 26 refusals out of the 27 came from respondents living in HICs (‘very high human development’ countries).

3.2.2.3 Round 2

In Round 2 the response rate was lower than the previous round. A total of 65 participants responded to the questionnaire, out of 133 participants who were sent emails, resulting in a response rate of 49%. Two reminders were sent to the participants to improve the response rate. The participants who responded were from 42 countries showing an increase in responses from those resident in HICs (67%) compared to responses from those living in LMICs (33%).
3.2.3 Online Questionnaire
The data for the consensus building was collected through dissemination of an online questionnaire to the experts via a link provided in an invitation email. In Phase I, three questionnaires were developed at various stages: pilot test, Round 1 and Round 2. The details of these questionnaires are given in Table 3.2.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Purpose</th>
<th>No. of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot test</td>
<td>To receive feedback on ambiguities, difficulty in understanding questions, and identification of unnecessary questions</td>
<td>20 (19 rating scale questions, representing the four core capacity domains or 15 sub domains)</td>
</tr>
<tr>
<td>Round 1</td>
<td>Consensus building on capacity domains</td>
<td>28 (22 rating scale questions, representing four core capacity domains and 18 sub domains)</td>
</tr>
<tr>
<td>Round 2</td>
<td>Consensus building on mapping tool items</td>
<td>57 (55 open and closed-ended questions on four core capacity domains and sub-domains)</td>
</tr>
</tbody>
</table>

The pilot test questionnaire consisted of 20 questions. Out of 20, 19 questions were rating-scale type on four core capacity domains and 15 sub-domains. Each question included a text box for comments. The one open-ended question asked participants about the overall view of the questionnaire. To facilitate the participants in filling out the questionnaire, an attachment was sent with the email invitation which comprised of a document in PDF and Microsoft Office Word document formats to print and read before filling in the questionnaire online. The document included the description on the health promotion capacity mapping conceptual framework, definitions of the capacity domains and sub-domains and a glossary of terms.

The Round 1 questionnaire was based on the feedback from the pilot test. The questionnaire included 28 questions in total, out of which 22 represented four core capacity domains and 18 sub-domains, for which the consensus was sought with an accompanying statement. Participants were
asked to rate their level of agreement with each domain and sub-domain using a 5-point Likert Scale question designed to allow for calculation of means in the analysis (Strongly Disagree=1, Disagree=2, Uncertain=3, Agree=4 and Strongly Agree=5). Each question also included a comment box where participants were invited to make comments on any changes, suggestions, improvements, etc. to the capacity domain. Please see example as Figure 3.2 below.

22. Infrastructure

At the national level Health Promotion infrastructure includes human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide Health Promotion response to health issues and challenges.

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. Health Promotion Workforce

A competent Health Promotion workforce needs to have necessary knowledge, skills and abilities in translating policy objectives and current research knowledge into effective action tailored to the social, cultural, economic and political context and realities of population groups, settings and communities. At a national level this includes practitioners, specialists by virtue of their dedicated training, specialist functions or experience in Health Promotion in both health and non-health sectors and generalists, whose primary profession or area of study may be something different, but whose responsibilities include promoting health.

<table>
<thead>
<tr>
<th>Health Promotion Workforce</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3.3 Snapshot from the Round 1 questionnaire

The Round 2 questionnaire comprised of consensus building on a data collection tool for health promotion capacity mapping in LMICs. The data collection tool was developed from the result of the consensus and feedback from participants on the capacity mapping framework proposed in Round 1, and further review of literature. The questionnaire was comprised of 57 questions in total. There were 55 open and closed-ended questions representing four core capacity domains and ten sub-domains. Questions 56 and 57 focused on taking an overall opinion from the participants about the tool. The participants were asked to rate each question on a Likert scale of 1 to 5 (Strongly Disagree / Disagree / Uncertain / Agree / Strongly Agree) on
3. Research Methodology

their relevance to the tool and also to comment, if needed, in the comment box provided.

Given the wide geographical spread of the intended respondents, an online survey software, Survey Monkey, was selected for dissemination of data collection tool to the experts in the two-round Delphi consultation (Dillman, 2011; Wright, 2005). The participants were given the choice to re-enter the questionnaire at any time, before the closing date, to update their responses or complete the questionnaire in more than one session.

Glossary
A Glossary was developed to help participants understand various terms used in the mapping framework and tool and bring uniformity to the comprehension of objectives of mapping by the participants. Due to an interdisciplinary approach taken to develop the mapping framework and tool it was felt necessary to define and/ or give small descriptions of the ‘new’ terms used. After each round of the Delphi, the Glossary was updated in light of participants’ feedback.

3.2.4 Procedure
In the pilot test and Round 1, the experts were invited to participate in the Delphi consultation via an email explaining the purpose of the consultation and providing a web link to the online questionnaire. The study background and a glossary were attached with the email in the pilot and given access via link to Google Docs - an online platform for sharing documents (docs.google.com) in Round 1.

In Round 2 of the consultation, the experts were again requested to participate in a consensus building exercise for the data collection tool for mapping health promotion capacity mapping in LMICs, developed from the capacity domains identified in Round 1. The experts’ panel was apprised of the findings of the Round 1 via a link to Google Docs. Links for the Round
2 questionnaire and an updated Glossary were also provided. A web link for
the online version of the questionnaire was sent in the email.

A timeline for the data collection for the Phase I is given in Table 3.3. The
two rounds of Delphi were forwarded over a seven month period.

Table 3.3 Timeline of data collection Phase I

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot</td>
<td>2 months (October – November 2011)</td>
</tr>
<tr>
<td>Round 1</td>
<td>3 months (December 2011 to February 2012)</td>
</tr>
<tr>
<td>Round 2</td>
<td>4 months (April 2012 July 2012)</td>
</tr>
</tbody>
</table>

3.2.5 Analysis

The consensus building approach was adopted in view of the diversity of
global health promotion developments across the globe. In the case of the
mapping study, the Delphi experts’ panel was requested to provide their
consensus on two things:

1. Capacity mapping domains: Set of core capacity domains and sub-
   domains for LMICs. The experts were asked to rate their level of
   agreement regarding relevance of each domain and sub-domain for
   inclusion in, or exclusion from, the capacity mapping framework.
2. Capacity mapping tool: Items in a data collection tool developed on the
   capacity domains agreed upon in Round 1. The experts were requested
   to rate their level of agreement regarding relevance of question items for
   inclusion in, or exclusion from, the mapping tool.

Note: The use of the term ‘item’ (plural – items) for Round 2 questionnaire
means an individual question in the questionnaire.

Most consensus processes seek unanimity, but ‘settle for overwhelming
agreement that goes as far as possible toward meeting the interests of all
3. Research Methodology

stakeholders’ (Susskind, McKearnen, & Thomas-Lamar, 1999). It is recommended in the literature that there should be agreement on what will constitute ‘consensus’ before the process begins (Keeney et al., 2006; Susskind et al., 1999; Williams & Webb, 1994). There are also differing opinions on when consensus is achieved, including, for example, when there is a convergence of opinion, when a point of diminishing returns is reached (Fink, Kosecoff, Chassin, & Brook, 1984) or when an agreed ‘consensus point’ has been reached (Hasson, Keeney, & McKenna, 2000; Keeney et al., 2006). It was agreed that for the purposes of the study a consensus point for retaining a domain, or question in the mapping tool, would be reached when 75% of respondents in the Delphi surveys scored 4 or more on a 5-point Likert scale for each of the rated questions. This score is at the higher end of the levels for consensus discussed in the literature (P. Green, 1982; Hasson et al., 2000; Hsu & Sandford, 2007; Loughlin & Moore, 1979; Witt & Almeida, 2008). Each question related to the consensus was analysed for rating average, standard deviation, percentage of participants in agreement, percentage of participants in disagreement and the number of total valid responses.

The feedback received from the questionnaires were analysed for content and the findings, considered together with the mean score, to retain, remove or modify the domains or their accompanying statements. Qualitative feedback was an important element of the consensus process and it was agreed that participants’ responses to open questions in the Delphi survey would be analysed and grouped into common themes. This feedback further informed the decisions made on retaining, removing or modifying each domain or question in the mapping tool and in revising other elements such as the Glossary. The closed-ended data was analysed quantitatively, calculating the mean for each domain in Round 1. The responses to open questions were collated and analysed thematically.
The findings of the Delphi consultation were used to develop a process and strategy for implementing the capacity mapping framework and tool in LMICs. The Phase II of the study focused on testing the new framework and tool for data collection in Thailand.

3.3 Phase II: Case Study
The Phase II study aimed to test the health promotion capacity mapping framework and the data collection tools within an LMIC context. A case study approach was chosen for this study to provide insight into the country-specific factors that influence health promotion capacity mapping in LMICs and the implementation process. The objectives of the Phase II study were:

- To test the mapping framework and data collection tools within an LMIC context.
- To make recommendations for further development.

3.3.1 Case Study Design
According to Yin, a case study is utilised to investigate a contemporary phenomenon in depth within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin, 2009). The case study was designed to facilitate a deeper understanding of the contextual issues surrounding health promotion capacity mapping in LMICs and the implementation of the mapping process at a practical level. This line of inquiry fits well with the findings of the Phase I study, which indicated the need for a deeper exploration of the contextual issues surrounding capacity mapping, and the complex nature of country level health promotion capacity issues specifically for LMICs. Along with this, the case study also sought to determine the feasibility of implementing the data collection process at a country level.

The study relied on multiple sources of information and data drawn from diverse sources to test the health promotion capacity mapping framework and data collection tools at a country level, and to gain a better insight and
3. Research Methodology

deeper understanding of the various contextual factors of relevance to the capacity mapping process. Originally the study planned to explore the country specific contexts which influence health promotion capacity, and implementation of the mapping tool through use of the online questionnaire developed in the Phase 1 study. However, the findings from Phase 1 indicated that the information regarding contextual factors cannot be studied solely through an online questionnaire and that the mapping process needed to be supplemented with additional data collection methods.

In light of the findings from Phase I, the mapping process was strengthened by combining data collection methods as follows; a desk review of key policy and related documents, an online questionnaire and semi-structured telephone interviews conducted with health promotion leaders and key informants at the country level, and a face-to-face discussion group with senior level policymakers, academics and practitioners. Each of these methods is explained in detail in later sections of this chapter.

3.3.2 Selection of the Case
This study has a specific focus on health promotion capacity development in countries which are deemed to be ‘developing’ or categorised as being of low and middle income. At the country level, health is the responsibility of either a ‘department’ or a ‘ministry’\(^3\). In health promotion, health is also regarded as being central to the development agenda of a country. There are no standard classifications of countries based on their ranking in ‘health’ but globally countries have been ranked on their development status which include variables such as income, health, education, etc. Intergovernmental organisations\(^4\) like the World Bank\(^5\) has classified countries based primarily

---


\(^4\) ‘An intergovernmental organization (or international governmental organization; IGO) is an organization composed primarily of sovereign states (referred to as member states), or of other intergovernmental organizations. Intergovernmental organizations are often called international organizations, although that term may also include international nongovernmental organization such as international non-profit organizations or multinational corporations’ ([http://en.wikipedia.org/wiki/Intergovernmental_organization](http://en.wikipedia.org/wiki/Intergovernmental_organization))
on income (GNI per capita) which is used in literature in various disciplines. In the UN system there is no established convention for the designation of "developed" and "developing" countries or areas. The Human Development Index by the UNDP utilises a system for assessing the development of a country which is not based on economic growth alone. Using the criteria given by any of these organisations meant limiting the study according to the objectives of the organisation. The Organization of Economic Cooperation and Development (OECD) follow the classification of the UN systems.

Because there were no standard classifications which seemed appropriate, the study first of all categorised countries into two broad categories: high income countries (or developed countries) and low or middle-income countries (LMICs or developing countries). The term LMIC was selected due to it being commonly used by global agencies such as the WHO. To include the ‘development’ status of the countries, the list of countries for selection was taken from the UNDP’s ranking based on the HDI (low, medium and high human development countries). A low- and middle-income country (LMIC) was defined as a ‘country which is ranked medium or low human development on the Human Development Index (HDI)’ (UNDP, 2010). The HDI is a summary measure of development which measures the average achievements in a country in three basic dimensions of human development: a long and healthy life (health), access to

---

5 http://data.worldbank.org/about/country-and-lending-groups
6 http://unstats.un.org/unsd/methods/m49/m49regin.htm
8 The HDI was created to emphasize that people and their capabilities should be the ultimate criteria for assessing the development of a country, not economic growth alone. The HDI can also be used to question national policy choices, asking how two countries with the same level of GNI per capita can end up with different human development outcomes (http://hdr.undp.org/en/faq-page/human-development-index-hdi#t292n36).
9 http://stats.oecd.org/glossary/detail.asp?ID=6326
3. Research Methodology

knowledge (education) and a decent standard of living (income) (Klugman, 2011). The list of countries ranked according to HDI can be found at the United Nations Development Programme website at http://hdr.undp.org/en/statistics/.

Phase II of the study was originally planned to employ a collective case study approach where a number of LMICs were to be purposefully selected (Creswell & Clark, 2007, 2011). However, due to time constraints a single country case study was considered to be more realistic. The literature on case study methodology states that even a single case could be considered acceptable, provided it meets the established objective (Hamel, Dufour, & Fortin, 1993; Yin, 2009). In this study, Thailand was chosen for the case study, based on its LMIC status and Human Development Index, its level of health promotion development, and feasibility of data collection at the country level through the medium of the English language. A list of medium and low human development countries with HDI ranking for 2011 that was used in the study can be found in Appendix E. A set of inclusion and exclusion criteria were developed to filter the list of LMICs (Table 3.4).

Table 3.4 Criteria for selection of LMIC

<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
<th>Inclusion Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant violent conflict</td>
<td>Access to information for data collection</td>
</tr>
<tr>
<td>Major epidemic/s</td>
<td>Sovereign state*</td>
</tr>
<tr>
<td>Small island nations</td>
<td></td>
</tr>
<tr>
<td>War (current or recent)</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Recent natural disaster with destroyed infrastructure (e.g. Haiti)</td>
<td></td>
</tr>
</tbody>
</table>

*A sovereign state is defined as a state with a defined territory on which it exercises internal and external sovereignty (Shaw, 2004; Temple Lang, 1987)*

Table 3.3 shows list of proposed LMICs for the case study after applying the exclusion and inclusion criteria stated above. Please note that this selection was carried out in 2012 and the situation has changed in many countries since that time. The table also identifies the countries where health promotion capacity mapping was conducted by the WHO.
Table 3.5 List of Medium and Low Human Development Countries after applying the inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Medium Human Development</th>
<th>Low Human Development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Jordan</strong></td>
<td>Kenya</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td><strong>Pakistan</strong></td>
</tr>
<tr>
<td><strong>China</strong></td>
<td><strong>Bangladesh</strong></td>
</tr>
<tr>
<td><strong>Thailand</strong></td>
<td>Cameroon</td>
</tr>
<tr>
<td>Suriname</td>
<td>Madagascar</td>
</tr>
<tr>
<td>El Salvador</td>
<td>Tanzania (United Republic of)</td>
</tr>
<tr>
<td>Gabon</td>
<td><strong>Papua New Guinea</strong></td>
</tr>
<tr>
<td>Paraguay</td>
<td>Senegal</td>
</tr>
<tr>
<td>Bolivia (Pluri-national State of)</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Maldives</td>
<td>Togo</td>
</tr>
<tr>
<td><strong>Moldova (Republic of)</strong></td>
<td>Djibouti</td>
</tr>
<tr>
<td><strong>Philippines</strong></td>
<td>Rwanda</td>
</tr>
<tr>
<td>Guyana</td>
<td>Benin</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Gambia</td>
</tr>
<tr>
<td><strong>Viet Nam</strong></td>
<td>Ethiopia</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>Guinea-Bissau</td>
</tr>
<tr>
<td><strong>Morocco</strong></td>
<td>Eritrea</td>
</tr>
<tr>
<td>Guatemala</td>
<td>Guinea</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>Central African Republic</td>
</tr>
<tr>
<td><strong>India</strong></td>
<td>Burkina Faso</td>
</tr>
<tr>
<td>Ghana</td>
<td>Burundi</td>
</tr>
<tr>
<td>Equatorial Guinea</td>
<td>Niger</td>
</tr>
<tr>
<td>Congo</td>
<td></td>
</tr>
<tr>
<td>Cambodia</td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td></td>
</tr>
</tbody>
</table>

**Mapping done by WHO in 2005, 2007 and 2010 (available literature and WHO reports do not provide sufficient information regarding individual countries)

Initially it was proposed that the countries selected for the case study would include one country with medium human development status and two further countries of low human development status. Table 3.5 and 3.6 provide lists of countries which were considered for inclusion in the case study after filtering out countries based on the inclusion and exclusion criteria. The countries filtered down to English-speaking in Table 3.6 were discussed with the Graduate Research Committee.
3. Research Methodology

Table 3.6 List of countries for final selection for Case Study submitted to the GRC

<table>
<thead>
<tr>
<th>Pilot Case Study (Any ONE of following)</th>
<th>Case Studies (Any TWO of following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thailand</td>
<td>Bangladesh</td>
</tr>
<tr>
<td>Kerala state in India</td>
<td>Kenya</td>
</tr>
<tr>
<td>Guyana</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Ghana</td>
<td>Madagascar</td>
</tr>
</tbody>
</table>

One LMIC, Thailand, was selected on the basis of its high ranking global reputation for health promotion development, the feasibility of data collection from accessible and known health promotion contacts and time constraints. Thailand was treated as an information-oriented selected case (Yin, 2009) which would enable the collection of relevant information on the country specific context for health promotion capacity development and the key issues arising from the pilot implementation of the capacity mapping process.

3.3.3 Key Informants

Senior level health promotion experts in Thailand were selected as key informants for the case study. A key informant was defined as an expert who is knowledgeable about health promotion development at a country level. These key informants participated in the study through semi-structured interviews, an online questionnaire, and a face-to-face discussion group. The key informants were requested to provide information regarding the country specific context of health promotion capacity development in Thailand, including the main strengths, challenges, gaps, and barriers.

This approach required identification of a select group of health promotion experts, leaders and influential people who were active in Health Promotion at the country level. The approach provided for structured contact with these informants, through online questionnaires, interviews and participation in a discussion group format.

Broadly, the key informants were selected from the areas of health promotion policy, academia and practice. To further categorise the participants, and ensure suitable representation, the study aimed to identify
key informants from the following sectors: international health and development agencies, donor organisations, public (ministries of health, etc.), private and non-profit (nongovernmental organizations [NGOs], foundations) and civil society.

The key informants were recruited from: an online literature search, existing contacts, online recruitment, and snowballing. The World Health Organization (WHO) Geneva Headquarters, the International Union for Health Promotion and Education (IUHPE) and Thai Health Foundation were contacted to help identify key people in Thailand who were well versed in health promotion development issues and willing to provide information. With support from the IUHPE, Thai Health Foundation sent on a list of 29 contacts that were expected to participate in the mapping exercise in Thailand. Another 40 participants were included in the key informants’ list from Phase I of the study, internet searches, authors of publications, and snowballing among known contacts.

The key informants’ database, developed on an Excel worksheet, included details such as the title, name, job position, organisation, email address, telephone number/s, health promotion expertise (academia/ research, policy or practice), sector (public or private [NGO]) and web link if any. These details helped in selecting the key informants for the relevant data collection methods i.e., online questionnaire (preference given to programme managers and practitioners), interviews (policymakers and academics/researchers), discussion group (policymakers, programme managers, etc.). The key informants with the most experience and/ or working at the ministry level were sent invitations to participate in all three activities: online questionnaire, interviews and discussion group.

This type of sampling of key informants has its advantages and disadvantages. For studies like this case study, which was conducted at a national level, it helps to identify a range of key experts in the field so that it
is ensures that the data are being collected from the relevant people. It is difficult to identify these specialists, especially those with health promotion experience at the national level, as many countries either do not have people in these key positions or have job descriptions that are not well defined, i.e. may not include Health Promotion in the title. Collecting as much information about the key informants as possible helps to utilise the relevant key informants’ expertise for the right type of information being collected. Nevertheless, identifying and contacting key informants at national level, for example, in the ministries, or working in national level public or private organisations, can be quite time consuming and may not result in a representative sample.
3.3.4 Response rates and Participants’ Profiles

3.3.4.1 Key Informants Interviews

A total of 23 senior level health promotion experts in Thailand were sent emails requesting a one hour interview through Skype/ Telephone. These key informants were purposefully selected from the key informant contact list based on their seniority, area of expertise and job description. Out of 24, seven senior level health promotion experts, including one of the founders of Thai Health, agreed to undertake the interviews (Response rate 29%). The profile of the participants is given at Table 3.7.

Table 3.7 Participants profile for Phase II interviews

<table>
<thead>
<tr>
<th>Participant</th>
<th>HP Area</th>
<th>Job / Institution category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>Academia</td>
<td>Public</td>
</tr>
<tr>
<td>Participant 2</td>
<td>Academia</td>
<td>Public</td>
</tr>
<tr>
<td>Participant 3</td>
<td>Policy</td>
<td>Autonomous (Ministry)</td>
</tr>
<tr>
<td>Participant 4</td>
<td>Policy</td>
<td>Autonomous (Ministry)</td>
</tr>
<tr>
<td>Participant 5</td>
<td>Policy &amp; Practice</td>
<td>Private</td>
</tr>
<tr>
<td>Participant 6</td>
<td>Practice</td>
<td>Regional International</td>
</tr>
<tr>
<td>Participant 7</td>
<td>Policy</td>
<td>Public (Ministry)</td>
</tr>
</tbody>
</table>

3.3.4.2 Online Questionnaire (Health Promotion Capacity Mapping Tool)

Out of 69 key informant contacts 53 were selected and sent invitations to complete the online questionnaire. These included seven participants who were originally requested for an interview but opted instead to complete the questionnaire. The response rate of the online questionnaire was 40% (n=21). These participants were classified based on their level of work (national, regional or global), job sector (public, private, semi-state or NGO), and health promotion area (research, policy or practice). Seventeen participants were experts working at a national level in Thailand (Figure 3.4). Nine participants worked in the public sector and eight were focused on health promotion research. Further details can be found in Appendix O, Table O1.
3.3.4.3 Group Discussion

The 53 participants who were sent online questionnaires were also invited to attend the Group Discussion session at the 21st World Conference on Health Promotion in Pattaya, Thailand on 27 August 2013. Out of these, 10 participants agreed to attend the Group Discussion. A total of nine key informants finally took part in the discussion including three who joined in response to an announcement made during the conference. A participants’ profile is presented at Table 3.8. These comprised of senior MoPH officials, policymakers, academics, practitioners working at various levels in public, private and non-governmental organisations. The participants were sent information sheets explaining the mapping process, the mapping tool and the themes to be discussed in the group. The participants were requested to sign a consent form and the discussion was recorded.

Table 3.8 Discussion Group Participants’ Profile

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>Practice (Program Manager)</td>
</tr>
<tr>
<td>Participant 2</td>
<td>Practice (Program Manager)</td>
</tr>
<tr>
<td>Participant 3</td>
<td>Policy (National Health Commission Office - NHCO)</td>
</tr>
<tr>
<td>Participant 4</td>
<td>Practice (Program Manager)</td>
</tr>
<tr>
<td>Participant 5</td>
<td>Practice (Program Manager)</td>
</tr>
<tr>
<td>Participant 6</td>
<td>Academia (University)</td>
</tr>
<tr>
<td>Participant 7</td>
<td>Policy (Ministry of PH)</td>
</tr>
<tr>
<td>Participant 8</td>
<td>Academia</td>
</tr>
<tr>
<td>Participant 9</td>
<td>Policy (Thai Health Centre)</td>
</tr>
</tbody>
</table>
3.3.5 Data Collection
The data on health promotion capacity mapping in Thailand was drawn from a combination of sources; a desk review of relevant documents and reports, telephone interviews and a face-to-face discussion group with key informants, and an online questionnaire. The desk review and key informant interviews were used to explore the country specific context for health promotion capacity mapping in Thailand.

The capacity mapping tool was tested through pilot implementation of the online questionnaire with Thai health promotion experts and the group discussion also provided further insights regarding the issues arising from use of the capacity mapping process at a country level.

3.3.5.1 Desk Review
The desk review was conducted with the aim of collecting data regarding the country specific context for health promotion developments in Thailand. The desk review explored the specific historical, political, socio-cultural and economic environments in which health promotion development took place in Thailand. The literature comprised of key policy and related documents affecting decision-making and implementation of strategies to develop health promotion capacity. The key sources of information were identified during correspondence with the Thai Health Foundation and the key informant interviews.

A search strategy was developed to search relevant databases in the James Hardiman Library at the National University of Ireland Galway. The literature included policy documents, research articles, books, newspaper articles, and relevant reports from international and national organisations (WHO, Thai Health Foundation, etc.). Email alerts were set up in various subject and multidisciplinary databases, in and outside the university library (EBSCOhost, SciVerse, Medline, JSTOR, Google Scholar, etc.), for research articles, books, reports, grey literature, etc. based on key search
3. Research Methodology

terms like ‘Thailand’, ‘health promotion’, ‘capacity’, and ‘public health’, ‘economy’, ‘history’, ‘political’, ‘social’, ‘culture’ and ‘health system’. These search terms were applied in various combinations employing operators, truncation and wildcard techniques to filter information. Additional literature suggested by the staff at the Thai Health was also consulted.

The desk review focused on providing a profile of Thailand in terms of sociodemography and geography in order to gain a deeper understanding of the factors influencing health promotion capacity development. The literature came from multiple disciplines including health promotion, public health, international and human development. The literature was confined to English language. The literature before 1995 was excluded to avoid outdated information. The approach of the desk review was exploratory. It was noted that due to the diversity of the subject matter and time constraints it was difficult to filter information systematically. In total 305 articles were collected under various themes. The presentation of the findings from the desk review was structured using the headings adapted from the Health Systems in Transition (HiT) series of the European Observatory on Health Systems and Policies. The key areas covered included Geography, Sociodemography, Culture, History, Economic Context, Political Context, Health Development, Health System, Health Promotion, Universal Health Coverage, General Country Profile, Government Organisations, and International Organisations.

3.3.5.2 Semi-structured Telephone/ Skype Interviews

Telephone interviews are used frequently in health and health promotion research (Bowling, 2009; J. Green & Thorogood, 2005; Grimshaw et al., 2004). This study utilised a semi-structured interview approach, which was conducted through Skype/ telephone to elicit key informants’ views on the country specific contexts that influence the development of health promotion capacity in Thailand. The interviews helped to identify existing strengths, gaps and challenges in the historical, political, economic and
3. Research Methodology

socio-cultural environments surrounding health promotion developments in the country. The interviews were designed to explore the related issues in-depth (Yin, 2009) by asking the key informants about the factual information regarding country specific context of capacity mapping, informants’ opinions about various health promotion developments affecting health promotion capacity and also informants’ own insights into relevant matters.

A list of participants from policy, academia/ research and practice areas were contacted and requested to take part in one hour-long telephone / Skype interviews. The participants were selected from a range of people working at national level including ministries, national and regional programme managers, policymakers, advisors, and national and international NGO and IGOs. Seven out of 23 health promotion experts agreed to undertake the interviews. The interviews were conducted in the English language. The interview guide is given in Table 3.9.
Table 3.9 Interview Guide for Key Informant Interviews

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thailand enjoys a unique position worldwide due to its achievements in health promotion development. Learning from this experience, what do you consider to be the key factors and influences that led the country to adopt a health promotion approach?</td>
<td>Historical, political, social, culture, economic environments. Adoption of Health for All Policy (WHO, 1978), Health System Research Institute (HSRI, 1992), 1997 Constitution leading to National Health Act, etc.</td>
</tr>
<tr>
<td>2</td>
<td>How is the existing political system conducive to health promotion development in the country? What are the challenges?</td>
<td>Stability, democracy,</td>
</tr>
<tr>
<td>3</td>
<td>Thailand has a well-established system of financing health promotion activities through ThaiHealth. ThaiHealth is a key driver behind Thailand’s health promotion development. What is the secret behind ThaiHealth’s success and sustainability? Do any other financing mechanisms for Health Promotion exist in Thailand?</td>
<td>Financing, corruption</td>
</tr>
<tr>
<td>4</td>
<td>Could you identify the main institutions/agencies in the country which oversee the national Health Promotion policymaking? Please also identify the key mechanisms and institutions/agencies responsible for programme implementation. Are these at country or regional level? What are the main barriers that are faced by such institutions/agencies e.g. from outside the country (global health) and within the country (political parties)?</td>
<td>Role of Ministry of Public Health?, Who has the vision?, Vision for empowerment, health as right and equity?, leadership, ownership</td>
</tr>
<tr>
<td>5</td>
<td>In developing countries, cultural and language barriers have been identified as important considerations for the development of Health Promotion. Health Promotion is sometimes referred to as an approach which is more suitable for ‘western’ (or developed) countries. Do you agree with this? Are there any cultural challenges being faced now, or in the past, in advancing Health Promotion in Thailand?</td>
<td>Spiritual dimension of health (Buddhism), religion, translating literature, engaging the public.</td>
</tr>
<tr>
<td>6</td>
<td>Please identify the main strengths and weaknesses/barriers in developing national health promotion capacity in Thailand?</td>
<td>Governance, policymaking</td>
</tr>
<tr>
<td>7</td>
<td>You enjoy a key position in the health system in Thailand. What drove you personally to support health promotion in your country?</td>
<td>Equity, rights,</td>
</tr>
<tr>
<td>8</td>
<td>Do you think the capacity domains in the health promotion capacity mapping tool adequately capture the health promotion capacity needs in Thailand? What would you like to see changed in this tool?</td>
<td>Unnecessary domain, other domains you would like to see added?</td>
</tr>
<tr>
<td>9</td>
<td>Who do you think should be invited to participate in the mapping process as key stakeholders?</td>
<td>Civil society</td>
</tr>
<tr>
<td>10</td>
<td>This mapping study is also conducting a desk review to better understand the country specific contexts relevant to mapping process. Would you like to suggest any key sources of information?</td>
<td>Policy documents, government reports, research studies, etc.</td>
</tr>
<tr>
<td>11</td>
<td>Would you like to complete the online mapping tool as a contribution to this ongoing study? Your feedback will be very useful to the mapping process.</td>
<td></td>
</tr>
</tbody>
</table>

3.3.5.3 Online Questionnaire

The online questionnaire developed in Phase I was sent to 55 senior level key informants in Thailand. It comprised of 42 questions out of which 33
were close-ended (Table 3.10). The questions were related to the existing situation in LMICs with respect to health promotion governance, policy making, programme delivery and country specific contextual factors.

Table 3.10 Types of questions used in the Case Study questionnaire

<table>
<thead>
<tr>
<th>Close-ended</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose one best answer</td>
<td>5</td>
</tr>
<tr>
<td>Choose multiple answers</td>
<td>3</td>
</tr>
<tr>
<td>Yes / No / Uncertain</td>
<td>8</td>
</tr>
<tr>
<td>Rating scale</td>
<td>16</td>
</tr>
<tr>
<td>Participants’ demographics</td>
<td>1</td>
</tr>
</tbody>
</table>

A printable version of the online questionnaire (Appendix N), background information document and a Glossary of commonly used terms (Appendix Q), were attached to the email sent to the key informants to read and collect necessary information before completing the online version. The online version of the questionnaire was uploaded to the SurveyMonkey software. It was noted, and conveyed to the participant, that if they had the information ready they could fill the questionnaire in a 35-45 minutes session.

3.3.5.4 Discussion Group

A one hour face-to-face group discussion of a panel of key informants was held at the World Conference on Health Promotion, 27 August 2013 at Pattaya, Thailand in Pattaya Exhibition and Conventional Hall (PEACH). The aim of the discussion group was to explore their views on health promotion capacity mapping and the feasibility of implementing the health promotion capacity mapping tool in Thailand and other LMICs.

The key informants were selected from the participants who participated in the telephone interviews and the online questionnaire. With the experience of getting a low response rate in Phase I of the study, invitations were extended to as many participants as possible. The last question in the online questionnaire was based on an invitation to the respondents that attended the conference who then could participate in the discussion group. Similarly,
selected participants from the telephone interviews were invited to the discussion group.

The key informants for the discussion group were sent the background information sheet, consent form, mapping tool (online questionnaire), Glossary and a Group Discussion information sheet where key themes were presented as a guide for discussion.

The themes for discussion were as follows:
1. The best way to develop a capacity mapping strategy/system for LMICs.
2. Participants’ views on the usefulness of a health promotion capacity mapping framework and tool for use in Thailand and in other low and middle income countries.
3. Use of the mapping framework and tool in the Thai context. What is missing in the capacity mapping tool?
4. Importance of the country specific context for health promotion capacity development based on participants’ experience in Thailand and in other countries.
5. Ownership of the capacity mapping activity and other stakeholders in the mapping process.

3.3.5.5 Procedure

The key informants were contacted via email to participate in the online questionnaire, interviews and the discussion group. As already mentioned, the participants for the online questionnaire and interviews were contacted simultaneously. The timeline of Phase II is shown in Table 3.11. The desk review, interviews and the questionnaire were conducted simultaneously. This provided the researcher with the opportunity of including issues emerging from the desk review and questionnaire as part of the semi-structured interviews or vice versa.
3. Research Methodology

Table 3.11 Timeline of data collection Phase II

<table>
<thead>
<tr>
<th>Research Method</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire (with Pilot)</td>
<td>7 months (March to September 2013)</td>
</tr>
<tr>
<td>Interviews (with Pilot)</td>
<td>6 months (May to November 2013)</td>
</tr>
<tr>
<td>Discussion Group</td>
<td>1 day (August 2013)</td>
</tr>
</tbody>
</table>

The desk review was started in early 2013. A database of relevant literature was developed. A structure of the desk review section was developed including available literature on the health promotion developments in Thailand and the capacity mapping domains. The review was completed after revising four drafts.

The key informant interviews were conducted and recorded in the Meeting Room of the Health Promotion Research Centre, National University of Ireland, at Galway. The key informants were given a choice to select either Skype software (skype.com) or telephone. Interviewing on Skype has the advantage of being in a video call where researcher and the interviewee can see each other on the computer screen. Skype calls are very low cost as compared to telephone calls. An interview protocol to guide the process of interviewing and interview questions with prompts was developed. Ten main themes were identified regarding the contextual information required for the mapping exercise. The questions related to the contextual environments which could influence health promotion capacity development, including the political, historical, socio-cultural and economic environments. The interviewees were encouraged to state their personal experiences relevant to health promotion developments in Thailand. The researcher also took the interviewees’ opinion on the ongoing mapping exercise and the tool being employed.

Each interviewee was sent a background information document which included the study and interview aims, a matrix on which the interview would be based (Table 3.12), a consent form, the mapping tool, and Glossary.
Table 3.12 Matrix sent to the key informants for the Telephone/ Skype interviews

<table>
<thead>
<tr>
<th>Health Promotion Governance</th>
<th>Health Promotion Policy</th>
<th>Health Promotion Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Two pilot interviews were conducted in May 2013 to test the interview protocol and the recording process. A total of 4.75 hours of audio files were recorded from the interviews of six participants. One participant due to time constraints responded in a written text format.

A pilot testing of the online questionnaire was conducted in early 2013. The online questionnaire was sent to a number of colleagues to either complete the questionnaire themselves or forward to those they thought would be interested in contributing. The pilot participants were invited via email and sent the background information document, printable version of the mapping tool (online questionnaire), a Glossary and a web link to access the questionnaire online. The pilot participants, in addition to providing the information asked in the questions, were requested to provide feedback on any ambiguities, difficulty in understanding question(s) (including any unnecessary question(s)), overall readability and any other aspect of the survey which they would like to highlight as a pilot participant. Each question had a comment box which could be used to provide feedback.

After two months of the pilot the online questionnaire was sent to the key informants in Thailand in June 2013. As a key informant, the participants were requested to respond to the questions to the best of their knowledge and experience. They were requested to respond to all questions and provide as much information as possible to make the mapping process a success.
The participants were informed that they were not expected to have ‘answers’ to all the questions as they were coming from a diverse range of backgrounds. The only mandatory question was Question 1, which inquired about the participant’s name, work, expertise and email address. The participants were assured that all their responses would be kept strictly confidential.

The participants were encouraged to use the comment boxes provided with all the questions. They were also asked to forward the email to a colleague or another leading expert if they felt that she/he could contribute significantly to the mapping process. It was decided that two reminders at regular intervals of two weeks each would be sent to the participants who were invited but did not respond to email invitation.

The group discussion was held at the World Conference on Health Promotion, 27 August 2013 at Pattaya, Thailand in Pattaya Exhibition and Conventional Hall (PEACH). The participants were those who were attending the conference. These participants had either expressed an interest during the interviews, answered yes to the question in the questionnaire to attend the discussion or had agreed to the discussion via invitation email. As there was a low response rate, a poster was put on the conference venue to contact the researcher if anyone wished to join the panel. Three participants joined the discussion from the conference venue.

The discussion was held in a pre-booked room from 12.30 to 13.30. The participants were given a brief account of study background and aim of the discussion group. Consent forms were signed before starting the discussion and participants were apprised of the confidentiality of the data being recorded.

Each theme was given approximately 15 minutes. It was explained to the participants that the themes were only guidelines for the discussion and
participants were welcome to discuss any other relevant issues. Participants were requested their permission to record the group discussions, using an audio recorder to ensure that all important issues raised in the discussion were captured. The participants were assured that all information recorded would be kept strictly confidential by the researcher. The participants were also informed that the results would be reported as group data and would not identify any individual in any way. The participants were informed that the recordings would be stored securely for six months after which they would be destroyed. The participants were requested to sign an attached consent form in the email and bring to the group discussion.

3.3.5.6 Analysis

The sources of data in the case study were the findings from the desk review, transcripts of interviews, findings from the online questionnaire and the transcript of the group discussion. The information from the findings was categorised according to the method of data collection:

1. Country specific context for health promotion capacity mapping in Thailand - desk review and key informant interviews.
2. Health promotion capacity mapping - online questionnaire.
3. Use and implementation of the capacity mapping process and tools - group discussion.

The case study sought to triangulate the data from the different sources in achieving an overall picture of the participants’ views concerning the health promotion capacity mapping process and its use at a country level in an LMIC context.

The literature on the desk review and the transcribed interviews were structured into themes describing the contextual issues for health promotion capacity developments in Thailand. The desk review was presented as a template, which could be used for carrying out future mapping desk reviews in LMICs. The interviews were first-hand accounts of senior level national
3. Research Methodology

health promotion experts (academia/researchers, policymakers and practitioners) who highlighted key capacity development issues in Thailand from a country specific perspective.

The content of the text (data) from the desk review and transcribed interviews was analysed and categorised into recurrent or common themes (J. Green & Thorogood, 2005). The thematic analysis of the findings from the two methods constituted the country specific contexts for health promotion capacity mapping in Thailand.

The online questionnaire data provided information on the existing situation of health promotion capacity development in Thailand under the four core capacity domains of: Governance, Policy Environment, Infrastructure and Country Specific Context. The closed-ended responses were analysed quantitatively. The closed-ended Likert scale questions were analysed for reliability and checked for internal consistency using Cronbach's alpha. Participants’ responses to open questions were analysed and grouped into common themes for thematic analysis. Similar to the data from the interviews, the audio file from the discussion group was transcribed and analysed for themes related to use and implementation of the mapping process and tools.

The case study findings were used to consider what health promotion capacity issues exist in Thailand within various contextual environments (historical, political, economic, social and cultural), how the mapping process was introduced and carried out in Thailand, what was mapped, and participants’ views on the strengths and barriers in implementing the mapping process in Thailand and in other LMICs.
4. Phase I: Conceptual Framework and Tool

Phase I of the study is comprised of an international consensus building process through an online Delphi method with a global panel of health promotion experts. A pilot study followed by two rounds of Delphi consultations led to the development of a country-level capacity mapping tool for health promotion in LMICs. The data collection and analysis were accomplished over a seven months periods. Round 1 of the Delphi focused on building consensus on a set of proposed capacity domains identified in the literature review, and a conceptual mapping framework for capacity mapping. Round 2 comprised of consensus building on a capacity mapping tool based on the agreed upon capacity domains and framework in Round 1. The resulting mapping framework and tool from Phase I of the study was then piloted in a LMIC as part of the Phase II study.

4.1 Pilot

The health promotion capacity framework, which was based on capacity domains and sub-domains identified in the literature review, was sent to a list of pilot participants. The email invitation to the pilot participants consisted of a brief overview of the study, the mapping framework and a Glossary (Appendix F). The pilot participants were asked whether each proposed capacity domain or sub-domain was suitable to be included in the questionnaire in terms of readability and workability (Appendix G). The pilot study also sought feedback from participants on any ambiguities in the questionnaire, difficulty in understanding question(s) and identification of unnecessary questions. The feedback from the participants was analysed in terms of time to complete the questionnaire and re-wording or re-scaling of questions, if needed, according to adequacy of responses. The pilot also helped identify technical issues in online dissemination and collection of responses.
4. Phase I: Conceptual Framework and Tool

4.1.1 Pilot study findings and analysis
The respondents rated the four domains using a 10 point rating scale where 1 = ‘least relevant’ and 10 = most relevant to health promotion capacity mapping in LMICs. All the domains were ranked at an average score of 8.25 on the scale and within a range of 8-10. Governance was ranked 10 (most relevant) by 4 out of 6 respondents. All the ranking for the relevance of the sub-domains for the health promotion capacity mapping fell between 6 and 10 with Political Commitment being ranked the highest (9.4) and Political Context the lowest (6.6) in terms of rating average. The Country Specific Context domain got the lowest rating average (8.7) among the proposed four broad domains in the framework, but was also deemed to be the most relevant domain of all others in the comments. The domain was identified as important in relation to identifying and responding to health promotion needs in each context but raised issues of comparability when mapping across different contexts mapped:

…..country specific context is at the core of all the other elements and influences and pervades all else to such a degree that is probably most important’, and, ‘this context (country specific) is very important in relation to identifying and responding to specific health promotion needs in each context. However, it is difficult to compare contexts.

The participants expressed difficulty in understanding various terms like ‘political context’, ‘political commitment’, ‘ownership’,

……using the term 'health in all policies' might be useful (in domain Policy Coherence).

While I understand what is being asked this question (on Infrastructure) is a bit 'dense' in language.

Question would be perhaps what is a national health promotion system- and is seen only in the context of government (which is sometimes overly
associated with governance) rather than the broader society including NGOs community associations/groups etc.

The label 'sustainable financing' is somewhat ambiguous, as is the interpretation of 'effective programme delivery'.

The participants also expressed difficulty in understanding the relationships between different domains and/or sub-domains.

I find it hard to disentangle B (Governance) and C (Policy Environment) - they are intermeshed - also how partnerships work is quite different from political commitment.

The participants found it difficult to score some sub-domains as they covered a broad range of features e.g. economic context. The participants agreed that the rating scale of 1-10 was not useful:

I agreed with all the domains and found it difficult to 'rate' them on a 1-10 scale.

Some themes cover a broad range of issues and it's therefore difficult to give one score. Some aspects or features of the map seemed to have a specific and not obvious interpretation on them, again creating some dissonance for those attempting to score. The level of abstraction required for scoring the mapping components is quite high - this again makes scoring quite difficult and uninformed.

The participants gave feedback on the overall questionnaire in terms of ambiguities, difficulty in questions (including any unnecessary question(s)), time taken to complete the questionnaire, overall readability. One participant stated that:
I think that the overall model stands up well. As usual there is the difficulty of how much to explain the domains etc. I think that in most of the
'definition' there could be a more focused core statement - as they are currently they present a lot of information but could be more succinct particularly if to be used for mapping.

### 4.1.2 Conclusion

There was general agreement from the pilot participants concerning the proposed Health Promotion capacity mapping framework and domains. In addition to the existing sub-domains, some new ones were added to the framework due to the emergence of new themes from the participants’ feedback. Table 4.1 presents the changes made to the proposed framework.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Proposed Framework for Pilot</th>
<th>New Framework for Round 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Country Specific Context</td>
<td>Country Specific Context</td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historical Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social and Cultural Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
<td>Governance</td>
<td>Governance</td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td>Political Commitment</td>
<td>Political Commitment</td>
</tr>
<tr>
<td>Leadership</td>
<td></td>
<td>Leadership</td>
</tr>
<tr>
<td>Ownership</td>
<td>Ownership of Health Promotion Capacity Development</td>
<td></td>
</tr>
<tr>
<td>Partnership and Intersectoral Action</td>
<td>Health Promotion Systems Approach</td>
<td></td>
</tr>
<tr>
<td>Intersectoral Collaboration</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
<td>Policy Environment</td>
<td>Policy Environment</td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td>National Policies and Plans</td>
<td>National Policies and Plans</td>
</tr>
<tr>
<td>Policy Coherence</td>
<td></td>
<td>Policy Coherence</td>
</tr>
<tr>
<td><strong>Domain</strong></td>
<td>Infrastructure</td>
<td>Infrastructure</td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td>Health Promotion Workforce</td>
<td>Health Promotion Workforce</td>
</tr>
<tr>
<td>Sustainable Financing</td>
<td></td>
<td>Sustainable Financing</td>
</tr>
<tr>
<td>Programme Delivery</td>
<td></td>
<td>Programme Delivery</td>
</tr>
<tr>
<td>Research and Knowledge Management</td>
<td>Research and Knowledge Management</td>
<td></td>
</tr>
<tr>
<td>Performance Monitoring</td>
<td></td>
<td>Performance Monitoring</td>
</tr>
</tbody>
</table>

The sub-domain Social and Cultural Context was broken down into two sub-domains separating social from cultural to avoid confusion in meanings. The domains like Governance and Policy Environment were revised to exclude overlaps. The name of the sub-domain Ownership was changed to Ownership of Health Promotion Capacity Development to make it focused
4. Phase I: Conceptual Framework and Tool

on national health promotion issues. Sub-domain Partnerships and Intersectoral Action was broken down into sub-domains Intersectoral Collaboration and Partnerships for Health Promotion. A new sub-domain Health Promotion Systems Approach was added to the core domain Governance.

Accompanying statements, with the domains and sub-domains, and Glossary items were redefined and modified to accommodate relevant comments. The participants’ statements were made simpler to read in light of recommendations from the respondents for greater clarity and comprehension. Some of the statements which focused on multiple issues were broken down and re-modeled to present one key issue only. The rating scale was re-defined to a five-point Likert scale (Strongly Disagree, Disagree, Uncertain, Agree, and Strongly Agree) and the questions for the Round 1 of the survey were planned to be based on relevance.

4.2 Round 1

A total of 781 emails were sent to 731 experts and 50 organisations around the globe to invite participation in the two-round Delphi consultation on consensus building for health promotion capacity mapping in LMICs (Appendix H). The conceptual framework, definitions of domains and sub-domains, the Glossary and further instructions to complete the questionnaire were uploaded to the web on Google Docs (docs.google.com) as a PDF document (Appendix I). The questionnaire is at Appendix J. The participants were provided with a link in the email to access the document and download and print if required. The deadline for submission of response to the questionnaire was extended once to maximise the response rate.

4.2.1 Data analysis

Each domain was analysed for rating average and standard deviation. The proposed capacity domains scored mean ratings ranging from 4.02 to 4.45 (Table 4.2). A capacity domain was considered for inclusion and consensus was deemed to have been reached when 75% of participants scored 4 or
more. Table 4.2 presents the rating averages, standard deviations (sd), minimum and maximum scores for the proposed health promotion capacity domains in Round 1 of the Delphi consultation.

Table 4.2 also shows that the standard deviations are low as compared to the high item mean scores suggesting that the distribution of the answers is positively skewed. This ‘ceiling effect’ indicates the tendency of respondents to rate the capacity domains at the higher end. This is identified as a limitation of the Delphi consultation method, which is discussed in Discussion chapter.

Table 4.2 Delphi Study Round 1 ratings for suitability of inclusion of the health promotion capacity mapping domains and sub-domains

<table>
<thead>
<tr>
<th>Capacity Domain</th>
<th>Rating Average</th>
<th>sd</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country specific context</td>
<td><strong>4.42</strong></td>
<td>0.63</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Historical context</td>
<td>4.17</td>
<td>0.87</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Political context</td>
<td>4.36</td>
<td>0.84</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Social context</td>
<td>4.32</td>
<td>0.90</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Cultural context</td>
<td>4.27</td>
<td>0.92</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Economic context</td>
<td>4.22</td>
<td>0.86</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Governance</td>
<td><strong>4.41</strong></td>
<td>0.74</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Political Commitment</td>
<td>4.23</td>
<td>0.92</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Leadership</td>
<td>4.44</td>
<td>0.77</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Ownership of Health Promotion Capacity</td>
<td>4.02</td>
<td>0.92</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Promotion Systems Approach</td>
<td>4.32</td>
<td>0.79</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Intersectoral Collaboration</td>
<td>4.42</td>
<td>0.80</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Partnership for Health Promotion</td>
<td>4.33</td>
<td>0.74</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Policy Environment</td>
<td><strong>4.34</strong></td>
<td>0.77</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>National Policies and Plans</td>
<td>4.21</td>
<td>0.91</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Policy Coherence</td>
<td>4.20</td>
<td>0.82</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Infrastructure</td>
<td><strong>4.38</strong></td>
<td>0.90</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Health Promotion Workforce</td>
<td>4.45</td>
<td>0.82</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Sustainable Financing</td>
<td>4.45</td>
<td>0.84</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Programme Delivery</td>
<td>4.22</td>
<td>0.78</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Research and Knowledge Management</td>
<td>4.34</td>
<td>0.78</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Performance Monitoring</td>
<td>4.33</td>
<td>0.72</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 4.3 shows the percentage of participants agreeing or disagreeing on the proposed domains out of the total valid responses received for each domain.

Table 4.3 Percentage agreement levels on the proposed health promotion capacity domains in Round 1 of the Delphi consultation.

<table>
<thead>
<tr>
<th>Capacity Domains</th>
<th>Agree (4 &amp; 5)</th>
<th>Disagree (1,2 &amp; 3)</th>
<th>Total valid responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>%</td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td><strong>Country specific context</strong></td>
<td><strong>100</strong></td>
<td><strong>6</strong></td>
<td><strong>5.8</strong></td>
</tr>
<tr>
<td>Historical context</td>
<td>89</td>
<td>17</td>
<td>16.0</td>
</tr>
<tr>
<td>Political context</td>
<td>95</td>
<td>10</td>
<td>9.5</td>
</tr>
<tr>
<td>Social context</td>
<td>92</td>
<td>11</td>
<td>10.7</td>
</tr>
<tr>
<td>Cultural context</td>
<td>91</td>
<td>15</td>
<td>14.2</td>
</tr>
<tr>
<td>Economic context</td>
<td>88</td>
<td>16</td>
<td>15.4</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td><strong>86</strong></td>
<td><strong>10</strong></td>
<td><strong>10.4</strong></td>
</tr>
<tr>
<td>Political Commitment</td>
<td>82</td>
<td>15</td>
<td>15.5</td>
</tr>
<tr>
<td>Leadership</td>
<td>91</td>
<td>5</td>
<td>5.2</td>
</tr>
<tr>
<td>Ownership of Health Promotion Capacity Development</td>
<td>72</td>
<td>23</td>
<td>24.2</td>
</tr>
<tr>
<td>Health Promotion Systems Approach</td>
<td>83</td>
<td>12</td>
<td>12.6</td>
</tr>
<tr>
<td>Intersectoral Collaboration</td>
<td>89</td>
<td>8</td>
<td>8.2</td>
</tr>
<tr>
<td>Partnership for Health Promotion</td>
<td>80</td>
<td>10</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Policy Environment</strong></td>
<td><strong>86</strong></td>
<td><strong>7</strong></td>
<td><strong>7.5</strong></td>
</tr>
<tr>
<td>National Policies and Plans</td>
<td>82</td>
<td>11</td>
<td>11.8</td>
</tr>
<tr>
<td>Policy Coherence</td>
<td>79</td>
<td>14</td>
<td>15.1</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td><strong>85</strong></td>
<td><strong>8</strong></td>
<td><strong>8.6</strong></td>
</tr>
<tr>
<td>Health Promotion Workforce</td>
<td>88</td>
<td>5</td>
<td>5.4</td>
</tr>
<tr>
<td>Sustainable Financing</td>
<td>84</td>
<td>9</td>
<td>9.7</td>
</tr>
<tr>
<td>Programme Delivery</td>
<td>79</td>
<td>14</td>
<td>15.1</td>
</tr>
<tr>
<td>Research and Knowledge Management</td>
<td>83</td>
<td>8</td>
<td>8.8</td>
</tr>
<tr>
<td>Performance Monitoring</td>
<td>86</td>
<td>4</td>
<td>4.4</td>
</tr>
</tbody>
</table>

4.2.2 Participants’ feedback

The feedback and comments of participants were analysed to inform changes to the framework. The key issues identified in the feedback were:

- Overlap and repetition between some domains
- The domain descriptions were too complex
- Framework is too idealistic

4.2.2.1 Country Specific Context

The Country Specific Context as a core domain included the sub-domains Historical Context, Political Context, Economic Context, Social Context and Cultural Context. The participants made a number of comments about how this domain could be defined and what it should include.
Regarding the ‘nature’ of various contexts (Historical, Political, Economic, Social and Cultural) one participant mentioned that all contexts have a history and creating a separate ‘Historical Context’ results in duplication. The participants agreed with the category heading but not with the domain description. They felt that there was overlap in the description between historical and political contexts, particularly ‘if you include health policies in "historical context".’

There were a number of suggestions regarding the Political Context, the description of which participants felt lacked representation of issues such as: socialism, dictatorships, military rule, party regimes, federal vs. central organisation of a country, literacy rate and awareness of political leaders on the importance of health, etc. One participant stated that it is not only about the policies but also implementation, especially in LMICs. Another participant stated that ‘Health promotion policies should not be determined as to which political party is in power and their manifesto. It should be constant and sustainable and must not vary with change in political regimes.’ Another participant suggested that ‘the political context be kept specific to the kind of political structures existing in the country since the kind of political structure within a country has a profound bearing on the liberty of people that affects health outcomes.’

Another participant noted that the contextual factors should also include the context of how health systems are developed. The participant clarified it with an example: ‘In Canada, After WWI/WWII, the idea of the social contract and how health systems were developed and designed also will impact how infrastructure is laid out.’ The participant further commented that the Fee-for-Service (FFS) system (payment model where services are unbundled and paid for separately) for physicians in Canada prohibits an optimal health promotion system.
One participant suggested including ‘Health Context’ to identify the prevalence of non-communicable diseases and/or communicable diseases, health threats etc. This could also include: health system development context, health promotion development, country’s level of attendance of international health related conferences, relevant global health context, consider landmarks like implementation of Primary Healthcare, Health For All, Ottawa Charter, health related behaviours/norms, etc. Another participant stated that a country’s health status needed to be determined by factors outside the health sector. Literacy rate, GDP, apartheid, racial discrimination, sectarianism and colonisation were other issues that participants considered should be included in the contextual factors.

Cultural Context was considered an important sub-domain with comments like ‘extremely important’, ‘must be understood and appreciated’, and ‘the success of any health promotion will depend on the extent to which it is appropriate in the local culture and context’ etc. A participant commented that cultural context plays an important part in how health promotion is interpreted. However, the statement was criticised for lack of clarity and ‘too many’ variables. Important suggestions made by the participants were to include terms like social norms (which govern normative behaviour), transmission of behaviours from group to group, cultural systems, beliefs and norms. One participant commented that in a globalised world culture is not simply transmission of behaviour from generation to generation but is influenced by the contemporary society which would deviate from traditional culture. The participant further stated that this is particularly true for developing countries where social norms predict the culture.

Participants highlighted the importance of cultural context not only for LMICs but also HICs: ‘in Canada and in particular a province like Ontario which is comprised of a very heterogeneous population of landed immigrants from across the world (primarily South Asians), can present an interesting study on the cultural context’. An important comment regarding
how the cultural context needs to be perceived by the professional in LMICs was ‘in developing countries, it may not have been so much about culture and language as a barrier for health promotion policies or actions rather it is the limited understanding of the role cultures can play in health promotion.’ Another participant highlighted that there is an urgent need, on the part of governments, to conduct culturally-specific research before initiating projects especially in the rural settings.

Some important themes emerged from the comments for the Economic Context. One was the need to clarify the relationship between economy and health, which is not only dependent on economic policies but includes the level of economic development, equity in economic development, financial systems, investment in health etc. The other issue that emerged was that these economic issues are the same across the globe and not only for LMICs. High levels of corruption and favouritism can take place in LMICs at the expense of the living standards of the general population.

In many countries with regards to the social and health spending within the public sector, only a small percentage consumes a large majority of the services. One participant mentioned that the economic context should focus not only on revenues but on spending, particularly public spending, and the incentives attached to spending. Given the health promotion focus, the participant stated that the incentives related to taxation are also important. Another participant stated that global wealth does not necessary lead to global health. The investment is more than raising the living standards but also investment in social systems leading to empowerment and improvement of health literacy and advocacy.

A participant reported that in the light of the global financial crisis it is now more than ever necessary to prioritize health promotion, so as to help minimise the cost of reducing the disease burden and other public health problems. One participant stated that health promotion is often restricted to
health education to avoid political involvement. It was further mentioned that the degree to which the country (LMIC) is dependent on external economic aid is also important.

One participant commented that ‘economic development is not directly linked to health promotion. There are examples of less economically developed countries in the world whose health promotion efforts are high and effective and vice versa.’

In the overall general comments for the Country Specific Contexts there was a general consensus that this domain is key to understanding the health promotion capacity in LMICs. A participant stated that geographical location and historical influences along the years have left their mark on the perception and evolution of health promotion in LMICs.

One participant noted that ‘(the framework) concerns to create a sort of "stereotype image" of so called "developing countries" (LMICs) assuming that these issues happened only in these countries’. This links categorisation of countries into low and middle income categories resulting in loss of focus on aspects of disadvantaged populations and groups. In addition, it fed to the core discussion essential to health promotion development in LMICs on whether economic growth is a means to achieve health outcomes or health a means to boost economic development. Other themes which the participants suggested to be added to the domain were: literacy rate, orientation of health concerns and their importance, corruption, conflicts, occupations, community specific contexts within a country including behaviours, values and attitudes, information technologies and systems.

A participant stated that while this domain and its sub-domains are relevant to the health promotion system, the number of items of sub-domains is quite high (5) compared to others. Two participants suggested the sub-domain
Political Context might be removed as it overlaps with the domain Policy Environment.

Overall, there was disagreement with the descriptions of the domain and its sub-domains. A participant expressed the view that the questions in this section were multifaceted which made them a little ‘tricky’ to respond to with a single response. Another participant agreed by saying that various aspects within this domain were intertwined, therefore; ‘none of the items can be discussed separately (i.e., which came first, chicken or egg)’. Another participant agreed that while overall the contextual factors were critical, along with the other domains and sub-domains, all were interdependent.

One participant was of the view that capacity problems are shared and that common capacity issues emerge regardless of a country’s history, administration, population, and other characteristics. This participant further mentioned that ‘these are useful background and explanatory variables. Our recent work on health policy capacity in three jurisdictions, however, suggested that the capacity problems are shared regardless of history, administration, population, etc.’

In light of the comments and the quantitative results from the Delphi survey, the Country Specific Context domain needed to be revised in order to be appropriately presented in the mapping framework. The participants expressed varying views about how a particular context could influence health promotion developments both nationally and globally. The participants expressed the need for more clarity in the domain descriptions and for the sub-domains to be redefined. It was decided that some key themes would be selected from the feedback received and that the sub-domains would be merged under one domain Country Specific Context for the next Round.
4. Phase I: Conceptual Framework and Tool

4.2.2.2 Governance

The core domain Governance included the sub-domains Political Commitment, Leadership, Ownership of Health Promotion Capacity Development, Health Promotion Systems Approach, Intersectoral Collaboration and Partnership for Health Promotion. Participants expressed the view that ‘implementation’ of Governance is a major issue. The reference to lack of trust in governments and the issue of corruption, which appeared in the domain description, were highlighted in participants’ comments.

One participant suggested that the sub-domain Political Commitment should include enabling health promotion action per the directions set out in the Ottawa Charter and later declarations on health promotion. Another participant stated that policy inconsistency could be a major barrier in countries with oscillating military-civilan rule. A participant suggested that though a political commitment is a mandatory requirement, ‘setting a statement is not, in and of itself, enough’. Another participant suggested that the description should include not just structures but also processes, putting health promotion on the agenda, and facilitating policy development and implementation. One participant expressed the view that political commitment is only meaningful when translated into budget and spending priorities.

With regards to the sub-domain Leadership, participants commented on the various dimensions of health promotion leadership: inclusion of ‘capability concepts’, ownership at national level to be portrayed, not only limited to MoH but also external to government (health professions, NGOs, etc.), leadership as investment, and collective leadership.

The health sector in many LMICs are dependent on foreign aid and the sub-domain Ownership of Health Promotion Capacity Development was included to address this issue. There was considerable confusion among
participants regarding their understanding of this domain. One participant stated that ‘a country could potentially have good control or command over development activities, yet still be quite dependent on aid’. Giving an example of a LMIC, the participant said that ‘in Pakistan, development partners (NGOs) do a lot in the field of health promotion, which presumably can help build national capacity, but the government is not a strong coordinator and so opportunities to work collaboratively with development partners are missed and efforts are duplicated or not well targeted’. Another participant stated that the domain definition needs to include participation as an enabling element.

In many instances foreign aid comes with conditions which are counterproductive for health promotion and social policies supporting health promotion. Often this aid is not culturally sensitive and planned by external experts through a top-down approach. One participant stated that ‘ownership also requires that countries have some sort of resource commitment to health promotion capacity development. It's not just temporary autonomy during capacity development activities but also taking ownership for the long-term’. Another participant commented that ‘ownership is not only country ownership; but also ownership by all sectors since a majority of the actual work (i.e., better urban planning) is carried out by the non-health sector’.

In responding to the question on the sub-domain Health Promotion Systems Approach, a number of participants agreed that the rationale for introducing a Systems Approach for health promotion capacity mapping was ‘rational and reasonable’, ‘could be combined with intersectoral collaboration and partnership’, ‘should also include emphasis on processes and the need for functionality in linkages between health system components’, ‘I would like to see this elaborated further’, etc. One participant commented that ‘I disagree in principle with mentioning of two systems which automatically leads to separation and confrontation. Any health system in any country
should have its own stable, basic infrastructure for public health, which includes health promotion as one of the three main unseparable domains: health protection, diseases prevention and health promotion'. Another participant expressed the view that ‘sometimes our systems are built on unstable conditions. This implies that the process should be driven with uncertainty. I am not sure that you need to have a "stable" infrastructure to have a system. Stability might be related to efficiency or successful outcomes, but the lack of it does not necessarily impede the delivery of health promotion services’.

The two sub-domains of Intersectoral Collaboration and Partnership for Health Promotion were found to be overlapping by the participants and were suggested to be merged. Regarding Partnerships, a participant suggested that the description of the sub-domain was similar to Intersectoral Collaboration. The participant further stated that ‘…….the focus of this sub-domain is participatory decision making, particularly in identifying problems. The key concept of this sub-domain is sharing power among key partners. The policy should reflect the intention on decentralization of power and aware of social determinants of health’. Other participants commented on various aspects of the two sub-domains. One participant stated that a multi-stakeholder approach that embraces civil society is needed. The participants also commented on lack of implementation in these areas. Another participant suggested categorising the various linkages within the country, such as a) linkages across NGOs, civil society, private and government sectors b) linkages between different policy sectors (e.g. environment, health, transport etc.), c) linkages between levels of decision-making (national, regional, local level). One participant suggested that mapping could also be used to identify potential opposition to health promotion development e.g., from the tobacco companies or other industries opposing health promotion interventions.

At the end of the section the participants were asked to give their overall views about the domain Governance and its sub-domains Political
Commitment, Leadership, Ownership of Health Promotion Capacity Development, Health Promotion Systems Approach, Intersectoral Collaboration and Partnership for Health Promotion. A participant commented that differentiation between the domain Governance and the sub-domain Political Context should be sharpened by focusing on health-related governance (more domestic political issues). Overall, the participants indicated that the differentiation between the sub-domains was unclear and this could result in isolation of specific aspects which usually belong together.

Participants suggested to include various other themes in this section: accountability, corruption, whole-of-government approaches, trans-national cooperation, city or county level governance, capacity of the existing community structures like the village health teams and hospital boards, and, the role, definitions and responsibilities of government, NGOs, industry, public, etc.

One participant stated that ‘usually in developing countries very good plans are made but not retained because no one does the follow up and ensure its sustainability and also the developing countries need to be more particular in accountability of spending resources’. One participant stated that the Governance section has tried to address the complex nature of social change in health promotion. This participant further stated that these issues can be better addressed by concepts like "complex adaptive systems”\(^\text{10}\).

The sub-domains under the domain Governance were reviewed and renamed as Institutional Capacity, Vision and Leadership, and Transparency. The sub-domain Partnerships was moved under the domain ‘Health Promotion Infrastructure’. The overall approach towards health promotion

\(^{10}\) A Complex Adaptive System (CAS) is a special case of a complex system which is also adaptive, i.e. it has the ability to change and adapt itself to the environment (http://goo.gl/3DY7tA). While it is not in the scope of the study to give details of the concept, it will be briefly described in the Discussion chapter.
development was considered to be a systems approach and should be reflected in the mapping tool throughout various capacity domains. A health promotion system was redefined based on the World Bank’s definition of health system: *Combination of resources, organisation, financing and management that culminate in the health promotion action for the population*.

### 4.2.2.3 Policy Environment

The core domain Policy Environment included the sub-domains National Policies and Plans, and Policy Coherence. There was a mixed response to the definitions and descriptions of the domain and the sub-domains. On the description of the sub-domain National Policies and Plans (‘National government policies and plans include Health Promotion priorities which conform to the underlying concepts of the five Ottawa Charter strategies’) a participant commented that ‘this seems to reify or sanctify the Ottawa Charter unnecessarily’. Another participant desired to be given the evidence-base for the statement.

On the sub-domain Policy Coherence a participant commented that ‘this is ideal. Conflict including within government may, in some instances, be indicative of changing. Absolute harmony can be indicative of over dominance of particular perspectives or uncritical acceptance of the status quo’. Other comments on the sub-domain were: ‘Coherence on principles and values is a very complex concept to be summarized in one sentence. More information needs to be presented to clarify or make this idea more tangible’ and ‘Seems to be an important and new issue, but how to measure and evaluate? Especially concerning collaboration with other domestic policy affairs, which policy is coherent to which one (health into all policies or all policies into health?)’.

---

Some other issues raised by the participants included the capacity to help policymakers see the relative value of investments in different sectors and the trade-offs involved in investing in health promotion. A participant commented that the policymakers 'need to have the capacity to negotiate agreements with international donor agencies to ensure that "external" priorities are consistent (and not disruptive, e.g., by poaching skilled workers) with national priorities'. The domain Policy Environment was seen as an indicator of how key stakeholders are enabled to participate in policy processes, and as a marker of how policies lead to practices.

The section on Policy Environment was redrafted by modifying the definitions of the domain and sub-domains.

4.2.2.4 Infrastructure

The domain Infrastructure included sub-domains Health Promotion Workforce, Sustainable Financing, Programme Delivery, Research and Knowledge Management, and Performance Monitoring.

Several issues were raised by the participants regarding the domain Infrastructure. A participant suggested that provincial level infrastructure should be included for countries where former federal ministries (including health) have been devolved to the provinces in countries such as Pakistan. Another participant suggested to include organizational learning mechanisms in the mapping framework. A participant suggested re-labelling the domain to be Infrastructure and Systems as some of the sub-domains - Research and Knowledge Management - were better suited as systems rather than structures. A participant expressed that there seemed to be a lack of emphasis on strategic planning in determining and setting priorities for the use of limited resources.

Themes arising from participants’ comments regarding the Infrastructure sub-domains are summarised below:
4. Phase I: Conceptual Framework and Tool

Workforce: defining workforce (who is included in the health promotion workforce?), recruitment to be transparent and not politically influenced, needs-based approach, invest to build workforce, health promotion competencies, accreditation of health promotion specialists, and need for system and intersectoral thinkers.

Sustainable Finance: funding not be deviated halfway and channelled to other programmes, sustainable financing implies ‘recurrent’ ability to provide adequate financing to priority areas for action, definition to include not only ‘to allocate these resources’ but also ‘to get these resources’, ring-fencing for health promotion structures and strategies so that these are not only dependent on intersectoral approaches, and lack of policy makers’ understanding of the value of health promotion.

Programme Delivery: accountability, stewardship role of the Ministry of Health, integration of health promotion as part of all health service delivery, and use of the word ‘programme’ and ‘delivery’.

Research and Knowledge Management: research budgets, participatory approaches to research, and mixed/multiple methods, translation and uptake of information, research on 'what is not known', and include communities.

Performance Monitoring: suitable indicators, link with academic institutions, expand beyond performance monitoring into performance management - monitor, set targets, performance improvement plans and public reporting.

Overall the domain Infrastructure was received well by the participants. There were a few comments regarding the wording of the definition and descriptions of the domain and sub-domains. The themes identified by the participants and their suggestions were utilised in developing the data
collection tool in the next round. The sub domain for Programme Delivery was renamed as Health Promotion Delivery to improve clarity. The sub-domains Knowledge Management and Performance Monitoring were merged and renamed Knowledge Development and Management. The sub-domain Health Promotion Workforce was renamed as Workforce.

4.2.3 Development of Mapping Tool
The consensus of the participants on the health promotion capacity mapping domains in Round 1 facilitated the restructuring of the framework which is presented in Figure 4.1 below.

While assessments for governance, policy and infrastructure are common topics in various disciplines such as public health, international and human development, sociology and health promotion, not many examples can be found for the domains and sub-domains like country specific context, policy coherence, and transparency and accountability. The questions (and their sub-items, if any) in the mapping tool were developed in light of the themes and issues identified in the participants’ comments and the definitions and descriptions of various domains and sub-domains. Various questions and sub-items from these tools consulted in the literature review were added with either modifying the wording or modifying wording and structure to accommodate the themes identified by the participants. The capacity domains and sub-domains were redefined and are attached at Appendix K.

The new health promotion capacity mapping framework and tool developed from the findings in Round 1 consisted of four domains: Country Specific Context, Governance, Policy Environment, Infrastructure and 10 sub-domains (Figure 4.1). The sub-domains of Country Specific Context were merged into one section containing eight questions. In Round 2 the revised framework and tool was sent to the same participants who responded to the Round 1 questionnaire.
4.3 Round 2
In Round 2 of the Delphi consultation the participants who responded in Round 1 were asked to rate and comment on the new health promotion capacity mapping framework and tool. The participants were sent an email with links to results of Round 1 analysis and the questionnaire in PDF format to download and print before completing the online questionnaire on SurveyMonkey.

4.3.1 Questionnaire Round 2
The questionnaire comprised of 57 questions in total. There were 55 open and closed-ended questions covering the four capacity domains and 10 sub-domains. Table 4.6 presents the structure of the questionnaire and the number and type of questions under each domain and sub-domains.
4. Phase I: Conceptual Framework and Tool

Questions 56 and 57 focused on taking an overall opinion from the participants about the tool. It was explained to the participants that the tool is intended for health promotion capacity development stakeholders in LMICs. The participants were asked to rate each question on a Likert scale of 1 to 5 (Strongly Disagree / Disagree / Uncertain / Agree / Strongly Agree) on its relevance for inclusion in the mapping tool and to also add any specific comment, if needed, in the comment box provided. The questionnaire may be seen at Appendix M.

Table 4.4 Number of questions under each capacity domain and sub-domains in Round 2 Questionnaire

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-domains and General</th>
<th>Number of Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country Specific Context</td>
<td>None</td>
<td>8</td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Institutional Capacity</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Vision and Leadership</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Transparency</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Policy Environment</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>National Policies and Plans</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Policy Coherence</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Infrastructure</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Health Promotion Delivery</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Partnerships</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Financing</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Knowledge Development and Management</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Overall opinion</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Total questions</td>
<td></td>
<td>57</td>
</tr>
</tbody>
</table>

4.3.2 Data analysis

Each question relating to the capacity domains (Q1 – Q55) was analysed for rating average, standard deviation, percentage of participants in agreement/disagreement and number of total valid responses. A question was considered for inclusion and consensus was deemed to have been reached when 75% of participants scored 4 or more. The proposed questions for inclusion in the tool scored mean ratings ranging from 3.6 to 4.54. Six questions were not found to be within the consensus standards, as only 58.2
– 73.2% participants agreed with the questions. In the overall selection and modification of questions participants’ comments were also taken into consideration. The detailed quantitative analysis of the Round 2 rating averages and percentage agreement levels are presented in Table 4.5 (page 126).
### Table 4.5 Quantitative Analysis of Round 2 Questionnaire

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-domains</th>
<th>Q No.</th>
<th>Rating Average</th>
<th>sd</th>
<th>% agree</th>
<th>% disagree</th>
<th>Total valid responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country Specific Context</td>
<td></td>
<td>1</td>
<td>4.01</td>
<td>0.81</td>
<td>88.06</td>
<td>11.94</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>3.73</td>
<td>1.16</td>
<td>67.16</td>
<td>32.84</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>3.75</td>
<td>1.01</td>
<td>68.66</td>
<td>31.34</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>3.60</td>
<td>1.17</td>
<td>58.21</td>
<td>41.79</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>3.66</td>
<td>1.04</td>
<td>65.67</td>
<td>34.33</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>4.54</td>
<td>0.61</td>
<td>97.01</td>
<td>2.99</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>4.25</td>
<td>0.86</td>
<td>85.07</td>
<td>14.93</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
<td>4.00</td>
<td>0.87</td>
<td>76.12</td>
<td>23.88</td>
<td>67</td>
</tr>
<tr>
<td>Governance</td>
<td>Institutional Capacity</td>
<td>9</td>
<td>4.44</td>
<td>0.61</td>
<td>92.31</td>
<td>7.69</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Vision and Leadership</td>
<td>11</td>
<td>4.21</td>
<td>0.74</td>
<td>84.13</td>
<td>15.87</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Transparency</td>
<td>14</td>
<td>3.90</td>
<td>0.99</td>
<td>75.81</td>
<td>24.19</td>
<td>62</td>
</tr>
<tr>
<td>Policy Environment</td>
<td>National Policies and Plans</td>
<td>21</td>
<td>4.46</td>
<td>0.56</td>
<td>96.72</td>
<td>3.28</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Policy Coherence</td>
<td>25</td>
<td>4.21</td>
<td>0.73</td>
<td>90.16</td>
<td>9.84</td>
<td>61</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Health Promotion Delivery</td>
<td>29</td>
<td>4.47</td>
<td>0.57</td>
<td>96.49</td>
<td>3.51</td>
<td>57</td>
</tr>
<tr>
<td>Infrastructure</td>
<td></td>
<td>30</td>
<td>4.30</td>
<td>0.65</td>
<td>92.98</td>
<td>7.02</td>
<td>57</td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
<td>32</td>
<td>4.26</td>
<td>0.70</td>
<td>89.47</td>
<td>10.53</td>
<td>57</td>
</tr>
<tr>
<td>Policy Coherence</td>
<td></td>
<td>33</td>
<td>4.19</td>
<td>0.93</td>
<td>85.96</td>
<td>14.04</td>
<td>57</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>40</td>
<td>4.19</td>
<td>0.83</td>
<td>89.47</td>
<td>10.53</td>
<td>57</td>
</tr>
<tr>
<td>Knowledge Development and</td>
<td>Management</td>
<td>46</td>
<td>4.30</td>
<td>0.69</td>
<td>91.07</td>
<td>8.93</td>
<td>56</td>
</tr>
<tr>
<td>Partnerships</td>
<td></td>
<td>47</td>
<td>4.27</td>
<td>0.67</td>
<td>91.07</td>
<td>8.93</td>
<td>56</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>48</td>
<td>4.21</td>
<td>0.71</td>
<td>91.07</td>
<td>8.93</td>
<td>56</td>
</tr>
<tr>
<td>Financing</td>
<td></td>
<td>49</td>
<td>4.09</td>
<td>0.72</td>
<td>82.14</td>
<td>17.86</td>
<td>56</td>
</tr>
<tr>
<td>Knowledge Development and</td>
<td>Management</td>
<td>50</td>
<td>4.48</td>
<td>0.57</td>
<td>96.43</td>
<td>3.57</td>
<td>56</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>51</td>
<td>4.52</td>
<td>0.54</td>
<td>98.21</td>
<td>1.79</td>
<td>56</td>
</tr>
<tr>
<td>About the tool</td>
<td></td>
<td>52</td>
<td>4.46</td>
<td>0.63</td>
<td>92.86</td>
<td>7.14</td>
<td>56</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>53</td>
<td>4.04</td>
<td>0.85</td>
<td>73.21</td>
<td>26.79</td>
<td>56</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>54</td>
<td>4.36</td>
<td>0.70</td>
<td>91.07</td>
<td>8.93</td>
<td>56</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>55</td>
<td>4.23</td>
<td>0.66</td>
<td>87.50</td>
<td>12.50</td>
<td>56</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td>56</td>
<td>4.04</td>
<td>0.73</td>
<td>85.19</td>
<td>14.81</td>
<td>54</td>
</tr>
</tbody>
</table>

119
In the following section a detailed analysis is presented of the participants’ agreement or disagreement with the various domains and sub-domain questions.

4.3.2.1 Country Specific Context

The overall rating average for the domain Country Specific Context was 3.9 with 75.7% of participants agreeing the domain to be relevant to capacity mapping. The main themes emerging from the feedback on the Country Specific Context questions included: existing terminology used in LMICs for health promotion development, country’s historical development of health promotion, political environment, economy, assets and barriers for health promotion capacity development. The participants gave the lowest scores to four questions about whether the country’s historical landmarks, political environment and economy are conducive for health promotion development (Table 4.6 – highlighted). Although the scores were above the cut-off point for exclusion (4.00), the ratings along with the comments demonstrated that the Country Specific Context was a complex area to cover in an online questionnaire. It was decided that for the next phase of the study i.e. the pilot testing of the mapping process, the Country Specific Context would be supplemented by a desk review and key informant interviews. Only general topics like historical health promotion landmarks, assets, barriers, etc. would be included in the final mapping tool.

Other key themes, which emerged from the participants’ comments, are summarised:

Health promotion and health education are used interchangeably in most countries. As one participant stated: ‘There is confusion and synonymous use of health education to mean health promotion and vice versa. The language of public health adds another confusion to the field and needs clarity’. The literature indicates that these are closely related but are not inter-dependent (Whitehead, 2004).
The terms ‘developing country’, ‘third world country’, ‘low or middle income country (LMIC)’, ‘least or medium developed country’, ‘low resource country’, are more suited to the field of International Development and other income driven developmental activities. Defining a country on the basis of income assumes ‘income’ to be a priority issue which is not compatible with country level health promotion capacity development priorities. The term ‘developing country’ also gives a wrong notion about a country, assuming that the country is actively developing when the case could be otherwise. To what extent do a country’s historical, political, economic, social and cultural environments influence health promotion development? Is it sufficient to only focus on factors affecting health promotion or health sector for mapping health promotion capacity? ‘Developing countries’ need to be empowered to take responsibility and make healthy decisions for their populations. A major issue in this regard is a country’s dependence on external economic aid/debt which doe not only restrict building suitable infrastructure but also affects governance and policymaking.

Issue of a participant disclosing her/his political views on an online questionnaire.

Use of terms like democracy, political will, oppression, etc. could have different meanings for countries under development process.

4.3.2.2 Governance

The domain Governance had three sub-domains: Institutional Capacity, Vision and Leadership, and, Transparency. In total there were 12 questions in the Governance section. The domain was overall rated 4.2 with 86% of participants agreeing to the relevance of the domain to be included in the mapping framework. One question in the sub-domain Transparency got the lowest score of 3.8.

Some key themes arising from the participants’ comments were:
Mapping Institutional Capacity needs to take into consideration decentralisation and devolution in some countries e.g. Pakistan where the federal Ministry of Health is devolved to provinces.

Across the globe countries have diverse ways of establishing structures to develop and implement health promotion policy and programmes.

It is difficult to collect information regarding health promotion strategies, policies, functions and implementation, which are often integrated within public health policies and programmes in LMICs.

Other issues identified by the participants to map under the domain Governance: decentralisation, settings-based approach, accountability, corruption, health reform strategy, and collaboration between donors and organizations.

4.3.2.3 Policy Environment

The domain Policy Environment had two sub-domains, National Policies and Plans and Policy Coherence. Overall the domain was scored 4.2 with 89% participants agreeing with the relevance of the domain to be included in the mapping framework. This section was comprised of eight questions in total. The participants agreed regarding the relevance of all questions to the capacity mapping tool.

In the sub-domain National Policies and Plans the questions were designed to include information regarding the existing status of health promotion policy or policies at a country level. A key issue relevant to mapping was the diffusion of health promotion policies in the public health policies and the level of awareness about this. One participant stated that ‘I can think of countries where health promotion strategies are adopted across many public health strategies, but they are not called health promotion, nor is there a health policy per se’. The participants also found a question on ‘use of
rights-based approach to improve health’ difficult to understand. Some queried whether this was similar to human rights approach. The participants agreed with the themes presented in various questions but suggested to change or simplify the statements of a number of individual questions.

4.3.2.4 Health Promotion Infrastructure

The domain Health Promotion Infrastructure had five sub-domains: Health Promotion Delivery, Workforce, Partnerships, Financing, and Knowledge Development and Management. The section had the highest number of questions in the mapping tool which was 27. Overall the domain was scored 4.2 with 91% participants agreeing with the relevance of the domain to be included in the mapping framework.

In the sub-domain Health Promotion Delivery four questions were included to collect information regarding availability of national guidelines for needs assessment, planning and evaluation of health promotion capacity, stages of planning, main focus of health promotion activities according to the Ottawa Charter (WHO, 1986), use of evidence-base, sensitivity with regards to gender and other cultural, social or linguistic dynamics, sustainability, etc. A participant suggested including mapping for Health Impact Assessment.

A total of 13 questions were based on collecting information about various dimensions of existing health promotion workforce at the country level in LMICs. These covered key areas such as: dedicated posts or job descriptions, specialist workforce, national-level education and training programmes, support of government for health promotion education and training, priority target audience for training and education, core competencies, networks, national professional associations, and barriers for education and training. Overall, the participants felt that the information being asked for was too much and in some cases difficult to obtain e.g. posts and job descriptions, adequacy of workforce, etc.
4. Phase I: Conceptual Framework and Tool

The terms ‘legal mechanism’ and ‘effective collaboration’ in the questions regarding the sub-domain Partnerships were found to be unclear by the participants. It was suggested for the question on the sub-domain Financing that Non-profit Organisations (NPOs) be added as one of the dedicated sources of funding for health promotion activities in LMICs. One participant commented that ‘International development agencies and international donors (countries) may overlap. For example, many countries channel their funds through big, international organizations such as United Nations’.

The question on the sub-domain Knowledge Development and Management included key themes like national health information system, adequate access to information on health promotion, and access to the data from other sectors. Other themes addressed were communication of relevant information to decision makers at national, regional and local levels, participation of universities and research institutes, health promotion monitoring activities, and research findings and results regularly communicated to policy and decision-makers. One participant suggested adding ‘earmarked research funding for academic institutions’.

4.3.2.5 Key actions taken

Less than 75% of participants agreed with the question numbers 2, 3, 4, 5, 17 and 53 (Table 4.6). The questions 2, 3, 4 and 5 were related to the domain Country Specific Context For Health Promotion. In light of the comments and overall focus of the capacity mapping tool, questions 2, 4 and 5 were excluded from the tool due to the perceived complexity of the subject. Question 3 on the landmarks in the history of national health system development, contributing to increase health promotion infrastructure was further modified to bring more clarity to the question statement and its answer options. Similarly, question number 17 on capacity of a country to create a health promotion working environment free from corruption, under sub-domain Transparency, was modified to make it more clear for readers. Question 53 relating to providing examples of health promotion implementation at national, regional and local level, under capacity domain
Infrastructure, was found by participants to be ‘too broad and too vague’ while 73.2% agreed with it. The statement of the question was modified to make it more clear. The rating scales for some of the questions were missing and these were added in the final version of the tool.

Many of the participants’ comments related to lack of clarity regarding various terms used in the mapping tool. A Glossary, which was also provided in Round 1 (Appendix I), accompanied the tool so that the participants followed a common language and understanding of the terminology as used in the document. In light of the comments in the second round, the Glossary was reviewed and updated again to include a number of new terms.

The study originally used the term ‘developing countries’ for the mapping. As a number of comments arose regarding this term, it was decided that a better term would be ‘low and middle income countries’ (LMICs) as currently used by the WHO and the World Bank12.

Participants, while agreeing with the question statements, often suggested a change in terminology or more clarity in the use of terminology. For example, terms like ‘to improve health’ in Q1, ‘improve population health in Q7, ‘health promotion landmarks’ in Q3, various terms to characterise the economy of a country in Q5, etc. A Glossary of some basic terms prepared for Round 1 was updated to include these terms as used in the tool. In addition, some other terms were also modified or changed according to the feedback.

Overall, the tool was found by the participants to be lengthy and some questions or answer statements (answer choices) were complex to follow. Use of the open-ended questions were not favoured by the participants. The number of questions in the tool were reduced by excluding some of those

12 http://data.worldbank.org/about/country-and-lending-groups
that were rated low on the Delphi survey questions. The question and answer statements were reviewed and revised to make them simpler and clearer.

The participants recommended piloting the tool in LMICs. In addition, the participants suggested using examples with certain questions, translating the tool into other languages. One of the participants suggested: ‘What can facilitate the development of health promotion is a relevant question to ask. Maybe there needs to be a tiered approach to the tool. For example, if a country does not even have a national health policy then what? A country might have a national health policy but without a focus on health promotion, then what? If the country has a policy on health promotion then what?’ A tiered approach in the use of the tool was considered an ideal approach to map capacity. This option, however, was not considered feasible in the context of the present study due to limited resources and time. Some of the future uses of the tool highlighted by the participants were: provide a standard system for collecting data on health promotion capacity, conduct a situation analysis, indicator for monitoring and evaluation, and resource to develop health education programmes.

4.4 Conclusion
The Phase I study was completed over 17 months including the data collection analysis and development of the new mapping framework and tool. The final mapping tool (see Figure 4.2) consisted of four core domains - Governance, Policy Environment, Infrastructure, and Country Specific Context. Each core domain, except the Country Specific Context, was further themed into sub-domains as follows:

3. Infrastructure: Health Promotion Delivery, Workforce, Partnerships, Financing, and Knowledge Management.
The final mapping tool for health promotion capacity in LMICs had 41 questions - 32 closed and nine open-ended based on the feedback from the Delphi study participants (Appendix N). In Phase II of the study the tool is pilot tested in an LIMIC context. In the Delphi consultation the domain of Country Specific Context was found to be somewhat deficient in collecting relevant information regarding various country level contextual factors (historical, political, economic and social environments). It was decided that for the Phase II study these dimensions should also be mapped by collecting data through interviews with key informants and a desk review.
5. Phase II: Case Study

5.1 Introduction
Phase II of the study focused on testing the new mapping framework and data collection tools from the selected low and middle-income country, Thailand. This chapter presents the findings of the case study of the health promotion capacity mapping tool in Thailand. The chapter is structured based on the four data collection methods: a desk review, key informant interviews, online questionnaire and a discussion group.

The first section which covers the desk review presents a review of existing literature on country specific contexts affecting health promotion capacity development and mapping in Thailand. These contexts are described as: i) Geography and Socio-demography, ii) Economic context, iii) Historical and political Environment, and iv) Health promotion capacity and capacity mapping. The second section which covers the key informant interviews presents findings from the in-depth semi-structured interviews of national health promotion and public health experts focused on the country specific context for capacity development and capacity mapping in Thailand. The third section which covers the online questionnaire presents findings from the health promotion capacity mapping data collected through an online tool from senior level health promotion experts in Thailand. The fourth section which is on the discussion group presents findings of a discussion held with senior level national health promotion and public health experts in Pattaya, Thailand on the usability of the mapping tool in Thailand and elsewhere. The fifth and last section of the chapter presents a summary of the findings from the various data collection tools used in the case study.

5.2 Data Collection Method 1: Desk Review
The desk review presented in the following section is primarily based on exploring the country’s historical, political, socio-cultural and economic environments in which health promotion development takes place. These
environments affect the decision-making and implementation of strategies to develop health promotion capacity.

The literature reviewed for the desk review came from multiple disciplines including health promotion, public health, international and human development. It included Thai government and Ministry of Public Health (MoPH) reports, research journal articles, relevant websites, reports from international health and development agencies, etc.

The desk review section is divided into the following sub-sections:
1. Geography and Sociodemography
2. Economic Context
3. Historical and Political Environments
4. Health Promotion in Thailand
5. Health Promotion Capacity Mapping

5.2.1 Geography & Sociodemography
The Kingdom of Thailand formerly known as Siam is a country located at the centre of the Indochina peninsula in Southeast Asia (Figure 5.1). Thailand is a democratic nation with the King as the Head of the State, a constitutional hereditary monarchy under the Constitution of the Kingdom of Thailand, 2007. The Prime Minister is the head of government.
The total area of Thailand is 513,120 sq. km which makes the country the 51st largest country in the world. The region of the country covered by land is 510,890 sq. km and by water, 2,230 sq. km (CIA, n.d.).

Most of Thailand has a tropical wet and dry climate. Countrywide, temperatures normally range from an average annual high of 38 °C (100.4 °F) to a low of 19 °C (66.2 °F). With only minor exceptions, every area of the country receives adequate rainfall, but the duration of the rainy season and the amount of rain vary substantially from region to region, and with altitude. The dry season is shortest in the South because of the proximity of the sea to all parts of the Malay Peninsula (Wikipedia, n.d.). The country is commonly divided into four main regions. The northern region is hilly, with much of its population concentrated in upland valleys and the flood plains of rivers; the dominant geographic feature is the Khorat Plateau. The southern region is a narrow isthmus with hills running down the centre (Howard, n.d.).

The WHO health profile of Thailand reports the population of Thailand as 67 million of which 34% lives in urban areas (WHO, n.d.). 50.9% of the
population is females and 49.1 % males (National Statistical Office, 2010). There are significant projected changes in the demographic profile and characteristics of the population from 1960 to 2000 and 2020 (WHO, 2011c). The Thai population is aging over time due to the decreasing fertility rate from 5.58 births per woman in 1970 to 1.82 in 2000 and the increasing life expectancy. The proportion of the population above 60 years is expected to rise from 9.2% in 2000 to 16% in 2020. Currently, about 35% of the population lives in urban areas, and this is expected to increase to 40% in 2020 (WHO, 2011c).

The declining annual population growth rate is contributed to a continually decreasing birth rate. Thais age 0-14 years are numbered about 12.7 million (19.2%), while the working-age population totals 44.8 million (67.9%), and the elderly account for 8.5 million persons (12.9%).

The population pyramid in Figure 5.2 shows changes from a young to an older profile due to a continuous decrease in birth rate. Official policies and private family-planning programmes have slowed population growth dramatically, making the country a model for other countries seeking to reduce their high population growth rates. The population profile has nonetheless placed demands on the country’s education, housing, health, and employment systems (Hafner, Keyes, & Keyes, 2014).

Figure 5.2 Population Pyramid Thailand 2010 adapted from (UN, 2012)
The World Bank calculates that the over-60s will account for a sharply rising percentage of the population from 2015 onwards, reaching 35% by 2060. In 2010, the figure was 15%. Conversely, the percentage of people of working age will start to fall in 2020.

Thailand’s dependency ratio – the ratio of senior citizens, children and young teens to the working-age population – is currently 56%. According to World Bank forecasts, it will top 100% by 2070. There will then be more dependent people than people of working age – and most of them will be old (World Bank, 2012). These changes in population structure impact negatively on economic development, and place a heavy burden on the health care system – that is, the low birth rate impedes economic growth and may force the government to slash welfare expenditure, including that dedicated to health care.13

Thailand’s central position on the mainland has made it a crossroads for population movements from diverse cultural, linguistic, and religious backgrounds. The modern political boundaries of Thailand were fixed at the end of the 19th century but it has done little to impede the centuries-long migrations of people. This diversity is characteristic of most Southeast Asian countries. The vast majority of the inhabitants of Thailand are speakers of Tai languages (the national language of Thailand, known as Standard Thai, is based on the language spoken in central Thailand). In addition, English is widely used in Thailand for commercial and many official purposes. It is a required school subject from the primary grades on up, although only children who go beyond those grades, and especially those who attend elite schools, gain significant competence in the language (Hafner et al., 2014).

13 The demographic statistical information is mostly taken from international sources such as the United Nations, World Health Organisation, World Bank, etc. Though the sources such as the National Statistical Office (NSO) Thailand were given a priority while quoting statistical data, it was found that its information system is not well developed and information is not suitably disseminated or accessible for research purposes. For example information related to population and demography is either not available or only available in Thai language on the NSO website.
Buddhism is the dominant religion in Thailand followed by 93.6% of the population. The Theravada tradition of Buddhism came to Thailand from Sri Lanka and is shared by peoples in surrounding countries. The community of monks (sangha) is central to this tradition. Buddhist teachings and ‘sangha’ hold an important role in community health care (Bhikkhu, 2007) and professional education in the health system (Burnard, 2006). In Thailand almost every settlement has at least one temple-monastery (wat), where monks reside and communal rituals take place. Other religions are also found in the country: a significant minority of Muslims (4.9%) live primarily in southern Thailand, and Christians (1.2%). Most Christians are members of ethnic minorities, mainly Sino-Thai (CIA, n.d.; Hafner et al., 2014).

Literature shows that burden of diseases in Thailand is gradually shifting to non-communicable diseases (NCD), injuries and mental disorders. The transition to unhealthy lifestyles and health risks has been found to be linked with urbanization, internal migration and changes in social environment (Adulyanon, 2012).

The sex industry and sex tourism have a major influence on the socio-cultural and economic situation in Thailand (Bishop, 1998; Lee, 2013; Nuttavuthisit, 2007). The number of sex workers in Thailand increased considerably after the 1960s when the United States implemented the R&R (Rest & Recreation) program for the military after the Vietnam War which opened the political, social, and economic markets in Bangkok. According to an estimate in the 1980s, eight percent of Thai women between ages of fifteen and thirty-four worked as sex workers (Truong, 1990). While many root causes, such as the economic, social, political, institutional and ideological factors, have been cited for sex tourism in Southeast Asia (Barry, 1984), poverty appears to be the basic cause of prostitution, although not exclusive (DaGrossa, 1989; Phongpaichit, 1982).
5. Phase II: Case Study

5.2.2 Economic Context
Thailand is an LMIC currently undergoing a rapid social and economic transition. Over the past 50 years the Thai economy has changed from agriculture to services and manufacturing. The adoption of the first national development plan in 1963 spurred the shift from agriculture to industry. The main income of the country comes from three sources: industry, agriculture, and tourism. According to the International Monetary Fund, Thailand’s GDP (PPP) for 2008 and 2009 were US$ 8239 and US$ 7998 per capita, respectively. Exports account for about 70% of GDP indicating it is among the economies most vulnerable to global financial or economic crises.

According to the WHO, Thailand has achieved some overall success in its poverty alleviation demonstrated by a reduction in the poverty incidence (ratio of total number of poor households to total number of households) from 14.9 in 2002 to 9.5 in 2006. Despite the gains, disparities among regions and urban/rural localities are evident; e.g. the poverty incidence in the northeast is about five times greater than that of the central region and almost 34 times that of Bangkok. Over time, the gap between rich and poor has not narrowed; according to the Thailand Human Development Report 2009, the wealth of the richest quintile is 3-4 times greater than the wealth of the poorest quintile.

To address health inequities and social determinants of health, a National Health Act was passed in 2007, which led to the establishment of the National Health Commission Office, health impact assessments, and the National Health Assembly. Nevertheless, social inequity remains one of the underlying causes of political unrest in Thailand in recent years.

The frequent changes of the government and cabinet since 2006 led to continued shifts and uncertainties in national policies, including health policies such as on decentralization as well as termination of the “Healthy Thailand” strategy and a food safety project called “Clean Food, Good Taste”. In 2010, the government therefore established two National Reform
Committees and a participatory process to formulate proposals to reform Thailand. In addition, the Eleventh National Economic and Social Development Plan (NESDP), for 2012-15, aimed to address social inequity while simultaneously promoting environmentally friendly and creative economic growth.

Prior to the 1960s, the Thai economy was based primarily on the production of rice and other foods and goods for domestic consumption and of rice, rubber, teak, and tin for export. The government began to promote a shift from agriculture to the manufacture of textiles, consumer goods, and, eventually, electronic components for export. By the 1980s, Thailand embarked on a solid path of industrialization (WHO, 2011c).

From 1963 until 1997 the Thai economy was one of the fastest growing in the world. During the 1980s and '90s numerous export-oriented industries emerged, primarily in the areas surrounding Bangkok. The large-scale migration of young women and men from rural communities to the greater Bangkok area drained labour from the countryside. Those continuing to pursue agriculture turned increasingly to machines to make up for the shortage of workers, bringing about a shift in the rural economy from subsistence to market-oriented agriculture. Most of the investment in new technology in the agricultural sector came from the savings of family members who had gone to work in the cities (Hafner et al., 2014).

Social changes have accompanied these economic movements, with rapid urbanization and exposure to western culture being examples of two significant developments (Brodsky, Habib, & Hirschfeld, 2003).

On August 2, 2011 the World Bank upgraded Thailand’s income categorization from a lower-middle income economy to an upper-middle income economy (World Bank, 2011). The World Bank acknowledges Thailand as a country which made great progress in social, economic and
development issues with sustained strong growth and impressive poverty reduction in spite of political uncertainty and volatility\textsuperscript{14}.

Thailand continues to make progress towards meeting the Millennium Development Goals (MDGs). The maternal mortality and under-five mortality rates have been greatly reduced and more than 97% of the population, both in the urban and rural areas, now have access to clean water and sanitation. At the same time, there are concerns about environmental sustainability (World Bank, 2014).

Thailand had reformed its health care system to increase access and treatment for the poor during East Asia’s rapid growth period. These reforms helped mitigate the effects of the East Asian financial crisis on health care utilization. Because of these reforms, Thailand was the only country in which health care utilization did not initially decline when the crisis hit (Xiaohui, Velényi, Yazbeck, Iunes, & Smith, 2013).

\textbf{5.2.3 Historical and Political Environments}

This sub-section will be limited to historical and political developments in the Thai health sector from a health promotion perspective. Historically, since the end of absolute monarchy in 1932, Thai politics has gone through various stages: constitutional military rule, military dictatorship, democratic experiments, ideological conflicts, rise of the middle class, and the promulgation of a reformed constitution (Puntarigvivat, 1998). From the Hindu and Buddhist Dvaravati culture which pre-dominated Thai society from the 7th to 14th cent AD the modern Thailand is a constitutional hereditary monarchy under the Constitution of the Kingdom of Thailand, 2007.

\textsuperscript{14} The World Bank annually revises its classification of the world’s economies based on gross national income (GNI) per capita estimates using the Atlas method. As of July 1, 2011, upper-middle-income economies are those with average incomes of US$3,976 to US$12,275.
5. Phase II: Case Study

Thailand's modernisation was initiated during the reign of King Mongkut (Rama IV), who embraced Western innovations from 1804-1868. Under the reign of King Chulalongkorn (1868-1910) western advisers were employed to modernise Siam's administration and commerce and railway network was developed.

Thailand is considered to be the only Southeast Asian nation that has never been colonized despite European pressure. The country remained a buffer state between parts of Southeast Asia that were colonized by the two colonizing powers, Great Britain and France. Nevertheless Western influence led to the loss of a large territory on the east side of the Mekong to the French and the loss of the Malay Peninsula to Britain. Siam’s struggles against European imperialism in the 19th century are regarded as the advent of a modern nation which is owed to the ‘intelligence of the monarchs who responded wisely and timely to the threats of the European powers by modernising the country in the right direction at the right time’ (Winichakul, 1994). An alternate point of view given by Loos is that ‘(Siam)….was not a sovereign country, except in the most formal political sense but suffered a kind of surrogate colonisation overseen by its own rulers, who collaborated with imperial countries in order to maintain their positions at the helm of an ‘independent’ Siam’ (Loos, 2006).

5.2.3.1 Medical Facilities and Personnel

Thailand launched the first National Economic and Social Development Plan (NEDSP) in 1961 which resulted in a rapid expansion of network of public health facilities. A mix of public and private health service providers supplies health services in Thailand. In the public sector, the MoPH is responsible for two-thirds of all hospitals and beds across the country. Other public health services are medical school hospitals and general hospitals under other ministries (such as the Ministry of Interior, Ministry of Defence). There are health centres and community hospitals in sub-districts (tambon), district hospitals, provincial hospitals, a few special
centres/hospitals at provincial level, and large referral hospitals in the capital and major cities.

Health centres provide primary care by nurses, midwives and sanitarians. Doctors, full-time or part-time now work at some health centres, called Community Medical Units (CMU). At community-level, primary health care is provided by health volunteers or by self-care. Currently, MoPH owns 900 hospitals, which cover more than 90% of districts, and 9762 health centres, which in turn cover every sub-district. Local governments play a very limited role in health services today. Under the Decentralization Act (1999), the MoPH was to transfer most of its health facilities to local government by 2010; however, the action plan to achieve it was never finalized or implemented.

Thailand has a shortage of public health specialists. The majority of public health personnel have a medical background instead of a public health background (WHO, 2011c). In addition, distribution of the health-care personnel is also a major problem. The WHO recommends deliberate long-term planning to ensure adequate public health training and experience at all levels of the system. While the health system has shown achievements in terms of quality and sustainability in antenatal care, water and sanitation facilities and nutrition programme, gaps exist in coverage of public health services among the poorest segments of the population (WHO, 2011c).

**5.2.3.2 Medical Tourism**

Thailand became known as a destination for medical tourism as early as the 1970s but there are no reliable national figures to record the steadily rising medical tourists (Connell, 2006). According to an estimate in 2004 some 247,238 Japanese, 118,701 American, 95,941 UK and 35,092 Australian patients were treated in Thai hospitals, though this includes locally based expatriates and other injured and sick tourists (Levett, 2005). In 2004, the cabinet approved a strategic plan for developing Thailand as a medical hub of Asia. The country recently set a target of 2 million medical tourists by the
year 2010; however, concerns remain about some potential negative effects of a major medical hub on Thailand’s own health system, in terms of attracting healthcare personnel into the private sector and thereby exacerbating the health personnel shortage in Thailand’s public sector (WHO, 2011c).

The expansion of private health facilities, resulting from Thailand’s economic growth and the government policy of promoting Thailand as the medical hub of the region have made an impact on the Thai health system. In Thailand potential impact of the role of governments and private actors in promoting the medical tourism industry on health systems in terms of equity in access and availability for local consumers, is unclear (Pocock & Phua, 2011).

5.2.3.3 Primary Health Care

Thailand’s history of primary health care (PHC) development started before the Declaration of Alma Ata in 1978. The National PHC programme was implemented nationwide as part of the Fourth National Health Development Plan (1977–1981) focusing on the training of “grass root” PHC workers, Village Health Communicators (VHCs) and Village Health Volunteers (VHVs). Since then PHC has evolved through many innovative health activities: community organization, community self-financing and multisectoral coordination.

The WHO regards PHC as successful in Thailand because of community involvement in health, collaboration between government and nongovernmental organizations, integration of PHC into the health sector, decentralization of planning and management, intersectoral collaboration at operational levels, resource allocation in favour of PHC, and the management and continuous supervision of the PHC programme at all levels (WHO, 2011c). The implementation of PHC in Thailand which is based upon a service-oriented approach has resulted in less community self-
5. Phase II: Case Study

reliance. This has been ascribed to the VHVs’ role of linking the community with the local health system and providing health services at the community level (WHO, 2011c).

5.2.3.4 Traditional Thai Medicine

Buddhist temples have traditionally been centres for community activities, including education, health care and cultural events. Buddhist monks, dubbed as the “bare-headed doctors”, were trained in diverse community health-care techniques when primary health care had just started in Thailand: (http://www.who.int/bulletin/volumes/86/1/08-010108/en/).

In a paper presented at the 6th Global Conference for Health Promotion in Bangkok, the role of ‘Thai traditional medicine’ (TTM) in health promotion is highlighted (Chokevivat & Chuthaputti, 2005). TTM enjoys a legal status with an Act ‘Protection and Promotion of Thai Traditional Medicine Wisdom Act B.E 2542’ passed in 1999. TTM is defined as ‘the practice of the art of healing that is based on Thai traditional knowledge or textbooks that have been passed on and developed from generation to generation, or based on the education from academic institutes that the Professional Committee approved’. TTM originated during the Sukhothai period (1238-1377) and developed as a parallel means of national health care until the early 20th century.

5.2.3.5 International Health Partners

There are 23 international agencies and two development bank offices with programmes in Thailand (WHO, 2011c). The key health partners include: the WHO, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Bill and Melinda Gates Foundation, Bloomberg Initiative, Rockefeller Foundation, UN agencies, development banks and a few bilateral donors (e.g. Australia, the EU, Japan and the United States). The health-related UN agencies that are currently working in Thailand, such as United Nations Population Fund (UNFPA), address the integration of
reproductive and maternal health as well as strategies for aging within overall health strategies. The work of the United Nations Children's Fund (UNICEF) in Thailand is to ensure the well-being and rights of all children living in Thailand. WHO and UNICEF work closely on issues of breastfeeding, immunization and control of iodine deficiency (UNICEF, 2014). UNDP’s health-related work addresses the MDGs and decentralization issues. International Labour Organization (ILO), United Nations Environment Programme (UNEP) and WHO are working together on eliminating asbestos-related diseases, while International Organization for Migration (IOM), WHO and other partners are addressing issues of migrant health. Thailand is an active member of the Association of Southeast Asian Nations (ASEAN) and there are several priority issues that are addressed by the ASEAN member states related to communicable diseases (including HIV/AIDS), food safety, tobacco control, emergency preparedness and response, and pharmaceutical development. Some new areas under discussion are improving maternal and child health, addressing the health of migrants, promoting healthy lifestyles, and containing artemisinin-tolerant malaria. The MoPH and United States Centers for Disease Control and Prevention (CDC) have also established the Thailand MoPH–US CDC Collaboration Centre to strengthen national capacity in the prevention and control of emerging infections, HIV and TB.

Thailand has endorsed a range of UN conventions and treaties on human rights: Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR).

5.2.3.6 Contributions of the Country to Global Health

The following are some notable contributions Thailand has made to global health development adopted from the report ‘WHO country cooperation strategy Thailand: 2012-2016’:
1. Establishment of the Thai Health Promotion Foundation (Thai Health): Established in 2001, the foundation served as an example for other countries of innovative ways to finance health promotion and health in all policies. The foundation also works closely with WHO on NCD issues of global importance. Thai Health will be discussed in detail in later sections.

2. Development and implementation of PHC: Thailand has been a pioneer in the PHC approach, even before the Alma Ata Declaration in 1978.

3. Establishing a system of universal health care coverage.

4. Vaccine development: In 2009 Thailand publicized the results of the largest ever HIV vaccine trial (“Prime-Boost” HIV Vaccine Phase III Clinical Trial), which suggested 31% effectiveness in preventing HIV infections over a period of three years. Thailand is one of the six LMICs that successfully competed to receive a grant from WHO to establish in-country manufacturing capacity for influenza vaccine.

5. Tobacco control: Thailand is a leader in the Region, and shares its valuable experiences with other countries. Two comprehensive tobacco control laws, the Tobacco Consumption Control Act and the Non-smoker Protection Act, were enacted and implemented starting in 1992, 12 years before the WHO Framework Convention on Tobacco Control (FCTC) went into force. Thailand was a strong supporter of the FCTC process and is a signatory to it.

6. The National Health Assembly is a social innovation of Thailand, established under the National Health Act 2007. It aims for participatory and constructive dialogue involving all stakeholders towards consensus on critical health issues (http://en.nationalhealth.or.th/nha2010).

5.2.4 Health Promotion in Thailand

Health promotion is defined as a key strategy for sustainable health development under “Health Promotion, Disease Prevention and Control, and Consumer Protection”, a national agenda set by the Thai government in the 4th ASEAN and Japan Meeting on Caring Society 2006. The following
section describes some key health developments in terms of history, processes and players in Thailand’s health sector development.

Health promotion in Thailand evolved through various phases (Table 5.1). The developments in health promotion underwent many changes from a focus on curatives services to the WHO strategies including a broader social determinants of health approach by adopting “Health for All” to “Ottawa Charter”, “Jakarta Declaration” and “Bangkok Charter”. The major outcomes included conventional public health focused services, such as maternal and child health care, nutrition, and family planning.

The 1997 Constitution’s focus on people’s rights to good health started a process that mobilized people from the health and non-health sectors into a nationwide movement for health promotion. These ‘movements’ helped create and coordinate health promotion initiatives in health and related sectors for healthy behaviours, policies, environments and systems.

The country implemented primary health care in early 1978 as a member country of WHO to promote Health for All Thais. In 1986, Thailand adopted the new paradigm of health promotion under “the Ottawa Charter” which contributed to strengthening the policymaking and delivery of health promotion. After the 20th year of the Ottawa Charter, the WHO chose Thailand to host its 6th Global Conference on Health Promotion in August 2005, while praising Thailand as a leader in the field of health promotion.
Table 5.1 Health promotion development milestones Thailand timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Institution / Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>Adoption and implementation of the Health for All Policy of the World Health Organization (WHO)</td>
</tr>
<tr>
<td>1992</td>
<td>Health System Research Institute (HSRI) established to support health system reform</td>
</tr>
<tr>
<td>1997</td>
<td>1997 Constitution endorsing people’s rights to good health</td>
</tr>
<tr>
<td>2000</td>
<td>National Health Reform Office (HSRO) established to support drafting of the National Health Act</td>
</tr>
<tr>
<td>2001</td>
<td>Launching of the Universal Health Coverage Scheme (UCS) and establishment of the Thai Health Promotion Foundation (Thai Health)</td>
</tr>
<tr>
<td>2001</td>
<td>Thai Health Promotion Foundation Act</td>
</tr>
<tr>
<td>2002</td>
<td>National Health Security Office (NHSO) established to be in charge of the UCS implementation</td>
</tr>
<tr>
<td>2005</td>
<td>Thai Health sponsored the Public Health Systems Research Institute (PHSRI) to develop a national health information system</td>
</tr>
<tr>
<td>2007</td>
<td>National Health Act: health constitution for all Thai citizens</td>
</tr>
</tbody>
</table>

The 2009 Health Policy states 12 primary health care concepts focused on community health development, by defining the basic minimum needs (BMN) and essential elements of PHC. Following the introduction of the National Primary Health Care Programme, a series of developments centred on community participation in PHC. People from the community were selected and trained to be key actors in community-based health development known as VHV and VHC.

The WHO Country Cooperation Strategy (CCS) 2012-2016 includes health promotion and healthy public policy as one of the seven priority areas. The CCS priorities are consistent with the priorities of the Tenth National Health Strategy/Plan (2007-2011). Health promotion is mentioned as Strategic Objective SO6 in the Medium Term Strategic Plan (MTSP). In the CCS report the budget allocation section for SO6 terms it as ‘Risk factors (health promotion)’.

5.2.5 Health Promotion Capacity Mapping

The Royal Thai Government has been collaborating with the WHO since its inception and has had a WHO country office since 1949. The collaboration consists of technical support, capacity-building, supporting small projects research and pilot activities, and facilitating collaboration with other countries.
As mentioned earlier, the activities of WHO in Thailand are derived from the framework described in the CCS reports which, according to the WHO, are consistent with the priorities of the National Health Strategies or Plans. Currently health promotion is confined to a ‘risk factors’ approach in the country’s MTSP SO6 (to promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex). Most activities implemented and addressed in collaboration with the WHO are related to tobacco control and alcohol harm reduction. Others include support to strengthen multisectoral approaches to address risk factors of NCDs under a national health promotion programme.

In 2005, the 6th Global Conference on Health Promotion took place in Bangkok in which health promotion capacity building was a major theme. In preparation for the Bangkok Conference, WHO initiated a mapping exercise of national capacity through its network of Regional Health Promotion Advisers or Focal Points (Catford, 2005). The mapping exercise was conducted under a proposed mapping framework proposed by Catford in a publication ‘The Bangkok Conference: steering countries to build national capacity for health promotion’. The framework defined eight broad domains to track national capacity in health promotion mentioned in detail in the literature review section. Thailand also hosted the 21st IUHPE World Conference on health promotion in Pattaya, Thailand in August 2013 on the theme ‘Best Investments in Health’.

The following section gives an account of the existing situation in Thailand under the newly developed mapping framework for this study. The framework consists of three broad domains: governance, policy environment and infrastructure.
5. Phase II: Case Study

5.2.5.1 Governance

For most of the 60 years following the 1932 democracy movement, Thailand was under military rule. From 1973, the country began the transition to civilian rule, although at times the military again took control of the country. The first democratically elected Prime Minister came to power in 1988; and up to 1997, when a new constitution was adopted, there was a number of leaders and coalition governments. The 1997 Constitution brought reforms in government institutions and the relationship between the state and the people. Political instability since that time brought a new Constitution in 2007 and a continued heightened political environment (ADB, 2011).

Under the present Constitution of Thailand, the Prime Minister must be a Member of Parliament. Cabinet members do not have to be Members of Parliament. The legislature can hold a vote of no confidence against the Premier and members of the Cabinet if it has sufficient votes. The judiciary is independent of the executive and the legislative branches. Thailand’s first Constitution was promulgated in 1932 at the crux of a democracy movement, but this Constitution was not long lasting and has since been changed by interim charter or formal constitutional promulgation 16 times (ADB, 2011).

Governance relates to processes and decisions that seek to; define actions, grant power and verify performance. It refers to "all processes of governing, whether undertaken by a government, market or network, whether over a family, tribe, formal or informal organization or territory and whether through laws, norms, power or language" (Bevir, 2012). According to the Tenth NESDP’s vision, “Thailand will be a Green and Happy Society in which people have integrity and knowledge of world standards; families are warm; communities are strong; society is peaceful; the economy is efficient, stable, and equitable; the environment is of high quality and natural resources are sustainable; the administration follows good governance under
the system of democracy with the king as head of state; and the country is a respected member of the world community.” Under the UN reform process, Thailand is committed to “Delivering as One”, and the United Nations Development Assistance Framework (UNDAF), referred to as the United Nations Partnership Framework (UNPAF) in Thailand, has been developed jointly with the government. As a specialized agency, the WHO is one of the signatories to this framework, which outlines governance as one of the key five areas of cooperation.

The country’s government system comprises three major administrative categories as follows:

1. The central administration: These include the King, the Head of the State, the cabinet - the government body responsible for administrative or government function through the parliament system, and the central administrative system with 15 Ministries led by the Prime Minister.

2. Provincial administration: Local authorities under central governments operating at provincial and district levels within the local governing jurisdictions for specific administrative tasks. According to the provincial administrative law, the provincial administration consists of 76 provinces and 876 districts.

3. Local administration: The local authorities are the autonomous administrative body possessing juristic person status and owning an administrative autonomy under the laws. The Bangkok Metropolitan Administration and some large cities are among local authorities under this category. The others include: 76 provincial administration organizations, 1,129 municipalities, and 6,745 sub-district administration organizations.

The Ministry of Public Health (MoPH) has the overall responsibility for developing and implementing the national health policy. MOPH is the principal agency responsible for promoting, supporting, controlling and coordinating all health services activities for the well-being of the Thai
5. Phase II: Case Study

people. The Office of Permanent Secretary is the central administrative authority of the MoPH. There are seven technical departments and one administration unit working under this office. These are the: i) Department of Medical Services; ii) Department of Development of Thai Traditional and Alternative Medicine; iii) Department of Mental Health; iv) Department of Disease Control; v) Department of Health; vi) Department of Health Service Support; vii) Department of Medical Science, and viii) Food and Drug Administration. The MoPH played a key role in facilitating the fundamental, institutional changes that led to transforming Thailand’s health system through the health promotion movement. Other factors comprised of implementation of the WHO Health for All Policy, the establishment of the HSRI, the introduction of National Health Act, and finally, the launching of the Universal Health Care and Thai Health.

**The Thai Health Promotion Foundation (Thai Health)**

Thai Health was established in 2001, and is considered the first organization of its kind in Asia. Created under the Health Promotion Foundation Act 2001, Thai Health is an autonomous state agency outside the formal structure of government. It is funded by ‘sin taxes’ collected from producers and importers of alcohol and tobacco.

Thai Health is governed by a board chaired by the Prime Minister. It is not part of the conventional health services. Thai Health pursues a “socio-cultural” rather than a “biomedical” model of health. It fosters strategic partnerships with government, private sector, nongovernmental organizations, and communities to implement health promotion plans. In 2010, its budget was 3700 million bahts (119 million US dollars). According to (Adulyanon, 2012) Thai Health plays a catalytic, coordinating, empowering and enabling role and its impact can only be assessed “collectively” with all partner organizations. Thai Health contributed to the development of several policies that led to enactment of laws and building the capacity of organizations, communities and individuals in planning and carrying out health promotion activities. The “collective impact” includes a
5. Phase II: Case Study

Thai Health is responsible for the development of programmes on important health risks and issues such as alcohol, tobacco, narcotics, exercise, accidents and mental health. Other programmes are settings-based, for example, school, work-place, urban or rural communities. Some programs target specific population groups, for example, the young, the elderly, women, handicapped, Thai Muslims, and other disadvantaged groups. The open grants programme invites proposals for funding from all kinds of organizations/groups that need support for their health promotion initiatives.

Policy advocacy and public awareness campaigning is an important area of Thai Health’s work. Thai Health’s policy advocacy focuses on issues directly related to health risks such as legislation on cigarette advising, alcohol sales, as well as emerging issues, for example, healthy public policy, health impact assessment and healthy cities. Thai Health’s strategy places a strong emphasis on knowledge management to develop the technical capacity of health promotion professionals. In 2005, Thai Health sponsored the Public Health Systems Research Institute (PHSRI) to develop a national health information system that includes measurable health indices, a national health information map, issue-specific health information systems, local health information systems, and health information standards (Thai Health, 2005).
Thai Health is said to have achieved through flexibility, financial security and effective strategy. However, inadequate understanding among the public and stakeholders about the philosophy, governance and operation of Thai Health is reckoned as a huge challenge. Thai Health acts as a catalyst and a change agent. The foundation focuses on its roles as an assistant and facilitator, rather than being an actor. Its objectives are therefore, “to spark, stimulate, support and develop health promotion processes that will lead to good health of the Thai people and Thai society”.

There are several other public health agencies with an autonomous or semi-autonomous status operating side by side with the MoPH. The following section describes these various agencies.

1. The Health System Research Institute (HSRI) is a semi-state research institute established in 1992 sponsored by the Ministry of Public Health (MOPH) to support health system reform. Its objectives are to create and stimulate the generation and synthesis of policy relevant health systems knowledge and encompassing evidence, tools, methods and interventions. HSRI paved the way for the establishment of Thai Health through knowledge generation and developing a common ground on significant health promotion issues among health personnel, civil society, and policymakers.

2. The National Health Security Act, 2002 approved the National Health Security Office (NHSO) as an autonomous body with the following objectives: a) to collaborate with other health care organizations; and b) to drive Thailand’s health-care system towards equitable and accessible quality health care for all. The 2007 Universal Health Coverage Scheme (UCS) budget was about 91 billion baht, about 70% of the total MoPH budget. The role of NHSO is to purchase health services for people under the UCS. The office is under the supervision of the Public Health Minister. A National Health Security Board (NHSB) appoints the Secretary General of NHSO.
3. The National Health Commission (NHC) is an autonomous government agency chaired by the Prime Minister in accordance with the National Health Act 2007. The NHC establishes policies, direction, development, and solutions for the happiness of all members of society throughout the life course. The primary tasks of NHC involve promoting healthy public policy. It facilitates participatory dialogue with all constituencies whether private, public, civil society, academic or technical, from the community to central levels. The NHC organizes the National Health Assembly, promotes the use of health impact assessments, and performs other duties prescribed under the National Health Act or as entrusted by the council of ministers or NHC.

4. Under the Ministry of Public Health, the Emergency Medical Institute of Thailand (EMIT) is an institute that was established by the Medical Emergency Act 2008. Missions of the institute include a) developing a medical emergency system to meet international standards; b) developing networks with participation of all stakeholders; c) developing an efficient medical emergency management system; d) working as a medical emergency coordinating body during disasters. The Secretary General of the EMIT is the secretary to the National Emergency Medical Service Committee, chaired by the Minister of Public Health.

5. The International Health Policy Programme (IHPP) was established in 2001 and is a semi-autonomous programme conducting research on national health priorities related to health systems and policy in Thailand. The programme is part of the Bureau of Policy and Strategy of MoPH. It aims to improve the national health care systems and policies through the generation and synthesis of knowledge and evidence. An additional aim of the programme is to strengthen the policy research capacity in Thailand in the areas of healthcare finance, economic evaluation and health policy analysis and through the provision of training grants. The Health Intervention
and Technology Assessment Program (HITAP), was established in 2007 under IHPP to appraise a wide range of health technologies and programmes, including pharmaceuticals, medical devices, interventions, individual and community health promotion, and disease prevention.

6. In addition to these public health agencies, WHO has officially designated some centres as the WHO collaborating centres (CCs). There are 34 designated WHO Collaborating Centres in Thailand along with some other key networks such as Thai Public Health Institute Network (THAIPHIN) and South-East Asia Public Health Institute network (SEAPHEIN).

In 2000 the National Health Reform Office was established to support the mobilization of all societal groups into the drafting of the National Health Act. Together with the National and Provincial Assemblies a forum for alliances was set up to develop a nation-wide network of health promotion.

In the year 2001 the UCS was launched together with the establishment of the Thai Health in the Thai health system. Thai Health is the largest funding mechanism for health promotion which developed through enactment of a Royal decree. In 2002 the National Health Security Office was established to be in charge of the UCS implementation.

In 2007 the National Health Act was passed which is regarded as the health constitution for all Thai citizens. The Act includes the rights-based principle of the Constitution and key principles of the Ottawa Charter (WHO, 1986). The Act defines health as encompassing ‘physical, mental, social, as well as spiritual’ wellbeing and outlines a path for a sustainable health system through health governance, health promotion, health hazards control, health service, health research, consumer empowerment, health information, and health manpower management.
The 2007 National Health Act also led to the establishment of the National Health Commission Office, Health Impact Assessments, and the National Health Assembly. The Act has a mandate to establish NHA: “A process in which the relevant public and State agencies exchange their knowledge and cordially learn from each other through a participatory and systematically organized forum, leading to recommendations on Healthy Public Policies or Public Healthiness”. The Act specifies three categories of health assemblies: the Area-Based Health Assembly (AHA), the Issue-Based Health Assembly (IHA) and the National Health Assembly (NHA). These health assemblies provide a forum for all state and non-state stakeholders to discuss and build consensus on key issues. The health assemblies are considered a ‘social innovation’ meant to increase public participation to develop healthy public policy and address social determinants of health. A National Health Constitution was also developed in 2008 and National Health System Statutes were produced in 2009.

The National Health Commission (NHC) has a mandate to prepare and hold the NHA at least once annually. It comprises over 1500 people from 178 constituencies including 76 area-based constituencies (one from each province including Bangkok) with the remainder from civil society, government organizations, health professionals, academia and the private sector. During the NHA, key health issues are discussed and resolutions are produced to guide policy-making. Based on the NHA deliberations, results and resolutions, the NHC will submit recommendations to the National Assembly.

5.2.5.2 Policy Environment

The health policies in Thailand evolved from the First National Health Development Plan (1961-19660) to the present Ninth National Health Development Plan (2002-2006). During the First to the Third Plan (1961-1976), health policies were focused on expansion of health facilities, health promotion, disease prevention and control. In 1972 the Ministry of Public Health established the Health Planning Division under the Office of the
5. Phase II: Case Study

Permanent Secretary. In 1993, the Health Planning Division was restructured by combining with the Health Statistics Division and named “Bureau of Health Policy and Planning”. The bureau is responsible for formulation of health policy and plans. Other responsibilities include coordination of the result-based budgeting system, analysis of the health situation and trends, development of health information system, inter-sectoral and intra-sectoral coordination (within health, other sectors and non-governmental organizations), health policy research, and support decentralization. The national health policies (till 2009), mentioned above, are available for download at the bureau’s website (http://bps.ops.moph.go.th/webenglish/Policy.htm).

The Health Policy in Thailand 2009 is developed by the Bureau of Policy and Strategy, Ministry of Health, Thailand. It consists of sections on the evolution of the health care system, trends in the health sector, Universal Health Coverage Policy, MDGs, international health cooperation and the health industry.

The Ministry of Public Health is responsible for implementing the Universal Health Care Coverage Policy (UC) focused on creating universal health insurance coverage for the entire population. The health service benefit package includes inpatient/outpatient treatment at registered primary care facilities and referral to secondary and tertiary care facilities (except for emergency cases), dental care, health promotion/prevention services, and drug prescription. The main objectives and characteristics of the Universal Health Care Coverage Policy are: universal coverage, single standard, and sustainable system. Legislation was initiated through a law, the National Health Security Act enacted in November 2002 to ensure sustainability in terms of policy, financing, and institutional support.

5.2.5.3 Infrastructure

Health promotion infrastructure consists of human and material resources, organisational and administrative structures, knowledge management and
information systems which facilitate country-wide health promotion response to health issues and challenges. The following is an account of these resources and their existing status in Thailand:

**Health Promotion Delivery**

Health promotion delivery consists of the delivery structures and mechanisms for health promotion priorities at national and/or subnational levels according to country needs. The institution playing the key role in delivering health promotion in Thailand is the Thai Health Promotion Foundation (Thai Health). The main functions and operations in terms of health promotion activities have been discussed under Governance. Thai Health is responsible for the development of various programmes such as alcohol, tobacco, narcotics, exercise, accidents, mental health including settings-based programmes related to school, workplace, urban or rural communities. Some programs target specific population groups, for example, the young, the elderly, women, handicapped, Thai Muslims, and other disadvantaged groups. In addition the open grants programme system invites proposals for funding from all kinds of organizations/groups that need support for their health promotion initiatives.

Along with Thai Health, the Universal Coverage Scheme (UCS) ensures equal access to health care nationwide. The beneficiary of the UCS is entitled to a benefit package that includes inpatient/outpatient treatment at a registered primary care facility and/or referral care facilities, dental care, health promotion/prevention services and drug prescription. The services are delivered by primary health care centres, which are accessible and are a strategic point for delivering prevention and health promotion services (Jongudomsuk, 2005).

**Workforce**

The Universal Coverage Scheme implemented in 2001 resulted in increasing service utilisations. Also the public sector reform implemented in 2001 which came with the downsizing of civil servant positions made it
difficult to attract and retain health workforce in public sectors. The Decentralization Act implemented in 1999, prompted the Ministry of Public Health (MoPH) to prepare the delegation of some health facilities to local authorities, which has not shown much progress. Furthermore, the growth of the elderly population accompanied with the increase of chronic illness brings an increasing demand for health services. These transitions have indicated an increase of health workforce requirements both in public and private sectors (WHO, 2010).

The existing health workforce in Thailand provides care that relates to health promotion, curative care, health prevention, and rehabilitation. The workforce includes health professionals, allied health professionals, Thai traditional medicine personnel, local health wisdom healers, alternative medicine personnel, health volunteers, and civil health networks including health and health-related activities in the public sector, the private sector and communities (Pagaiya, Noree, & Bank, 2008).

In 2007 a National HRH (Human Resources for Health) strategic plan was developed and a National HRH commission was set up to oversee, mobilise, and monitor the plan. The plan states that an evidence-based and effective HRH information system should be developed for decision making in development and implementation of policy on HRH planning. In 2010 the WHO and MoPH developed a report ‘Human Resources for Health Country Profile Thailand’ which considers the HRH plan implementation as a challenge which requires capacity in HRH research, management and leadership. The report asserts that the system needs a sustainable capacity, involving individuals, institutions, and networks to ensure sustainability (WHO SEARO, 2010) Human Resources for Health Country Profile Thailand).

In this report the WHO SEARO classification mapping of the health workforce designates health promotion officer/specialists under the category
of ‘non-medical Public Health Practitioners’ (sub-category: ‘Public Health Specialists’). The health workforce classification mapping of Thailand presently has no such designations and mentions ‘promotion’ under the scope of work for public health generalists who are non-medical professionals with 4 years of university education in a public health bachelor’s degree. Although the trend toward reducing health expenditures by expanding health promotion approaches has been widely accepted, there is insufficient discussion about which categories of the health workforce would function best at this task (Pagaiya et al., 2008).

Health Promotion Competencies and Standards

In 2008 the WHO reported a meeting of WHO SEARO experts on ‘Developing Health Promotion Competencies and Standards for Countries in WHO South-East Asia Region’ (WHO SEARO, 2008). The objective of the meeting was to identify competencies and standards for health promotion practice in member states of the South-East Asia Region and participants came from Bangladesh, India, Indonesia, Maldives, Sri Lanka, and Thailand.

The report states that health promotion training can be categorized into two groups namely, (a) stand-alone health promotion programmes or (b) integrated health promotion courses (WHO SEARO, 2008). Thailand along with Bangladesh, India, and Indonesia has developed short courses which are offered even to people from other countries through fellowships.

The recommendations made by the group of experts were:

- To review existing training programmes and courses on health promotion and education in order to document the competencies and performance indicators currently offered in health promotion training;
- To conduct an assessment of the competencies among health promotion practitioners functioning in various fields;
5. Phase II: Case Study

- To support countries in conducting consultative meetings in order to reach consensus on core competencies relevant to the needs of the country;
- To support academic institutions training in health promotion to incorporate the relevant competencies into the existing training curricula;
- To develop a short course incorporating health promotion core competencies for implementing actions contained in Bangkok Charter

_Village Health Workers/ Volunteers_

In the national PHC programme the concept of involving villagers as volunteers in government service development projects is applied through the development of two types of Community Health Workers known as the Village Health Volunteers (VHVs) and Village Health Communicators (VHCs). At the community level VHCs are the focal contact points of communication of health prevention and promotion. The VHCs are trained and given work guidelines to serve as disseminators of knowledge and information to their groups each consisting of 10-15 families. The ratio of 1 VHV to 10 VHCs was selected to train and work in their own villages. From the year 1993 onwards, there has been only one type of volunteer, the VHV. These volunteers constitute the largest cadre of community health workers in the nation, numbering over 800,000 volunteers (2006) covering all villages in Thailand. These volunteers are not considered as government employees or under government control.

_Partnerships_

Health promotion partnerships refer to relationships between various partners in the health and non-health sectors (donor countries, development agencies, NGOs, civil society, private and government sectors) which work towards a set of shared outcomes thereby strengthening the health promotion system in a country. Thailand’s health promotion system is based on collaboration among various sectors of society (national to the grassroots level). Examples of these partnerships are networks of governmental
officials and non-governmental organizations in the campaigns for tobacco control and against drunk-driving. The MOPH and Thai Health are the national focal points for health promotion with a responsibility for engaging local organizations and community groups as partners in their health promotion programs (Figure 5.3).

Health related non-governmental organizations and health research institutes such as the National Health Reform Office HSRO, the HSRI, and the National Health Foundation (NHF) facilitated the health promotion network expansion in terms of both knowledge management and social mobilization. Village health volunteers played a major role in expanding the existing networks from the grass roots level (Berman, Gwatkin, & Burger, 1987; Kauffman & Myers, 1997; Vichayanrat, Steckler, & Tanasugarn, 2013).

The basic rights stated in the 1997 Constitution strengthened through the National Health Act 2007 provide a foundation for cross-sectoral exchange and collaboration. People have learned of their rights and expect better services as well as more participation in shaping the national and local health system.

Figure 5.3 Health Promotion Networks in Thailand (Adapted from Buasai, Kanchanachitra, and Siwaraksa (2007))
Financing

Innovative approaches to health promotion financing started with the tobacco control drive. From 1988 to 1993, Thailand worked on developing policies and enacting laws for tobacco control and succeeded in advocating for a tax increase on tobacco for health reasons in 1994. However, the financial support from the government for tobacco control was limited and showed a declining trend.

Financing for health promotion refers to the allocation of sufficient resources and incentives to create and sustain effective national health promotion structures and strategies. In this regard, it is important to study health-care financing in Thailand which has a long history leading to the mandating of universal coverage for health care in 2002. It started with user fees with exemption, and gradually moved to a pre-payment system. Various forms of pre-payment systems have been tested in Thailand to reduce out-of-pocket payments.

Universal coverage for health care was declared a national policy for Thai nationals in 2001 under the slogan “30 Baht to cure every disease”. To make the Universal Coverage Scheme (UCS) sustainable, health-care reform was introduced as well as a new public management concept, which separated the purchaser and provider and introduced demand-side financing (i.e., money follows the patient) versus the traditional approach of allocating funds on a historical basis.

The National Health Security Office (NHSO) was established as the purchaser. Since the Universal Coverage Policy was introduced in 2002, the social health protection is divided into three categories: a) a Civil Servant Medical Benefit Scheme (CSMBS) covering 7% of the population; b) schemes for private employees, the Worker Compensation Scheme (WCS) and the Social Security Scheme (SSS) covering 15%; and c) a scheme for all other Thai people, the Universal Coverage Scheme (UCS) which covers
76% of the population. As a result the public health protection schemes now cover almost all Thai citizens, and a migrant health insurance scheme is available for purchase among registered non-Thai migrants who have a work permit. A majority of the 2-4 million non-Thai migrants in the country are not covered by health insurance and do not enjoy the same degree of access to health services. The total health budget for UCS in 2002 was 51 billion baht (1202 baht per capita). In 2009, the government spent 105.9 billion baht (2002 baht per capita) from general taxation. The UCS, as part of the constitutional rights to health services, provides a broad range of medical and health promotion services free of charge. The budget for prevention and promotion (P&P) services was initially estimated at 20% of the cost of curative services. Nevertheless, this portion was often used to subsidize the curative care services (Balabanova et al.).

Thai Health is the largest domestically funded mechanism for health promotion in Thailand. Titled as the most innovative funding for health it is funded by ‘sin tax’ a two percent levy on government collected tax from producers and importers of alcohol and tobacco earmarked for Thai Health, stipulated by the Thai Health Promotion Foundation Act 2001. This earmarked tax generates an annual income of EUR 38-42 million\textsuperscript{15} (Buasai et al., 2007). In the 2008 fiscal year the Thai Health Promotion Foundation Board approved EUR 8.6 million\textsuperscript{16} to support various health promotion projects, with disbursement of EUR 7.6 million\textsuperscript{17} in that year. 25.21 percent of the total budget disbursement, was used to support projects to reduce main health risk factors (Thai Health, 2009). For the term 2009 – 2011, the yearly budget was EUR 2.5 million\textsuperscript{18}.

\textsuperscript{15} Converted the United States dollar (USD) 50-60 million figure to euros through xe.com (14 September 2014)
\textsuperscript{16} Figure in Thai Baht converted to euros through xe.com (14 September 2014)
\textsuperscript{17} Figure in Thai Baht converted to euros through xe.com (14 September 2014)
\textsuperscript{18} Figure in Thai Baht converted to euros through xe.com (14 September 2014)
Knowledge Management & Development

Creation of relevant knowledge through research is very crucial, but not adequate by itself as it needs to be translated into effective practice and policy and interact with social movements and change. Knowledge derived from research must be translated into forms and languages that can also empower the public. Health promotion knowledge development refers to developing a body of knowledge and an evidence base to support policymaking at all levels. Knowledge management consists of using this knowledge to develop capacity for health promotion research, information systems, performance improvement, evaluation and monitoring to promote health and strengthen the national health system.

Thai Health’s strategy places a strong emphasis on knowledge management in developing the technical capacity of health promotion professionals (Buasai et al., 2007). Thai Health’s strategy has employed the concept of Triangle as the strategy to solve difficult social problems, by strengthening in-parallel the capacity in three interrelated sectors. These are: 1) the creation of knowledge, 2) social movement and 3) political involvement (Figure 5.4).

![Triangle diagram](image)

**Figure 5.4 Triangle that moves the mountain adapted from (Thai Health, 2009)**
Another institution contributing to knowledge development is the International Health Policy Programme (IHPP) established in 2001. It is a semi-state programme which is part of the Bureau of Policy and Strategy and MOPH. It conducts research on national health priorities related to health systems and policy in Thailand. The programme aims to improve the national health care systems and policies through the generation and synthesis of knowledge and evidence. An additional aim of the programme is to strengthen the policy research capacity in Thailand in the areas of healthcare finance, economic evaluation and health policy analysis and through the provision of training grants. These aims are achieved through trainings, coordination and cooperation and by carrying out various research projects (http://www.ihppthaigov.net/).

5.3 Conclusion
The desk review of country specific contexts for health promotion capacity mapping encompasses various contexts in which the Thai health promotion system exists. These factors influence national health promotion capacity development at governance, policymaking and programme delivery levels and need to be included in the capacity mapping processes. The key findings from the desk review along with findings from the key informant interviews are presented under ‘Summary of Country Specific Contexts’ at the end of the next section.

5.4 Data Collection Method 2: Key Informant Interviews
The aim of the semi-structured telephone interviews for the Thailand case study was to elicit key informants’ views on the country specific contexts that influence the development of health promotion capacity in Thailand. The interviews helped to identify existing strengths, gaps and challenges in the historical, political, economic and socio-cultural environments surrounding health promotion developments in the country.

The content, direction and subject matter of the interviews varied from interview to interview depending upon person’s role in the health system but
broadly the questions were related to the specific environments or themes mentioned (Table 5.2). All the interviews were conducted in English.

Table 5.2 Matrix of themes for interview participants Phase II

<table>
<thead>
<tr>
<th>Health Promotion Governance</th>
<th>Health Promotion Policy</th>
<th>Health Promotion Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The analysis of data was an ongoing and iterative process beginning at data collection and continuing through reporting (Silverman, 2013). The analytical process consisted of several phases, including managing the data, reading and note-taking, describing, classifying and interpreting and representing it (Creswell, 2012). The data were examined for emerging themes and categorised accordingly.

5.4.1 Country Specific Context
The country specific context includes the contextual factors such as historical landmarks, economic situation, political context and socio-cultural variables which influence the development of health promotion at the country level. These contexts can have varying effects on health promotion capacity at policy, research and practice levels. One participant commented on the importance of the country specific context to health promotion capacity mapping as:

*The country specific context shows the commitment of the country to invest in health promotion and links into the policy, legislation related to risk reduction, financing of integrated approach to universal health coverage, etc.*

5.4.1.1 Historical and Political Context
The participants were asked to comment on the country’s key historical developments and underlying major political decisions for health
development. The aim of this theme was to explore the context surrounding Thailand’s adoption of the health promotion approach, key decisions taken in this regard and identifying the main strengths and barriers.

According to the participants the history of health promotion developments in Thailand dates back to 1960s (40 years ago) when the 1st National Economic and Social plan was developed. The major landmark developments were Thailand’s adoption of the WHO’s Primary Health Care strategy to promote Health for All Thais in 1978, setting up of the health volunteer system and the Tobacco control movement in the early 1980s.

The participants mentioned some key institutions that were established at various points in time, to strengthen the health promotion movement, and are actively involved in health promotion governance, policymaking and delivery. The participants stated that these institutions, most of which are autonomous, played various roles in developing the knowledge base and resources for the health system, legislation, funding mechanisms for health promotion and universal access to health care which supported health promotion.

Besides the Ministry of Health, these institutions included: the Health System Resource Institute (1992), Health System Reform Office (2000), Thai Health Foundation (2001), National Health Security Office (2002), and the National Reform Committee (2010). The main achievement of the health promotion movement was the creation of Thai Health and the National Health Assembly (NHA) in 200719.

One participant stated that the NHA and the Thai Health Promotion Foundation came into being through enacting the National Health Act. The Act, which is perceived as a tool for health system reform, significantly affected the development of health promotion.

---

19 The National Health Assembly, a social innovation of Thailand, was established under the National Health Act 2007. It is instrumental in conducting participatory and constructive dialogues involving all stakeholders towards consensus on critical health issues (http://en.nationalhealth.or.th/nha2010).
The ‘health assembly’ process, as a provision in the National Health Act, prescribes that it is a major mechanism and is efficient in moving, reforming and turning the concepts of health promotion into living concrete actions.


**Political Will**
Some participants were of the view that strong political will is well-demonstrated in Thailand by the participation of politicians as stakeholders in the decision making processes in the elected government. This, according to the participant, was reflected in the prime minister’s support of health promotion activities who chairs the Board of the Thai Health and National Health Assembly. However, another participant commented:

*In the political environment it depends on how the policymakers use the window of opportunities to use health promotion for either their personal agenda or for breaking out new strategies of empowerment for people participation. In many countries politicians don’t like people to be to educated and understood.*

Some participants considered political will, and the level of understanding of health promotion by the politicians as a challenge.

*Politicians with the traditional way of thinking cannot do much in terms of building infrastructure for health promotion unless they change their thinking.*

**Health Promotion Mandate**
The health promotion mandate is considered to be the key driver behind Thailand’s health promotion developments which was accepted in the
government policies and has a law to support that. One participant remarked that the government is also responsible for the health promotion, and therefore, there is ownership of health promotion policies in Thailand.

On the other hand some participants were of the view that law implementation is a weak area in the political system. The participants stated that though there are quite a number of good laws but some powerful lobbies manage to influence their implementation. One participant explained this through the example of decentralization, which has been politically delayed for the health sector, and is impacting, on the local authorities that have the potential to develop/improve their own population health.

Some issues regarding policy implementation were highlighted by a participant as:

There are issues at policymaking and governance level: We need to have concrete knowledge before we do social mobilisation and push the issue towards policy. (An) example is the area of reproductive health which Thai Health is involved in for the last 3-4 years but we have not heard from the Parliament yet. Also once we start to push forward, they are changing the government again. Although this is normal, we have to start again (nonetheless), and it is a challenge. This also brings in issues of ownership which need to be reviewed again.

Policy Advocacy

The participants stated that there is strong policy support leading to empowerment strategies for well-being for Thai people, of which 80% live in the rural area. Some notable initiatives are: Women’s Health Advocacy Network (WHAN), Thai AIDS Treatment Action Group (TTAG), Ministry of Education (MOE) and the MOPH collaboration to develop curricula for courses on gender, sexuality and reproductive health, etc. Participants mentioned a wide range of existing policies from alcohol and tobacco control to asbestos control, health workers programme, health education,
etc. There are quite a number of projects involving lot of policy advocacy, and health surveys to help politicians learn about health issues.

5. Phase II: Case Study

5.4.1.2 Social and Cultural Context

Health Promotion as a Social Movement

Most participants recognised health promotion as a social movement which brought about establishment of the Thai Health and National Health Assembly. The establishment of these institutions has resulted in impacting the learning processes within the areas of staff and members’ networks of these institutions, in the civil society, and has provided support to healthy public policy process on the horizontal scale.

One of the participants gave a brief account of the history of social changes in Thailand with respect to health which, by the rough measure of mortality rates, has increased in the country since the end of the colonial era after WWII due to the combined effects of increased nutrition, improved public health, and greater access to primary health care (Frankenberg, 1995). The participant said that decades before 1997 were the decades of health promotion nurturing in Thailand. Several rural health development policies and projects were an expansion of community participation in self-healthcare and creating supportive environments for health. Over the two decades of the implementation of the primary health care policy, opportunities were open or local communities took care of their own health through activities such as training of village health volunteers (VHVs) and village health communicators (VHCs) and setting up village health funds (Bender & Pitkin, 1987; Boonperm, Haughton, Khandker, & Rukumnuaykit, 2012; Kauffman & Myers, 1997).

Influence of Cultural Traditions

The participants were of the view that existing cultural and religious traditions and teachings helped in pushing the health promotion agenda forward. Several health promotion developments take the support of cultural and religious (Buddhist) traditions. The policymakers and programme implementers successfully utilised various teachings within advocacy,
communication and awareness for health promotion among public, politicians, etc.

A participant gave an example of this:

*The main communication strategies take the support of Buddhist traditions for alcohol control to target the behaviour of people especially during religious festivals, etc. To reduce alcohol consumption, in some sub-districts, health statute is implemented through which a district is not allowed to sell alcohol in the festivals. Those not following the statute are punished by the people of the village. Also there are some models villages where no alcohol is consumed.*

**Understanding of Health Promotion**

One of the prominent themes which came out from participants’ responses is the varying levels of understanding of the concept of health promotion among various stakeholders like politicians, policymakers, public, etc. The participants responded to the issue from various perspectives.

One participant differentiated service-based health promotion from society or community-based:

*In Thailand disease prevention is mainly focused on infectious diseases through vaccination, sanitation, etc. which is actually promotion at the service area, by the service providers. This health promotion is part of medicine, as individual-focused HP. The new concept of health promotion addresses factors that affect health like environment, policy, community action, to prevent disease and reduce risk factors. For example smoking, alcohol, exercise, unhealthy food, etc. This new concept of health promotion addresses people in society at large with risky behaviour, living in a risky environment. They never come to the hospital or a healthcare service unless they get sick. This new way of thinking is not widely acknowledged in the society and perhaps it is the same in many societies.*
A participant considered the lack of understanding of health promotion by the policymakers (politicians, political advisors, civil servants) and professionals as a main barrier:

One of the main barriers in advancing health promotion developments in Thailand is that policymakers and even the professional do not fully understand the contemporary health promotion and this was something faced by Thai Health in the early stages. It links to the 100 years old mindset which limited health to be only found in hospitals or clinics.

Another participant further focused on the role of policymakers:

The policymakers only need people to elect the government. They do not want the people to be strong or have a strong community in which people are empowered and build their own community. Most of them limit health promotion to the activities of MoPH and the healthcare services. Health should be in all policies and not only something for MoPH to do but for all of Thailand. It is not only the job of MoPH to be involved in health promotion but all sectors must play their parts.

One of the participants commented on how health promotion is perceived in non-health sectors and ministries:

The same mindset is also present in non-health sectors and ministries. The Ministry of Public Health doesn’t like to acknowledge that tobacco or alcohol should not be in the free trade agreement. They say it’s a legal product. They don’t understand that if tobacco and alcohol are treated like any other commodity, you take away the control and thus get more people consuming it affecting their health. So that’s barrier no 1, understanding of health promotion.

One of the participants mentioned that in a mid-term evaluation of PROLEAD\textsuperscript{20}, two years ago, approximately 65 fellows trained in

\textsuperscript{20} ProLead - a health promotion leadership and management development programme by the WHO that focuses on applied leadership and management in health promotion intended
PROLEAD responded to the evaluation. The biggest obstacle reported by the participants was that the people who worked with them did not understand health promotion in the way they were trained in the course.

Some participants reported that health promotion is increasingly being misunderstood as education and communication:

90% of people think of health promotion as education and information. All the schools and all the degrees which have been given are only about that in spite of Thai Health activities. There is no curriculum, or any other professions involved in service delivery. There is a mix and match situation with public health education, communication science, how to communicate health in information science, etc. This kind of situation dilutes the meaning of health promotion.

Another participant also emphasised that the MoPH can play a major role in changing the way health promotion is structured within the Ministry:

MoPH need to understand that health promotion and communication should be separate units. MoPH have the authority to reshuffle the organisational structure but health promotion is still under the Department of Disease Control. But it will be upgraded soon because it is a cross cutting area. This reflects on MoPH’s understanding about HP. This is important because this can lead to health promotion bureau loosing coordination and power. And this is what is going on.

There also exists a lack of understanding about the five action areas of the Ottawa Charter and some key health promotion projects like Healthy Cities, etc. One participant commented that Health Promoting Hospitals are usually thought of as something for nurses only.

A participant mentioned that lack of established curriculums for health promotion contributes to lack of health promotion workforce and capacity:

for advocates, practitioners and partners in the health sector, government and private sector and civil society, for the promotion of health (http://prolead.org/).
We have very few people in Thai Health who think this way to change environment, change policy, do advocacy and influence policy. This is [the] same situation with VicHealth which has existed for 20 years, and many other countries. This is because many countries do not have an established curriculum for health promotion in any university. Most courses are very short ones, for 3 or six months. Due to these issues most projects take years to start or be implemented, e.g. presently we cannot find somebody who wants to work full-time at the policy level on traffic accident prevention.

One participant from the policy sector mentioned that the term ‘health promotion’ was modified and introduced as a new term in Thai language to help people better understand the concept:

During advocacy for health promotion it was found hard to advocate for health promotion with the term ‘health promotion’, which the MoPH was already using. The term health promotion was translated to Thai language which means ‘push / strengthen / build health’, meaning if you want to have good health you need to build it, which people from rural populations understood better. The slogan for the campaign for health promotion was ‘build health before repair’ or ‘build health before it needs repairing’ (spoken in Thai language) which the policymakers and parliament accepted easily due to its link with cultural and traditional Buddhist teachings.

In English (language), people can interpret health promotion in two ways: one is the service- and individual-based health promotion and, other is (based on) five action areas given in the Ottawa Charter which is more like societal-based health promotion. Health promotion needs to be seen in terms of risk factors to be addressed by policy, by law, by price, by changing environment, etc. This makes it easier to differentiate between service-based or individual-based health promotion ... traditional vs. contemporary health promotion. We also wanted to communicate to public what Thai Health is doing is different from MoPH. This was a new addition to Thai vocabulary to let people understand better the difference between what Thai Health and what the Ministry of Public Health want to do.
Responding to a question on existing differences in understanding health promotion, one participant responded:

*Western countries have clear concepts about knowledge and health literacy in the system. This helps a lot in terms of helping people learn to do prevention or promotion. In the eastern or under-developed countries this kind of literacy is not much acceptable but fortunately the culture or Buddhism helps in the Thai situation.*

Another participant commented that:

*So far for developing countries like Thailand and South East Asia any behaviour issues leading to disease and illness can be resolved by suitable communication. Health is a universal concept and I do not see any problems in this regard.*

A participant summed up how the health promotion approach should be given a direction in future in Thailand:

*The history of Thai health system in the future will have to have a record saying that, during the decade of 1997-2007, the concept of “health promotion” is recognized as a significant development philosophy and strategy resulting in unprecedented changes in health model, system and status of Thai society, with such a philosophy and strategy, “health promotion” has been known and defined as “a modern public health approach that emphasizes the participation of people and all sectors in society in developing determinants of health in a holistic manner, especially social and environmental factors.*

*Human Rights, Equity and Social Justice*

The participants were asked whether themes like human rights, equity and social justice are included in developing health promotion strategies. According to one participant advocacy for human rights, equity and social justice is carried out mostly by the International NGOs which include
consumer rights. The participant said that the government listens but is not actively involved in action to implement.

Another participant highlighted the example of the 30 Baht scheme contributing to health promotion principles in the development framework:

[The] (30 Baht Scheme) was started by an NGO as a move against the government to support the funding for the poor for free health for all. This put [a] pressure on politicians and policymakers to get into the ‘climate’ of health promotion for empowerment, ownership, equality, participation, etc. and health promotion advocates want to bring in this culture.

Health Volunteer Networks

All participants mentioned health volunteers’ networks in villages as a cornerstone for health promotion delivery in Thailand. These volunteers work at local level in the villages and are trained in PHC and health promotion communication. According to the participants this project of MoPH works as a tool for developing the health promotion system in Thailand. A number of examples like the Bicycling Network can be found at provincial and national levels.

Behaviour Focused Strategies

Commenting on the type of strategies employed by policymakers in Thailand to bring about changes in behaviour, one participant remarked:

This is a challenge in Thailand because here people have strong ties with others who influence them, like parents, teachers, friends, etc. Therefore health promotion needs to have a kind of collective action. This is different than the individual-based focus in the West.

Another participant from a health promotion practice area said:

---

21 Health volunteers are one element of the primary health care system in Thailand. According to the WHO there are more than 800,000 health volunteers working in Thailand to promote primary health care for different communities across the country (http://www.who.int/bulletin/volumes/86/1/08-010108/en/).
In Thailand instead of focusing more on behaviour there are efforts to try to change environmental factors. People can be educated later when the environment has changed. It is like changing the 'mechanical’ factors before approaching the people. For example: If you want people to use safety belts, before you promote the safety belts, you should move the law and then educate people. You can tell people that law has changed so now you have to change your behaviour.

5.4.1.3 Economic Context

Policies and Major Decisions

The participants identified the development of awareness of the costs of the curative approach as the main factor influencing the creation/formation of Universal Health Care Coverage Policy, and the Thai Health fund (THPF). A participant remarked that previously the Thai health system was financed by out-of-pocket payments and local budget tax.

Health promotion developments picked up pace with the advocacy for Universal Health Care. Infrastructure developments within the economic environment included financing Universal Health Care Coverage Policy, and [the] Thai Health.

The National Health Security Act, (2002) guarantees universal access to health care and has incorporated the “building rather than fixing health” concept into the basic benefit package for healthcare recipients. To achieve this, a budget was allocated to health facilities to carry out health promotion activities in parallel with curative care. The Act also supported the establishment of a “Community Health Fund” at the sub-district level to chiefly finance health promotion activities.

Another participant suggested some major policy recommendations regarding the economic context. These included:

- mobilize more resources through increased public investment for health promotion
• explore the potential feasibility of establishing innovative financing for health promotion through introducing an earmarked tax from tobacco and alcohol
• ensure that health insurance covers prevention and health promotion in the benefit packages
• technocrats have to observe the window of opportunities which usually open especially during the general election to push public opinion towards better investment in health promotion
• increase value for money, namely efficiency gain from the existing spending on health promotion
• there is a need to reorient health programmes’ nature towards a primary prevention focus

**Universal Health Coverage**

A participant mentioned a 2005 study (Leesmidt, Pitayarangsarit, Jeegungwal, Piravej, & Burns, 2005) which explored the rise in medical costs which Thai people could not shoulder. According to the participant the study led to the health system reforms and development of mechanisms to fund health promotion to go hand in hand with UHC. A draft bill was passed where prevention was agreed to be a priority rather than treatment. Thailand’s UCS policy experience on universal health insurance coverage is considered a landmark intended to benefit every citizen, those not covered by social security or by the civil servant medical benefit scheme.

**Influence of International Business Lobby**

Some participants commented on the role of international business organisations and considered them as barriers to health promotion development especially.

One participant commented on the issue of rational use of crops in the agriculture sector which could lead to conflict of interests between health promoting perspective of Thai Health and their counterparts like Ministry of Commerce who would deal it from trade perspective. The participant was of
the view that although there is a general support from International organisations but not when there is conflicting benefits.

Another participant gave an example of a similar situation in the alcohol and tobacco business where government’s decisions could be challenged or changed due to pressure from the International business lobby:

The international businesses have a strong lobby to influence politicians to favour them at policy level. The political parties are often funded by the donations by the business lobby. Alcohol is an example of how international business intervenes by telling people to ‘drink responsibly’ which is different from our approach. In general Thailand has a good system of health communication but it can benefit greatly from international support.

International Donors
The participants agreed that in Thailand there are fewer international donors now than in the past. One of the participants gave the reason that this could be either because of Thailand’s rise in the development status or because the country is repeatedly under coup:

The coup affects the assistance from donors as compared to Cambodia, Vietnam, etc.

A participant, when asked about major activities of international donors, replied that:

International global donors are mostly active in AIDS programmes. This could be because they are able to sell their costly medicine. This could be stopped if Thailand starts producing its own products but this can make some (International) sectors very concerned.

Most participants agreed that Thai Health is the chief funding body for health promotion in Thailand and the WHO and World Bank oversee health promotion development in Thailand. One participant mentioned that in the private sector health promotion could be financed through CSR (Corporate Social Responsibility http://www.csrthailand.net/en/about).
One participant also showed concern about globalisation which is bringing in new issues to Thailand:

_Similarly in the area of nutrition the phenomenon of rapid urbanization, globalization in trade and financial markets, all help to diminish further the importance of the geographic boundaries of traditional food supply. This leaves the country to be faced with new nutrition challenges such as food security, typified by both under-nutrition and over-nutrition in different groups._

These issues are very close to international development and participants expressed their views on how the changing global health and development can influence health promotion developments in Thailand. As one participant responded:

_The health promotion system in Thailand has progressed a great deal with a tendency to expand or branch out into several dimensions and directions including national and local levels. However, trends in social and global changes together with intensive globalization may cause both crises and opportunities for health promotion like:_

- **Globalization and Changes in People’s Health problems: aging society, climate change, trans-boundary labour migration, economic, emerging diseases and re-emerging diseases.**

- **Changes in social, economic and political context affecting people’s lifestyles and wellbeing.**

### 5.4.1.4 Infrastructure

The interviews were mainly focused on exploring the country specific contexts. However, the interview participants often mentioned some issues which can be better explained under health promotion delivery including planning and implementation and roles of various stakeholders. These issues are mentioned below:
5.4.1.5 Planning for health promotion

One of the participants from the policy sector mentioned that earlier health development plans employed conventional planning processes (problem-based planning), which was later replaced by strategic planning with community/civil society participation.

The participants were of the view that all sectors should be involved in planning.

*HP planning should include stakeholders from the rural area and local government utilising the strong health volunteers’ network. The health promotion plan should come from the people from the rural areas and not top down.*

5.4.1.6 Role of Government in Health Promotion Delivery

A participant reported on the government’s approach to health promotion as opposed to empowerment principles:

*Government’s approach is itself a barrier as it still follows the paradigm of ‘giving to people’ rather than empowering them (self-management). Government should not just rely on giving people money to do what it wants them to do. The government should make people think on what they want. The concerned government officials need to change their approach which is resulting in people ‘obeying’ the government rather than working with the government. This has to change.*

A participant mentioned that the government supports the quality of Thai people’s life via many projects / campaigns and strategies:

*Examples are “EWEC” concept, “every ANC can be free of charge” “Exercise by Hula-hoop”, “Good Health Start Here” etc. The government also influences the quality of private health sector services through rules and regulations on facilities/human resources for health.*
One of the participants involved in founding the Thai Health Foundation mentioned some difficulties in setting up a health promotion foundation:

- There is lack of understanding on what health promotion is:
  
  The first resistance comes from the MoPH itself who say they are already doing it but the budget allocated for health promotion is not enough. Even if they were provided a big budget, they would not be able to do it due to the culture (vision) of MoPH in health promotion which is 'service-based.'

- There is no (local) research to support five action areas of health promotion in Thailand:
  
  Up until 1986, after the Ottawa Charter, things started to change but only a few countries actually studied and implemented it. The five action areas were hard to understand for Thailand because they were not there in the practice and there was no funding to do it.

- Lack of knowledge base:
  
  Changing people’s behaviour is not effective when they are already sick. The real challenge is to stop them (or kids) from starting to smoke, etc. This requires new knowledge to convince policy makers.

- Financing:
  
  Financing is another issue. Health promotion is a low priority with the Ministry of Finance. This is probably the same case in most countries. You can get money for salaries, hardware, etc. but when you want more, you have to wait as they don’t have enough money for the programme activities. So when MoPH requests [a] budget for health promotion, they only get it for one year and even that is cut if there is any outbreak or emergency.

- Providing evidence for policymakers:
  
  It is harder to convince the Parliamentarians for a health promotion budget as they ask you how you know that the 100 million you are asking for people to stop smoking or drinking will work. What is the
5. Phase II: Case Study

evidence that the mass media campaign, health education will work? It is completely different from curative approach.

- Variation in organisation structures:
  Each country has a different model for health promotion. Taiwan gets $80 million but they do not have a foundation, instead they have a board/union in public health. Countries like Malaysia, Tonga and South Korea can get a new organisation set up but they could not get the dedicated tax system. On the other hand Laos and Vietnam got the dedicated tax system but did not get this money to spend as they couldn’t get autonomy. Thai health is about 1% of national health spending and is 0.001% of the total budget but they say it disrupts the discipline. So it depends on how it pans out finally.

- Lack of capacity to utilise the budget:
  All Health Promotion Foundations during the first few years face the problem utilising the money: the government gives you money but you cannot spend it. There is no capacity in the system to develop strategies to spend the money. This lasts for few years. You have the project but no capacity of people who know how to do this.

Some other issues mentioned by the participants were lack of dedicated people, lack of support for the lobby in Thailand, and lack of knowledge and capacity to use the money to do the so called contemporary health promotion. Two participants mentioned that Thailand needs to have her own ProLead training in the budget to bring out the context. They said that the language and socio-cultural contexts are different from South Asia, Asia and WPRO countries.

5.4.1.7 Role of Civil Society

The public’s role in health promotion development was highlighted by all participants:
People have to be active citizens and be responsible for health promotion and not only act for the government. Thai people need to get more involved in health promotion activities.

5.4.1.8 Key health promotion Interventions

The participants mentioned some key Thai Health interventions and health promotion programmes which contribute to health promotion development. These include: production of nurses and midwives, development of maternal and child health, nutrition (National Nutrition Development Plan), family planning, community health, occupational health, essential drug, training of village health volunteers (VHVs) and village health communicators (VHCs), village drug funds and community funds for health development, and the health information system.

The participants also mentioned some key institutions involved in the health promotion delivery system: National Health Assembly, National Health Commission Office, National Health Security Office and Thai Health Foundation. Commenting on Thai Health Foundation’s potential to address health risks a participant said:

Though per capita expenditure by Thai Health is small, it serves a catalytic function, engaging civil society and massive social mobilization. Thai Health is not an adequate financial leverage towards primary reduction of health risk, unless the conventional health promotion expenditure decides on a major shift from clinical setting[s] towards community-based public health interventions, tax and law enforcement and social mobilization towards healthy lifestyle[s].

5.4.2 Regional Development

Country level health promotion programmes and activities are influenced by activities in the surrounding countries and regions. One of the participants working in an Intergovernmental Organisation at a regional level raised some key issues related to health promotion capacity in Thailand (some words from quotes are omitted to preserve the identity of the participant):
• Lack of capacity for health promotion policy development at country level:
  In South East Asian countries only Thailand has clear vision of health promotion than other member countries and lot of work is being done at policy level. Very few countries are able to put together an effort to have a separate policy for health promotion. And even some countries like the Maldives show evidence of health promotion but still want to focus only on communication.

• Lack of capacity in terms of infrastructure and workforce:
  South East Asian countries are different from Europe and other regions. There (Europe) they already have infrastructure and are ready to intervene through different actions. In South East Asian countries we still need to build infrastructure and we don’t have the manpower and people who have comprehensive knowledge of what is this about. How can we provide successful intervention in any programme in these circumstances?

• Need for country assessment frameworks:
  South East Asian countries do not have assessment frameworks. And that’s one of the problems.

• Health promotion capacity mapping has a focus but needs a budget, even at regional level:
  Our organisation is starting to work on implementation of health promotion mapping activities but there is not enough budget.

• Health promotion is often confused with communication:
  European health promotion competencies were shown to some colleagues just to know what they think about what can be done to improve, how much capacity is there, for example, in areas of advocacy. Many reflected on whether it is really their area or what is different from what they have done. There seemed to be no distinction on understanding the differentiation between advocacy and communication on mass media. So if you are not in
the field and fully understand the different means and modes of communications, they can take political dialogue, advocacy, communication, public communication in almost the same manner.

The analysis of different participants’ responses to the interview questions revealed some key areas and themes to consider in mapping health promotion capacity at the country level in Thailand. The key findings from the key informant interviews along with findings from the desk review are presented in the following section.

5.5 Summary of Country Specific Contexts in Thailand

Thailand, as a country, has a number of unique features. Modern Thailand is a constitutional hereditary monarchy under the Constitution of the Kingdom of Thailand. The country is considered to be the only Southeast Asian nation that has never been colonized despite European pressure but has gone through stages of constitutional military rule and dictatorship, democratic experiments, ideological conflicts. Thailand, a Buddhist country, holds a central position on the mainland geographically and is a crossroads for population movements from diverse cultural, linguistic, and religious backgrounds.

In 2011 World Bank upgraded Thailand’s income categorization from a lower-middle income economy to an upper-middle income economy. The country is currently undergoing a rapid social and economic transition with industry, agriculture and tourism as the main sources of income. While Thailand has achieved some overall success in its poverty alleviation, disparities among regions and urban/rural localities are evident and the gap between rich and poor has not narrowed. Social inequity remains one of the underlying causes of political unrest in Thailand in recent years.

Demographics show an aging population with a declining annual population growth rate due to decreasing birth rate. Increasing trends towards urbanisation have put demands on the country’s education, housing, health, and employment systems. The burden of diseases is gradually shifting to
NCDs, injuries and mental disorders linked with urbanization, internal migration and changes in social environment. There is also increased influence of sex tourism due to poverty as a root cause. Thailand also faces effects of globalisation in trade and financial markets, and, rapid urbanization. Conflicts of interest exist between various sectors regarding agriculture, alcohol, tobacco, etc. with international trade organisations.

In terms of the structures that have supported the development of health promotion in Thailand, the following are notable landmarks. Thailand has endorsed a range of UN conventions and treaties on human rights: Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR). The International NGOs and other organisations are more actively involved in action to implement advocacy for human rights, equity and social justice than the government.

Two National Reform Committees and the Eleventh National Economic and Social Development Plan (NESDP), for 2012-15, are aimed at addressing social inequity and promoting environmentally friendly and creative economic growth. The health care system reforms helped the country maintain health care utilization during the East Asian financial crisis and have resulted in a rapid expansion of a network of public health facilities. A mix of public and private health service providers supplies health services in Thailand. At community-level, primary health care is provided by health volunteers or by self-care. Local governments play a very limited role in health services.

The developments in health have undergone many changes from curative services focus to broader social determinants of health approaches through adopting “Health for All” as well as health promotion charters and declarations. The country’s 1997 Constitution which focused on people’s
Phase II: Case Study

Rights to good health resulted in a nationwide movement for health promotion that mobilized people from the health and non-health sectors. The key institutions actively involved in health promotion governance, policymaking and delivery, mostly autonomous, include MoPH and Thai Health. Thailand hosted the 6th Global Health Promotion Conference in Bangkok in 2005 and 21st IUHPE World Conference on Health Promotion in Pattaya in 2013. Key legislations and decisions which pushed the country’s health promotion agenda forward include: Tambon (sub district) Council and Tambon Administrative Organization Act (1994), National Health Act (2007), Health Promotion Act (2001), National Health Security Act (2002), Emergency Medical Act (2008), and the Statute on National Health System (2009). Health promotion coupled with prevention services is included in the Universal Health Care Coverage Policy (UC) implemented by the Ministry of Public Health for the entire population. The WHO Country Cooperation Strategy 2012-2016 includes health promotion and healthy public policy as one of the seven priority areas which are consistent with the priorities of the Tenth National Health Strategy/Plan (2007-2011).

The Thai Health and the MoPH are the key institutions providing national vision and leadership responsibility for health promotion in Thailand. Thai Health was established in 2001, under Thai Health Promotion Foundation Act, and serves as an example for other countries, of innovative ways to finance health promotion, health in all policies and non-communicable diseases (NCDs). It is funded by ‘sin taxes’ collected from producers and importers of alcohol and tobacco.

Health and other professionals recognise health promotion as a social movement which brought about the establishment of Thai Health as a unique and innovative means of financing national health promotion developments. One of the key barriers for progress in health promotion in Thailand is seen as lack of the understanding about health promotion among
national and international stakeholders. The national stakeholders like MoPH envision health promotion as service-based (services provision and individual-focused) rather than society/community-based (environment, policy, community action, etc.). The meaning of health promotion is also ‘diluted’ due to it being misunderstood as health education and communication. MoPH’s decision to structure health promotion and health communication into one Unit can lead to the Health Promotion Bureau losing coordination and power. Lack of established curriculums for health promotion is also perceived to be contributing to a lack of health promotion workforce and capacity. Like most LMICs, including Thailand, health literacy can be difficult to achieve at a societal level and religion and cultural traditions are utilised to achieve health promotion aims e.g. Buddhism in the Thai situation.

The WHO recommends long-term planning to ensure adequate public health training and experience at all levels of the system and appropriate distribution of the health-care personnel. Thailand presently mentions ‘promotion’ under the scope of work for public health generalists who are non-medical professionals with four years of university education in the public health bachelor’s degree. There is insufficient discussion on reducing health expenditures by expanding health promotion approaches and which categories of the health workforce would function best at this task. Thailand along with other member states of the WHO SEA region is involved in identifying competencies and standards for health promotion practice, and, developing short courses since 2008.

Strong political will is demonstrated through the Prime Minister’s support of health promotion activities and the chairing of Board of Thai Health. However at the same time politicians pose a challenge in understanding health promotion issues. Law implementation is a weak area in the political system influenced by some powerful lobbies. The Government’s approach is itself perceived a barrier as it still follows the paradigm of ‘giving to
people’ rather than empowering them (self-management) resulting in people ‘obeying’ the government rather than working with the government. Nevertheless there is strong policy support for empowerment strategies for Thai people especially in the rural areas. Fewer international donors are involved in health development assistance either due to Thailand’s rise in development status (low to middle income) or due to repeated coups.

5.6 Data Collection Method 3: Online Questionnaire (Health Promotion Capacity Mapping Tool)

The online questionnaire was disseminated to senior level health promotion and public health experts, mostly working at national level, to provide information to help map health promotion capacity in Thailand (Appendix N). The questionnaire was focused at mapping existing health promotion capacity based on the capacity mapping process of four domains and 10 sub-domains (Figure 4.2, Chapter 4).

5.6.1 Reliability of the Health Promotion Capacity Mapping Tool

The questionnaire was a mix of open- and close-ended questions. The closed-ended questions included eight Likert type questions which were all designed as five-point rating scale questions. The rating scale questions were spread across the capacity domains. The number of items in each question ranged from 2 – 10 (Table 5.3).
Table 5.3 Internal consistency between rating scale questions

<table>
<thead>
<tr>
<th>Capacity Domain</th>
<th>Sub-domain (Q No.)</th>
<th>No. of Items</th>
<th>n</th>
<th>Cronbach’s alpha</th>
<th>Average % Agree /Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Institutional Capacity (Q 4)</td>
<td>3</td>
<td>15</td>
<td>0.88</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Vision and Leadership (Q8)</td>
<td>10</td>
<td>14</td>
<td>0.7</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Transparency &amp; Accountability (Q 12)</td>
<td>2</td>
<td>13</td>
<td>0.68</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Transparency &amp; Accountability (Q 13)</td>
<td>5</td>
<td>14</td>
<td>0.84</td>
<td>58</td>
</tr>
<tr>
<td>Policy Environment</td>
<td>National Policies and Plans (Q 15)</td>
<td>4</td>
<td>14</td>
<td>0.77</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Policy Coherence (Q 19)</td>
<td>3</td>
<td>13</td>
<td>0.8</td>
<td>64</td>
</tr>
<tr>
<td>Health Promotion Infrastructure</td>
<td>Financing (Q 34)</td>
<td>4</td>
<td>14</td>
<td>0.45</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Knowledge Development &amp; Management (Q 35)</td>
<td>7</td>
<td>14</td>
<td>0.48</td>
<td>56</td>
</tr>
</tbody>
</table>

The items in five questions had ‘good’ to ‘acceptable’ internal consistency with Cronbach’s α ranging from .7 to .88. One question on sub-domain ‘Accountability’ had Cronbach’s α=0.68. Questions on ‘Financing’ and ‘Knowledge Development and Management’ had unacceptable internal consistency with Cronbach’s α= 0.45 and 0.48 respectively. Item-wise details are presented at Appendix P. The analysis suggests that questions 34 and 35 are not good measures of health promotion capacity in the domains of Financing and Knowledge Development and Management. However, these domains are important sub-domains in the mapping framework and the mapping needs cannot be met without addressing these domains. The issue is addressed in detail in the methodological limitations section (7.8) on how to manage the problem.

The following sections presents the key findings from the data collected via the online questionnaire. Detailed findings are given in Appendix O.

5.6.2 Health Promotion Governance

The section on governance included questions based on three themes; institutional capacity, vision and leadership, and, transparency and accountability.
5. Phase II: Case Study

5.6.2.1 Institutional Capacity

The participants were asked 5 questions to find out if health promotion was institutionalised in Thailand, some key characteristics of institutional capacity for HP, government’s control over health promotion policies and strategies, and examples of organisations with a health promotion focus in Thailand.

Out of 16 participants, seven reported that the country has ways other than a designated unit to strengthen health promotion. The participants reported that an autonomous (semi-state) institution is dedicated to health promotion called the Thai Health Foundation. Three participants reported that a dedicated health promotion unit also exists within the MOPH (Table 5.4).

<table>
<thead>
<tr>
<th>Question Items</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>The country has a designated “health promotion” unit or section within</td>
<td>18.8</td>
<td>3</td>
</tr>
<tr>
<td>The National Ministry of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The country has no designated health promotion unit or section</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>The country has a unit or section described differently but which performs functions relating to health promotion</td>
<td>37.5</td>
<td>6</td>
</tr>
<tr>
<td>The country has other ways to strengthen the institution of health promotion</td>
<td>43.8</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 5.4 Response to the multiple-choice question on Institutional Capacity (n=16), %

The institution of health promotion in Thailand is strengthened by a national plan which guides health promotion policymaking and implementation, and the existence of clearly defined health promotion functions in the national health system to which 12 participants out of 15 ‘strongly agreed/ agreed’ (Table 5.5). The existence of political commitment to deliver health promotion was agreed upon by eleven participants. Participants also commented that the medicalisation of the health system, which focuses mostly on a personal care approach and disease diagnosis and treatment rather than employing a collective approach to empower communities, is a barrier to health promotion institutional capacity development. A lack of
sharing of resources and outcomes by the Thai Health Foundation was also reported.

Table 5.5 Institutional Capacity for health promotion in Thailand (n=15)

<table>
<thead>
<tr>
<th>Question Items</th>
<th>% Agree / Strongly Agree (n)</th>
<th>Item Mean (SD)</th>
<th>Cronbach's Alpha</th>
<th>Scale(^a) Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There is a national plan which oversees and guides the health promotion policy making and implementation</td>
<td>80 (12)</td>
<td>4.1 (1.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. There is a political commitment to deliver health promotion</td>
<td>73 (11)</td>
<td>3.7 (1.3)</td>
<td>.88</td>
<td>11.5 (3.3)</td>
</tr>
<tr>
<td>c. Essential health promoting functions in the national health system are clearly defined</td>
<td>80 (12)</td>
<td>3.8 (1.0)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)Range (3 to 15)

To understand the broader context of institutional capacity for health promotion in Thailand, a question was asked to explore how much the government depended on international assistance to implement policies and strategies for health and development. While 10 out of 15 participants reported that Thailand receives international assistance, none thought that international agencies led policymaking and strategies in Thailand. Eight participants said that the Thai government had complete control of health policies and strategies. In the comments the Thai Health Foundation’s role was highlighted as being central in developing the national strategic plan, and working with multi-sectoral and international agencies like the WHO and VicHealth.

Participants were asked to provide three examples of agencies or organisations who were legally obliged (responsible) to deliver health promotion in Thailand. Five key organisations mentioned by the participants were: Thai Health Foundation (n=16), Department of Health (n=7), Bureau of Health Promotion (n=5), Department of Disease Control (n=2), National Health Security Office (n=2), and other (n=8) (Table N2a, Appendix O). There was a mixed response when participants were asked to define the type
of organisation. For example, for the Thai Health Foundation 6 participants said it was semi-government, 4 non-government, 1 public, 1 autonomous, 1 independent and 1 reported it as ‘State agency administered and managed in an autonomous manner’. Similarly, there were mixed responses when participants were asked to provide information on what health promotion activities the organisation is focused on.

5.6.2.2 Vision and Leadership:

The sub-domain health promotion vision and leadership explored how health promotion stakeholders in Thailand understood health promotion as a concept, capacity for effective leadership for health promotion in Thailand, key agencies / sectors working in partnerships to achieve common goals for health promotion development, and main organisations involved in health promotion policy, practice and research development.

Out of 15 participants 7 agreed that the stakeholders have a clear understanding of health promotion, while 6 were uncertain whether stakeholders had an understanding of health promotion. In the comments box one participant expressed that:

*There is a clear understanding of the rationale for health promotion (e.g. NCDs) and a clear understanding that health promotion is about prevention and goes beyond health issues, but there is little understanding of health promotion approaches.*

A second participant identified the barrier to understanding health promotion as the absence of a ‘health in all policies’ strategy in ‘research and operations’. A third participant commented that some key stakeholders understand health promotion in a ‘health promotion care service’ context rather than in the social movement context which includes health in all policies. A fourth participant commented that ‘scholars, health personnel, and some health activists’ are among the stakeholders who have a clear understanding of health promotion. A fifth participant highlighted that the health promotion slogan ‘build before repair’ is an easy to understand
perspective. A sixth participant commented that health promotion is more understood by theory rather than perception and practice. Overall, the participants had mixed views of how health promotion is understood by the stakeholders.

Overall the participants agreed that Thailand possesses a significant capacity for effective health promotion leadership. The majority of participants ‘agreed / strongly agreed’ with all 10 statements on various aspects of health promotion leadership with the highest number (14) agreeing that the leadership is visible (Table 5.7). Four key organisations were identified as having a health promotion leadership role. These were the Thai Health Foundation, National Health Security Office, National Health Commission Office (NHCO) and National Health System Research Institute (NHSI) in addition to three universities leading health promotion research: Khon Kaen, Mahidol and Chulalongkorn. The participants also provided the names of 20 health promotion leaders.
Table 5.6 Health promotion leadership effectiveness in Thailand (n=14)

<table>
<thead>
<tr>
<th>Question Items</th>
<th>Agree / Strongly Agree %</th>
<th>Item Mean (SD)</th>
<th>Cronbach's Alpha</th>
<th>Scale Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. leadership is visible</td>
<td>94a</td>
<td>4.1 (.8)</td>
<td>.70</td>
<td>40.3 (3.6)</td>
</tr>
<tr>
<td>b. leadership is shared</td>
<td>73a</td>
<td>3.9 (.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. it provides a credible voice for the promotion of health</td>
<td>87a</td>
<td>4.1 (.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. promoting health is on the political agenda</td>
<td>80a</td>
<td>4.2 (.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. it oversees health promotion development at policy formulation and policy implementation levels</td>
<td>86</td>
<td>4.1 (.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. it improves linkages across sectors, policies and programme areas (e.g. Health in All Policies, Intersectoral Action for Health, Whole of Government Approach)</td>
<td>71</td>
<td>3.9 (.7)</td>
<td>.70</td>
<td>40.3 (3.6)</td>
</tr>
<tr>
<td>g. it develops policies and interventions that address health inequalities (e.g. Health Equity in All Policies)</td>
<td>86</td>
<td>4.0 (.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. it develops international and national partnerships and collaborations to achieve national, regional (provincial) and local health promotion goals</td>
<td>86</td>
<td>4.2 (.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. it recruits national health promotion experts to provide technical support</td>
<td>71</td>
<td>3.8 (.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. it monitors and evaluates the health promotion policies and interventions on a regular basis</td>
<td>86</td>
<td>3.9 (.9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*α=15

*Range 10-50

The participants were asked about which agencies and sectors, with common goals for health promotion in the country, partnered most frequently (Figure 5.5) and least frequently (Figure 5.6) with each other (n=11 to 14). The three most highly endorsed ‘most frequent’ partnerships were: Intergovernmental organisations partnered most frequently with the MOPH; Civil society partnered most frequently with the NGOs; MOPH partnered most frequently with various government sectors / departments. MOPH was endorsed at least once as the most frequent partner with all the agencies and sectors except Non Profit Organisations. Donor countries partnered least frequently with civil society and were endorsed as being the least frequent partner with all the 9 agencies and sectors.
Figure 5.5 Agencies / Sectors partnering most frequently with others
(Values have been rounded to the nearest decimal place and may not sum to
100%)
A total of 17 organisations were identified by the participants as significant players in health promotion policy, practice and research development. The organisations reported were a mix of public, semi-state (autonomous) or private sector with some of them having multiple functions with respect to policy, practice and research. For details of names of organisations please see Table O4, Appendix O.
5. Phase II: Case Study

5.6.2.3 Transparency and Accountability

A total of three questions were asked concerning the existence of transparency in information about health promotion, accountability of organisations and role of government, and transparency and accountability among various partners of government for health promotion. Sixty percent (n=10) of participants agreed/strongly agreed that information regarding funding and regulation of health promotion activities is accessible. Only one participant expressed a lack of transparency:

*Most information about health promotion funding and regulation available to health personnel is not generated to public.*

The majority of participants agreed with the statements: ‘accountability of organisations for the implementation of health promotion interventions is clearly specified within the regulatory / governance framework’, and, ‘government ensures that the organisations and institutions performing health promoting activities report their actions to the relevant higher authorities regularly’ (Table 5.7). One participant commented that Thai Health Foundation is required by law to report annually to the Cabinet/House of Representatives/the Senate, and is subject to an audit by the Auditor General.

Table 5.7 Accountability for health promotion in Thailand

<table>
<thead>
<tr>
<th>Question Items</th>
<th>Agree / Strongly Agree % (n)</th>
<th>Item Mean (SD)</th>
<th>Cronbach's Alpha</th>
<th>Scale* Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The accountability of organisations for the implementation of health promotion interventions is clearly specified within the regulatory / governance framework</td>
<td>93(13)</td>
<td>4.1(.4)</td>
<td>.68</td>
<td>8.3(.9)</td>
</tr>
<tr>
<td>b. Government ensures that the organisations and institutions performing health promoting activities report their actions to the relevant higher authorities regularly</td>
<td>86(12)</td>
<td>4.0 (.6)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There was a varied response regarding the various aspects of transparency and accountability among Thai government and national and international partners for health promotion development. The majority of participants agreed/strongly agreed that there is a wide representation of health promotion stakeholders in health promotion development in Thailand, while lobbying with public authorities for health promotion development was only agreed by 7 participants out of 15 (Table 5.8). More than half of the participants reported that priority setting processes are fair and explicit. Only half the participants were of the view that government and its partners adhere to accountability and transparency.

Table 5.8 Transparency and accountability for health promotion in Thailand

<table>
<thead>
<tr>
<th>Question Items</th>
<th>Agree / Strongly Agree % (n)</th>
<th>Item Mean (SD)</th>
<th>Cronbach’s Alpha</th>
<th>Scale* Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fair and explicit priority setting processes</td>
<td>64(9)</td>
<td>3.6(.7)</td>
<td>.84</td>
<td>18.2(2.8)</td>
</tr>
<tr>
<td>b. Wide representation of all relevant stakeholders</td>
<td>93(14)</td>
<td>3.9(.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Balancing of decision making powers</td>
<td>47(7)</td>
<td>3.5(.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Adherence to accountability and transparency</td>
<td>50(10)</td>
<td>3.9(.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Lobbying with public authorities</td>
<td>35(7)</td>
<td>3.3(.7)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[n=14\]

5.6.3 Policy Environment
The health promotion policy environment refers to national structures and mechanisms which enable formulation and implementation of healthy public policies to achieve health promotion objectives. It has two subdomains: national policies and plans, and policy coherence.

5.6.3.1 National Policies and Plans:
Five questions on national policies and plans were focused on inclusion of health promotion in the national policies, health promotion policymaking,
key health promotion policies and programmes, existence of a human rights-based approach, and examples of health promotion policy implementation.

Four fifths of the participants (n=11) were of the view that health promotion is part of an overall health policy (Table 5.9).

Table 5.9 Health promotion inclusion status in Thailand’s policies* (n=14), %

<table>
<thead>
<tr>
<th>Question Items</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There is stand-alone health promotion policy</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>b. Health promotion is part of an overall health policy</td>
<td>79</td>
<td>11</td>
</tr>
<tr>
<td>c. There are health promotion elements in policies other than health policy</td>
<td>57</td>
<td>8</td>
</tr>
<tr>
<td>d. There is no reference to health promotion in health policies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. No information available</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Don’t know</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Any other (box)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Participants could choose more than one response

Note: In considering ‘tick all that apply’ quests (MCQs) a participant is considered to have to responded to all question options (all tick boxes) if s/he has responded to any options.

The majority of participants agreed that health promotion policy making is aligned with the health needs of the population (Table 5.10). A little less than half of participants were uncertain that evaluation and monitoring of health promotion policies feed into future policy developments.

Table 5.10 Policymaking for health promotion in Thailand (n=14)

<table>
<thead>
<tr>
<th>Question Items</th>
<th>% Agree / Strongly Agree</th>
<th>Item Mean (SD)</th>
<th>Cronbach's Alpha</th>
<th>Scale* Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. General policymaking is conducive to advancing a ‘health in all policies’ approach</td>
<td>50 3.2 (.97)</td>
<td></td>
<td>.77</td>
<td>14.5 (2.3)</td>
</tr>
<tr>
<td>b. Health promotion policy making is aligned with the health needs of the population</td>
<td>86 4.0 (.55)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Evaluation and monitoring of health promotion policies feed into future policy developments</td>
<td>50 3.6 (.85)</td>
<td></td>
<td>.77</td>
<td>14.5 (2.3)</td>
</tr>
<tr>
<td>d. Health promotion policy making is a participative process i.e. based on consultation with key stakeholders</td>
<td>79 3.7 (.61)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Range (3 to 15)
The participants were asked to rate the level of implementation of 17 health promotion policies and programmes in Thailand. Figure 5.7 shows the percentage of participants who rated policies (n=14) and programmes (n=12) as fully or partially implemented, shown in decreasing order of policy implementation. The three policies and programmes which were rated fully/partially implemented were: Healthy Lifestyles i.e. reduced consumption of tobacco products, alcohol, fatty, sugary or salty food and increased physical activities, Tobacco Control and Prevention of Infectious Diseases. The two programmes which were rated the least fully/partially implemented were Suicide Prevention and Environmental Risks to Health.

The majority of participants (n=9) agreed that a human rights-based approach is applied in promoting health in Thailand. To support their
responses, participants gave examples such as: ‘accessibility of health promotion programmes which anyone can join voluntarily and are available for people for all age[s], gender[s], religion, etc.’; ‘[Health promotion] policies include strategies for reduction of health inequity, violence and focus on child health’; and ‘policy on restriction on smoking in public places’.

Participants were asked to provide example/s of existing health promotion policy or policies being implemented at national, regional or local level. Some key examples provided were; Annual Report from the Thai Health Foundation, National Quit Drink Day, National Tobacco Control Plan, Reduced sugar, salt and fat consumption, promotion of physical activities and policy on advertisement of tobacco and alcohol. For details of organisations names provided see Table O5, Appendix O.

5.6.3.2 Policy Coherence

Participants were asked to what extent different existing policies complemented or supported each other, including public, international and global health policies. While the majority agreed that mechanisms existed in the government to ensure that public policies support the attainment of national health promotion objectives, 3 participants were uncertain (Table 5.11). Participants were divided in expressing whether ‘global health policies do not undermine the attainment of national health promotion objectives’. While 6 agreed, 3 disagreed and 4 were uncertain. One participant commented that the existing mechanisms to ensure that public policies support the attainment of national health promotion objectives are found in ‘top-down commanding structure’ from national and regional levels to community level.
Table 5.11 Policy coherence for health promotion in Thailand (n=13)

<table>
<thead>
<tr>
<th>Question Items</th>
<th>% Disagree/ Strongly Disagree</th>
<th>% Uncertain</th>
<th>% Agree / Strongly Agree</th>
<th>Item Mean (SD)</th>
<th>Cronbach's Alpha</th>
<th>Scale Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Mechanisms exist in the government to ensure that public policies support the attainment of national health promotion objectives.</td>
<td>8</td>
<td>23</td>
<td>69</td>
<td>3.6 (.65)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Global health policies across a range of issues, in relation to Thailand, do not undermine the attainment of national health promotion objectives.</td>
<td>23</td>
<td>31</td>
<td>46</td>
<td>3.2 (.83)</td>
<td>10.6</td>
<td>9</td>
</tr>
<tr>
<td>c. Global health policies across a range of issues, in relation to Thailand, support the attainment of national health promotion objectives.</td>
<td>0</td>
<td>23</td>
<td>77</td>
<td>3.8 (.55)</td>
<td>.80</td>
<td>9 (1.7)</td>
</tr>
</tbody>
</table>

5.6.4 Health Promotion Infrastructure

Health promotion infrastructure consists of human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide health promotion response to health issues and challenges. Health promotion infrastructure consists of five sub-domains: Health Promotion Delivery, Workforce, Partnerships, Financing, and Knowledge Management.

5.6.4.1 Health Promotion Delivery:

Health promotion delivery refers to the delivery structures and mechanisms for health promotion priorities including support for inter-sectoral
partnerships located at national and/or subnational levels according to country needs.

Three questions were asked from the participants to identify the existence of delivery mechanisms, organisations responsible for these mechanisms and awareness about use of Ottawa Charter’s five action areas in programme delivery. Out of fourteen participants at least ten agreed that planning, implementation, monitoring, evaluation and health impact assessment were carried out by national bodies/agencies in Thailand (Table 5.12). Seven participants were of the view that health promotion needs assessment is either not carried out or they were uncertain.

Table 5.12 Health promotion delivery mechanisms in Thailand (n=14)

<table>
<thead>
<tr>
<th>Question Items</th>
<th>Yes % (n)</th>
<th>No % (n)</th>
<th>Uncertain % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion needs assessment</td>
<td>50(7)</td>
<td>14(2)</td>
<td>36(5)</td>
</tr>
<tr>
<td>Health promotion programme planning</td>
<td>93(13)</td>
<td>7(1)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Health promotion programme implementation</td>
<td>100(14)</td>
<td>0(0)</td>
<td>0(0)</td>
</tr>
<tr>
<td>Health promotion monitoring</td>
<td>86(12)</td>
<td>0(0)</td>
<td>14(2)</td>
</tr>
<tr>
<td>Health promotion evaluation</td>
<td>79(11)</td>
<td>0(0)</td>
<td>21(3)</td>
</tr>
<tr>
<td>Health impact assessment</td>
<td>71(10)</td>
<td>7(1)</td>
<td>21(3)</td>
</tr>
</tbody>
</table>

The Thai Health Foundation and Ministry of Public Health were identified as the organisations/ agencies involved in all health promotion delivery mechanisms including needs assessment, programme planning, implementation, health promotion monitoring, evaluation and health impact assessment. The highest number of organisations/ agencies (7) was cited for health impact assessment while health promotion programme planning was found to be carried out by only two organisations. For details of the organisations identified see Table O6, Appendix O.

The participants were asked to rate their familiarity with the five action areas of the Ottawa Charter (WHO, 1986) on 4-point rating scales (Uncertain, Not aware, Aware, Aware) and use action areas in developing strategies. There was a high level of awareness about all 5 action areas (the lowest number of participants who were aware and/or use the action areas in
their work was 12: ‘Developing personal skills’) (Table 5.13). The category ‘Awareness and/or use of action areas in developing strategies’ had the highest percentage of participants for 3 out of 5 action areas.

Table 5.13 Participants’ familiarity with the 5 action areas of Ottawa Charter

<table>
<thead>
<tr>
<th>Question Items</th>
<th>Not aware % (n)</th>
<th>Aware % (n)</th>
<th>Aware and use action areas in developing strategies % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Building healthy public policy (e.g. bicycle helmet legislation)</td>
<td>7(1)</td>
<td>36(5)</td>
<td>57(8)</td>
</tr>
<tr>
<td>b. Creating supportive environments (e.g. banning junk food in elementary schools)</td>
<td>7(1)</td>
<td>29(4)</td>
<td>64(9)</td>
</tr>
<tr>
<td>c. Strengthening community action (e.g. supporting community coalitions taking action on homelessness)</td>
<td>7(1)</td>
<td>43(6)</td>
<td>50(7)</td>
</tr>
<tr>
<td>d. Developing personal skills (e.g. health parenting programmes)</td>
<td>14(2)</td>
<td>50(7)</td>
<td>36(5)</td>
</tr>
<tr>
<td>e. Reorienting the health service (e.g. baby friendly hospitals)</td>
<td>7(1)</td>
<td>57(8)</td>
<td>36(5)</td>
</tr>
</tbody>
</table>

5.6.4.2 Workforce

Health promotion workforce refers to the availability of qualified human resources with sufficient skills and knowledge to deliver essential health promotion action. The sub-domain was covered by eight questions in total.

According to six out of ten participants, Thailand has a specialist workforce for health promotion. Details about this workforce included staff working in Thai Health Foundation, health technical officers, specific health promotion workers in Government agencies, etc. However, none of the details provided fit the criteria given in the question which stated ‘practitioners with dedicated posts or job descriptions, which contain the title health promotion’ (Table O7, Appendix O). Four participants who expressed lack of such workforce in Thailand reported that health promotion jobs are fully integrated into routine systems with health workers trained on health promotion actions.

Participants were asked to choose various options about the availability of education and training programmes at national level in health promotion in
Thailand (Table 5.14). All participants (15) reported that there was no specific training in health promotion. Nine participants affirmed that there were courses in which health promotion is a module, a subject or a part. One participant commented that there were workshops related to the development of health promotion capacity for scholars, health professionals and community workers provided by Thai Health.

Table 5.14 Health promotion Training and Education in Thailand * (n=15),

<table>
<thead>
<tr>
<th>Question Items</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes, there are specific courses (postgraduate Diploma and Master’s courses or undergraduate Bachelor training) dedicated to health promotion</td>
<td>40</td>
<td>6</td>
</tr>
<tr>
<td>b. Yes, there are courses in which health promotion is a module, a subject or a part</td>
<td>67</td>
<td>10</td>
</tr>
<tr>
<td>c. Yes, there are short courses in health promotion for health and community workers (e.g. nurses, community workers, teachers, health professionals etc.)</td>
<td>60</td>
<td>9</td>
</tr>
<tr>
<td>d. Yes, there are courses which include health equity and the socio-economic determinants of health</td>
<td>47</td>
<td>7</td>
</tr>
<tr>
<td>e. No, there is no specific training in health promotion</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. No information available</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>g. Other (please specify) or comment</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

*Participants could choose more than one response

Note: In considering ‘tick all that apply’ quests (mcqs) a participant is considered to have to responded to all question options (all tick boxes) if he has responded to any options.

Fourteen participants reported that the available health promotion education and training was not sufficient. One participant commented that there is a lack of understanding on translating ‘health in all policies’ into action, along with lack of inter-sectoral action and policy coherence across sectors, in particular, trade and transport. A second participant commented that Thailand needs more international comparison to understand the different contexts of health promotion. The two target audiences who were given priority for training and education in health promotion in Thailand were health promotion practitioners and public health practitioners (Table 5.15). Health service managers received the lowest score for training in education in HP.
### Table 5.15 Mean importance score for health promotion training and education for target audiences

<table>
<thead>
<tr>
<th>Question Items</th>
<th>Rating</th>
<th>Average</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>health promotion practitioners</td>
<td>4.6</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Public health practitioners</td>
<td>4.4</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Community workers</td>
<td>4.2</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Primary health care professionals</td>
<td>4.2</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Other health service professionals (doctors, nurses, etc.)</td>
<td>4.2</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Health education practitioners</td>
<td>4.1</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Local government managers</td>
<td>4.0</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Policy makers (e.g. Ministry of Health)</td>
<td>4.0</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Educators (teachers in schools, colleges etc.)</td>
<td>3.9</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Health service managers</td>
<td>3.6</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

Seven out of thirteen participants were uncertain about whether there was a set of core competencies specified for professionals working in the field of HP. Six participants were uncertain about a national professional association for health promoters or an association that caters for the interests of health promoters in Thailand. The majority of participants, on the other hand, reported professional expertise and capacity within universities and research institutes to carry out health promotion research. One participant commented that:

...though there is professional expertise in universities to carry out health promotion research, the recommendations of the researchers were likely to be neglected in the national health promotion policies and during implementation.

Seven programmes for training and development in health promotion in Thailand were identified by the participants (Table O8, Appendix O). Three of these were offered in three state universities (ranging from doctoral to master degree programmes), one by Thai Health Foundation, and two focused on specific issues of disabilities (health promotion programme for persons with disabilities) and injury prevention (TEACH VIP), through government partnering with international stakeholders.
5.6.4.3 Partnerships

HP Partnerships refer to relationships between various partners in the health and non-health sectors (donor countries, development agencies, NGOs, civil society, private and government sectors) to work towards a set of shared outcomes. Seven participants reported ‘very strong/strong’ partnership between health authorities and other sectors, while only four reported ‘very strong/strong’ partnership between national, regional and local levels of decision-making. Likewise ten participants reported ‘very strong/strong’ partnership between Thai government and non-governmental organisations, while only five reported ‘very strong/strong’ partnership between private organisations promoting health.

5.6.4.4 Financing

Financing for health promotion refers to the allocation of sufficient funding and incentives to create and sustain effective national health promotion structures and strategies. The option ‘Government’ was the most reported dedicated funding source for health promotion activities in Thailand (n=13), while only two participants reported ‘Donor countries’ as the source of funding (Figure 5.8). Half or more participants were uncertain about the international sector as the funding source which included international development agencies, international NGOs, donor countries and intergovernmental organisations.
5. Phase II: Case Study

With regards to the sustainable financing of health promotion in Thailand, participants ‘strongly agreed/ agreed’ to existence of a stable flow of financial resources for health promotion development and funding of health promotion from dedicated taxes or levies on tobacco, alcohol, gasoline, or other products and services (Table 5.16). The system of sustainable financing by the Thai Health is mentioned in detail in Section 5.2.5.1. There was wide variation in the participants’ agreement with regards to financial resources for health promotion being channelled through other government sectors (5 disagree/ strongly disagree, 7 agree / strongly agree), and the adequacy of funding for health promotion development (6 disagree/ strongly disagree, 7 agree / strongly agree). It should be noted that the items in the question on sub-domain Financing had poor internal consistency.
### Table 5.16 Sustainable Financing for health promotion in Thailand (n=14)

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>% Disagree / Strongly disagree</th>
<th>% Uncertain</th>
<th>% Agree / Strongly Agree</th>
<th>Item Mean (SD)</th>
<th>Cronbach's Alpha</th>
<th>Scale Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There is a stable flow of financial resources for health promotion development (i.e. annual allocation of funds)</td>
<td>7</td>
<td>0</td>
<td>93</td>
<td>4.2(0.80)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Financial resources for health promotion are also channelled through other government sectors (education, transport, environment, etc.)</td>
<td>36</td>
<td>14</td>
<td>50</td>
<td>3.2(1.05)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. There are arrangements for the 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</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>4.6(0.49)</td>
<td>.45</td>
<td>15.21 (2.3)</td>
</tr>
<tr>
<td>d. The funding for health promotion development is adequate (fulfils national health promotion objectives)</td>
<td>43</td>
<td>7</td>
<td>50</td>
<td>3.1(1.29)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 5.6.4.5 Knowledge Development and Management

Health promotion Knowledge Development refers to developing a body of knowledge and an evidence base to support policymaking at all levels. Knowledge Management consists of using this knowledge to develop capacity for health promotion research, information systems, performance improvement, evaluation and monitoring to promote health and strengthen the national health system.

There was wide variation in the participants’ agreement regarding the various dimensions of health promotion knowledge development and management. The participants ‘Strongly agreed/Agreed’ that universities and research institutes are initiating or participating in health promotion research and that there is professional expertise within the universities and research institutes to carry out health promotion monitoring activities and interpret outcomes and trends (Table 5.17). But a considerable majority of the participants were uncertain that a system exists where health information is channelled to decision makers at national, regional and local level for health promotion development, and that stakeholders have access to relevant
knowledge and use it in their health promotion actions and interventions. The items in the question on sub-domain Knowledge Development and Management had poor internal consistency therefore the items should be interpreted individually.
Table 5.17 Knowledge development and management for health promotion in Thailand (n=14)

<table>
<thead>
<tr>
<th>Question Items</th>
<th>%Disagree</th>
<th>% Strongly disagree</th>
<th>% Uncertain</th>
<th>% Agree / Strongly Agree</th>
<th>Item Mean (SD)</th>
<th>Cronbach’s Alpha</th>
<th>Scale Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There is adequate access to information on health promotion (i.e. theory, models, research, examples of best practice, etc.).</td>
<td>14</td>
<td>21</td>
<td>64</td>
<td>3.46 ( .77)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. A national health information system is in place which collects, processes and analyses population health related data</td>
<td>21</td>
<td>29</td>
<td>50</td>
<td>3.15 (.98)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. There are periodical (i.e. yearly) governmental reports that define common health promotion objectives, priorities and strategies</td>
<td>14</td>
<td>29</td>
<td>57</td>
<td>3.38 (.76)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Universities and research institutes are initiating or participating in health promotion research</td>
<td>0</td>
<td>29</td>
<td>71</td>
<td>3.92 (.64)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. There is professional expertise within the universities and research institutes to carry out health promotion monitoring activities and interpret outcomes and trends</td>
<td>7</td>
<td>21</td>
<td>71</td>
<td>3.69 (.75)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. A system exists where health information is channelled to decision makers at national, regional and local level for health promotion development</td>
<td>8</td>
<td>39</td>
<td>54</td>
<td>3.46 (.66)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Stakeholders have access to relevant knowledge and use it in their health promotion actions and interventions</td>
<td>14</td>
<td>50</td>
<td>36</td>
<td>3.23 (.72)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.6.5 Country Specific Context for Health Promotion

The questions regarding Country Specific Context explored the environmental, historical, political, economic, social and cultural factors which influence the development of health promotion capacity in a country. The developments which contributed to improve health promotion infrastructure selected by most of the participants were; adoption of the Ottawa Charter, development of healthy public policies and inclusion of health promotion objectives into the Health Reform Strategy (Table 5.18). ‘Thai Health Promotion Act 2001’ or ‘surcharge tax from tobacco and
alcohol for health promotion fund’ were reported as significant developments specific to the Thai context.

Table 5.18 Health promotion development landmarks in Thailand* (n=13), %

<table>
<thead>
<tr>
<th>Question Items</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Government papers and policies on achieving Health for All/Primary Health Care</td>
<td>62</td>
<td>8</td>
</tr>
<tr>
<td>b. Adoption of the Ottawa Charter (WHO, 1986)</td>
<td>77</td>
<td>1</td>
</tr>
<tr>
<td>c. Steps taken towards development of healthy public policies</td>
<td>69</td>
<td>9</td>
</tr>
<tr>
<td>d. Inclusion of concrete health promotion objectives into the health reform strategy</td>
<td>77</td>
<td>1</td>
</tr>
<tr>
<td>e. Health promotion education and training</td>
<td>23</td>
<td>3</td>
</tr>
<tr>
<td>f. Health promotion conferences</td>
<td>54</td>
<td>7</td>
</tr>
</tbody>
</table>

*Participants could choose more than one response

The majority of participants viewed ‘strong leadership provided by key individuals and organisations’ as the most important asset in relation to health promotion capacity building (Table 5.20). Political commitment, civil society partnerships (e.g., multiple levels of government, NGOs and community organisations) and health promotion financing were equally considered to be the second most important assets. The question items linked to workforce, commitment of the existing workforce and health promotion trained workforce, were considered the least ‘most important’ assets.

Table 5.19 Assets of Thailand in health promotion capacity development * (n=15), %

<table>
<thead>
<tr>
<th>Question Items</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Community knowledge, tradition and culture</td>
<td>53</td>
<td>8</td>
</tr>
<tr>
<td>b. Eagerness to learn and to build capacity</td>
<td>47</td>
<td>7</td>
</tr>
<tr>
<td>c. Low cost infrastructure leading to more sustainable health promotion capacity development</td>
<td>47</td>
<td>7</td>
</tr>
<tr>
<td>d. Political commitment</td>
<td>67</td>
<td>10</td>
</tr>
<tr>
<td>e. Commitment of the existing workforce</td>
<td>33</td>
<td>5</td>
</tr>
<tr>
<td>f. Strong leadership provided by key individuals and organisations</td>
<td>93</td>
<td>14</td>
</tr>
<tr>
<td>g. Links to regional and global networks</td>
<td>40</td>
<td>6</td>
</tr>
<tr>
<td>h. Civil society partnerships (e.g., multiple levels of government, NGOs and community organisations)</td>
<td>67</td>
<td>10</td>
</tr>
<tr>
<td>i. Health promotion financing</td>
<td>67</td>
<td>10</td>
</tr>
<tr>
<td>j. Health promotion trained workforce</td>
<td>27</td>
<td>4</td>
</tr>
</tbody>
</table>

*Participants could choose more than one response
The participants also reported on the barriers affecting health promotion capacity development in Thailand (Table O10, Appendix O). These are summarised below:

5.6.6 Barriers in capacity development and mapping

5.6.6.1 Political environment
Out of ten comments three stressed the dominance of economic issues in policymaking for health. In descending order, other themes that emerged were: frequent changes in MOPH/government, political conflicts, transparency, self-reliance, understanding of health promotion and commitment.

5.6.6.2 Economic environment
Barriers mentioned by the participants were: poverty, inequality, unemployment, GDP focused strategies, consumerism and materialism, effect on agriculture and disagreement on issues related to alcohol and tobacco trade.

5.6.6.3 Socio-cultural environment
Some key barriers mentioned by the participants with regards to the socio-cultural environment were: lack of self-reliance, inequality, urbanisation and poor infrastructure and alcohol consumption.

5.6.6.4 Health promotion expertise
Lack of workforce, professionalism and training, and evaluation capacity were the key barriers mentioned by the participants.

Participants were invited to identify barriers which in their view affected implementation of good governance, political environment and infrastructure for health promotion development (Table O11, Appendix O). The responses are summarised below:
5.6.6.5 Governance
Corruption, more focus on financial/economic issues, abuse of power by the politicians, conflicts of interest, and lack of capacity for leadership and commitment.

5.6.6.6 Policy environment
Some key barriers mentioned by the participants were: Lack of diversity of stakeholders, lack of understanding of health in all policies and social determinants of health, lack of finances and domination of ‘opposition’ trade policies.

5.6.6.7 Infrastructure
Lack of (political) vision and participation of local leaders, lack of finances, too much focus on service-based health promotion and ‘over-loaded’ jobs of community health personnel were some of the key barriers mentioned.

The participants were asked whether there are any other aspects of health promotion capacity mapping that they would like to see represented in this tool (Table O12, Appendix O). Some key areas identified were:

5.6.7 Participants’ suggestions for domains

Governance
Engagement by civil society, need for a flexible management system and strong commitment by the public (or public sector) were the issues participants wanted to see reflected in the mapping tool.

Policy Environment:
Key areas related to the policy environment mentioned by the participants to be included in the mapping tool were realisation of people at the community level that policies are not formulated by the elite class, lobbying of policymakers, and understanding of health in all policies.
5. Phase II: Case Study

*Infrastructure*

With regards to the infrastructure, the participants identified empowerment of the local volunteers, health literacy and autonomy of the health promotion unit as some key areas to be included in the mapping tool.

Overall the majority of participants were of the view that information provided by this research tool could be used for planning, implementing, developing health promotion capacity in Thailand (Table O13, Appendix O). The participants thought that the information from this tool was very useful; the information could also be used in health policymaking, and could also be used as an advocacy tool for improving health promotion capacity in Thailand.

5.7 Data Collection Method 4: Group Discussion

A group discussion with nine key informants was held on 27 August 2013 at the 21st World Conference on health promotion in Pattaya, Thailand. The aim of the discussion group was to explore the feasibility of implementation of the health promotion capacity mapping tool in Thailand. In the discussion, feedback was received from health promotion key informants in academia, policy and practice areas in Thailand. The discussion, held during the lunch break, lasted for forty minutes.

The participants were sent following themes for discussion:

1. The best way to develop a capacity mapping strategy/system for LMICs?
2. Participant’s views on the usefulness of a health promotion capacity mapping framework and tool for use in Thailand and in other low and middle income countries.
3. Use of the mapping framework and tool in the Thai context. What is missing in the capacity mapping tool?
4. Importance of the country specific context for health promotion capacity development based on participant’s experience in Thailand and in other countries.
5. Ownership of the capacity mapping activity and other stakeholders in the mapping process.

5.7.1 **Thematic Analysis**

After analysis of the transcript of the digital recording of discussion, following main themes emerged:

1. Who would use the tool: target group
2. How will the tool be used: process and purpose
3. How will the results be presented

The participants showed interest both in the process of capacity mapping and the content in the capacity mapping tool.

5.7.1.1 **Target Group (who will use the tool)**

One of the main concerns of the participants was identification of the target group who will use the mapping tool. A participant stated that if the target group is known, it will help shape the idea (behind mapping) and the context.

The participant explained further by saying that in Thailand the decisions for health promotion are not taken by a single authority. If a questionnaire is sent to various sectors (or experts), one would get different responses from them according to their background e.g. there could be difference in opinion about the governance structures from the Ministry of Public Health, a non-public expert or the national health authority.

Another participant suggested if it was possible to start with mapping the stakeholders. The participant explained that as health promotion capacity is a very broad topic involving different sectors and stakeholders, mapping stakeholders before mapping health promotion could help avoid complexities. The system or the strategy, according to the participant, could be mapped later.
5.7.1.2 The Process (how will the tool be used)

The discussion also focused on the ‘process’ of mapping health promotion. One participant stated that capacity and building or capacity strengthening is a long-term process and carries diversity as it involves different groups. The participant further said that:

*In my view capacity strengthening should be like sharing of ideas, sharing of experience, and sharing something you need in the society. Your tool can be used for sharing but if you don’t understand the process, it will just be used for collecting information from different people.*

The importance of the mapping process was highlighted as compared to the tool itself:

*The process can be more important than the tool, or it can be other way round, the tool could be more important than the specific process.*

A participant remarked that effective decisions can be taken after collecting the information from all stakeholders in the society. The participant added that the tool can be useful to identify the similarities or differences in the society but its usefulness depends on the process.

5.7.1.3 Flexibility in the tool

Within the process of mapping, the participants also discussed whether the tool possessed any degree of flexibility and ability to adapt to different government processes or organisational frameworks.

The discussion further progressed to the level of complexity addressed by the mapping tool. For example, discussing about governance, a participant asked whether the mapping tool helps identify the capability of the system to reflect on various decisions (at different points of inputs).

Another participant raised a point about the mapping tool’s ability to record dynamic capacity compared to static capacity, which could in turn address complex health promotion capacity issues. Linked to this, a participant
commented on the tool’s ability to capture the built-in learnability especially with regards to the workforce in the health system, through a systems thinking approach. The participant suggested that:

[Health promotion] evolves all the time. So it means, if you assess it, you need to assess for example whether there is built-in learnability in the workforce in the health system. This needs to be constantly adjusted in each component (of the questionnaire).

5.7.1.4 The Purpose (why would the tool be used)

Most participants were not clear on the purpose of the mapping tool. The suggestions included using the tool as a policy advocacy tool or a resource guiding tool. The participant further asked if there are any guidelines in the mapping process to improve this mechanism. One participant said:

If this is just a snapshot of the situation of the country it seems likely that we know it already but we might not have documented it well. I’m not sure of the purpose of using this.

5.7.1.5 Design of the Mapping Tool

One of the participants raised some issues regarding the results of the mapping:

And also, to capture those contextual or cultural factors that might affect, how will this affect[s] the results when you are looking at data from different countries. Who will use the data? Who do you intend to contact to help countries plan strategies?

Another participant asked:

What information and knowledge would we want to generate from this mapping tool to fit with the target group and how we want to use it later on?

And:
And then how do you collect different (types of) information and combine it together? And how are you going to use it? [The] Ministry of Public Health have [a] different perspective about improving health promotion in Thailand than us (Thai Health).

A participant suggested designing the mapping tool based on the AIDS Accountability Country Scorecard (http://aidsaccountability.org/), a tool used by AIDS Accountability International, a multi-partner International organisation based in Sweden. The tool which collects data on eight ‘elements’ to show a country’s progress in responding to the AIDS epidemic, presents results in the form of the AIDS Reporting Index that measures failure of countries to report. The participant said that the tool is used for policy advocacy, resource mobilisation and compares various countries. The participant said that this is a useful approach as many LMICs lag far behind in policy advocacy.

Another participant mentioned a governance tool used by Thai Health prepared by an evaluation board. The tool is developed and prepared by an evaluation subcommittee which also insulates Thai Health from outside political pressure. In this tool there are 5 to 6 criteria and a list of steps to find out whether there is compliance with each step or not. This self-rating is submitted to the evaluation board once a year or every six months.

The participant suggested that the mapping tool could be designed like the UNDP Human Development Report and a group of experts who know the country very well could rate health promotion progress, anonymously or otherwise. The participant commented that it should be rating and not a ranking to identify individual country’s needs.

5.7.1.6 The Format of the Tool

The participants raised some key issues regarding the format of the questions in the mapping tool to the contents of the tool. These included how various capacity domains were expressed in the tool.
1. The capacity domain Governance was criticised for not addressing governance related issues in Thailand. One participant commented on the way the domain is presented and how it could be responded to by various sectors:
   
   a. *This tool doesn’t fit at all. It seems to me that the domains do not fit in the way we are working. For example, we have our own governance tool which has four of five criteria. In each criterion we have a list of questions / steps that we should achieve. In the governance tool we have country interest, integrity, observance of the rule of law, as components.*

   b. *We have developed a governance audit for Thai Health now. Our classification is different from your classification.*

   c. *In Thailand Governance structure is ‘alive’ with the bureaucratic (government) system in Thailand. So in this case who will be your target group to do this rating? In [the] Thai Health Centre if you want to ask about governance, we have [a] certain infrastructure or system, and I can give you a score because we annually monitor governance (by giving a score). But the Ministry of Public Health, who have a permanent Secretary in charge of that, can give a completely different answer to that question.*

2. Health promotion areas and domains in the tool:

   One participant was of the view that asking one expert about all the health promotion areas might not be suitable.

   *The health promotion areas are wide, like NCDs, exercise, etc. In each area development and partnerships are also different. In one area there can be lot of progress and improvement but in another, it could still be in the initial stages. So one person cannot respond to all the areas mentioned in the tool. It is difficult to use a simple tool to answer all things or areas. Some areas*
are still in the beginning, some are well advanced. Different areas have
different degrees of development in health promotion.

A participant suggested that the tool can focus on one specific area and
compare it across others:

That is one of the issues you can face in the second phase. In the general
capacity mapping of Thailand you can identify one specific area of health
promotion. Like this you can see differences in terms of capacity mapping
and also check with other evidence that may help you to understand and
improve it.

One participant suggested that tool be re-designed based on physical, social
and spiritual health dimensions:

It could be more useful if you can subdivide this into more dimensions like
physical, social and spiritual health because each area is different in
development. Then the tool can be applied to each dimension separately and
not combine[d] all in the same tool.

3. Understanding about terminology used in the tool
Some participants did not think that certain terms like capacity, governance,
and infrastructure had been clearly defined:

And the second thing is that you need some definitions for example capacity,
infrasturcture, and governance. Without these definitions people have
different opinions and ideas about these common terminologies.

And the term you put in as infrastructure, we consider it as resource. But for
resource itself there are certain components that are more critical than the
other. I think in resources the most important thing is the financial resource
and people’s capacity at individual level.

A participant commented on the concept of health portrayed in the tool and
suggested to include spiritual health / well-being:
The definition of health in Thailand is broader than the conventional definition that the other countries use. We think not only of physical health but social and spiritual health too. That makes a difference in Thailand.

When we mention spiritual health we try to achieve that in a learning process: we define it, the type of intervention we are going to implement and it is not only about individual health but collectively as social / community health.

5.7.1.7 Communication from Elsewhere

The following comments and feedback about the mapping tool were taken from informal communications with some stakeholders:

Coverage of domains

The mapping tool covers all the aspects of health promotion capacity development. They are all very good questions but it could be complex to answer them.

And there is a lot of adaptability that we can use for understanding in-depth local context.

The domains are interesting but I wonder how many people responded to the section on infrastructure as we are still struggling with it.

Complexity of questions

The questions require more than one person to fill because it needs brainstorming and comprehensive understanding of the issues asked.

The questions were too complex and no space to check/tick with [a] simple answer.

Some institutions could be hesitant to answer, because they would not understand it correctly. I think that those who are submitting their responses will have to submit their responses to their superiors too.
5. Phase II: Case Study

Complex practices

Many practices are quite complex. For example research could be carried out by one institute while other institution could be responsible for producing communication materials. Another institution could be focused on practices on behavioural change, or another one might be doing a community empowerment.

Complex structures and processes

From outside it might look good, but there are some very complex structures and processes going on inside. When the Office of International Affairs at the Ministry receives this questionnaire they might pass it on to the health promotion unit. But that unit doesn’t function as comprehensive workforce in all the areas mentioned in the questionnaire. Many of practitioners working in this area may not even understand some of the policies and their references.

Role of Ministry of Public Health

There is not much coherent coordination in MoPH itself. They could be networking with others but do not have the monitoring power for all partners. They control the strategy and plan of action but [do] not necessarily coordinate and get results from all the partners involved.

On specific questions

The questionnaire is too long

In Thailand even in this present age, many professionals talk about the Bangkok Declaration without referring to Ottawa Charter, or they don’t know the link between various declarations or calls for action.

Many practitioners will find [the] question 22 (on Ottawa Charter and 5 action areas) difficult to respond to. It would be beneficial to ask them if they have heard of these 5 areas and whether it is integrated in the policies
they know of. This would raise an initial awareness and would indicate whether the institutions have a clear vision of health promotion or not.

There are few categories in the components of the mapping tool that are not relevant to Thailand's context. For example: health promotion governance. Components of health promotion governance are not consistent with 'good governance' adopted by public agencies in Thailand. In Thailand, there is no definite governance structure or single authority for health promotion. There are few key stakeholders in health promotion such as:

- the Ministry of Public Health which have manpower, health centres and hospitals at various level as executing unit[s];
- [the] National Health Security Office which is [a] financing agency and transfers money to community hospitals and local authorities;
- the Thai Health which works with both public agencies and civil society or community-based organizations.

On rating scales

It would be better if the rating scales are adjacent to the question to make it easy to respond (the way it’s done in question 9).

I was thinking of the financing part, but I see that you have covered quite good deal. I am not sure about measuring accountability though.

For question 12 on transparency you can ask if there is any reporting system for implementation of [the] health promotion system like a national report or annual report for the public. Like for Thailand one could ask whether they have any report for implementation for the national health assembly that could check and balance, to make them accountable.

I was looking at a comparative study on Uganda. They have advisory committees to look into the technical working group reports on the performance of health. I was just wondering who are the technical advisory groups, how is this information channelled back to the Ministry of Health and how the Ministry of Health reacts to all the reports and whether it is
open to public. This is an important process. If there are just advisers sending information to the Ministry then there is no accountability because then it is just internal review. If you have a public forum like an assembly then people can question government to say that why there is no output in spite of implementation and how come we did not have resources for certain areas. So on and so forth. A lot of deliberation at that public forum makes it strong accountability for government. My question to them is where does the report go?

Mapping tool’s contribution to WHO mapping

Yes, the tool can fill the missing gaps in the WHO tool as it includes many new things like health in all policies. Tools like these can empower personnel / institutions who participate in them as it asks them to assess themselves.

Language as barrier

Language is a big barrier as it could be very difficult for Thai experts to understand the questions. This requires a little bit more thinking and internal assessment. It will be difficult for them to fill in text in the comment boxes unless you get somebody to translate in Thai. But then again you have to translate back in English. Especially non-English speakers could find it complex to respond to the questionnaire. This is a key challenge unless you have English as a medium. How did Dr Sally map for Laos and Vietnam?

This questionnaire is in English thus it needs time to interpret.

On stakeholders’ profile

The teachers (academia) should be one of the most important stakeholders to get involved in mapping health promotion.

Few people are involved in health promotion in Thailand. I have never heard of anyone who assessed or evaluated overall health promotion development.
You can also ask people in health promotion hospitals or the school health programme, and Healthy Cities and perhaps use the term ‘practitioners’ instead of ‘experts’ (to improve response rate).

5.7.2 Summary of Discussion Group findings
Several issues regarding the future use of the mapping tools were discussed in the discussion group. These will be discussed in detail in the next chapter:

- A questionnaire sent to various sectors gets different responses according to the context e.g. information about the governance structures from the MoPH, a non-public expert or the national health authority. It will help the mapping process if the stakeholders are identified before starting the process.
- Various health promotion areas are at different stages of development and have different partnerships. It will be difficult for one person to respond to all the areas mentioned in the tool.
- These tools can also be used to empower personnel and institutions who participate in them as it asks them to assess themselves.
- The tools could also be used for policy advocacy or as resource guiding tools.
- Another issue raised is the use of information regarding the country specific context and its effect on the results when looking at data from different countries.
- In addition how the different types of information will be combined to present results needs to be considered.
- The tools need to have a built-in ‘learnability’ especially with regards to the workforce in the health system, through a systems thinking approach.
- Mapping tools should be able to record dynamic and multiple dimensions of the capacity domains to address complex issues, keeping in view the evolving nature of health promotion.
• Language is a barrier in using these mapping tools as it could be very
difficult for experts to understand the questions if it is not in a local
language.

5.8 Overview of the chapter

The findings of the case study of health promotion capacity mapping in
Thailand provide insight into the country specific context for health
promotion capacity mapping, identifies the nature of the existing key
infrastructure, its strengths and weaknesses, and provides suggestions on the
use of mapping tools and the mapping process. While legislations and
national policies and plans exist in the Thai health system, various areas in
developing the health promotion infrastructure and programme
implementation are perceived as needing attention. Gaps exist in terms of
suitable workforce capacity, distribution of funds, participatory approach
and intersectoral commitment. An overarch ing issue is the key question of
how health promotion is understood by the national stakeholders which will
enable them to work jointly. The Discussion chapter will discuss further
how the health promotion capacity mapping issues identified in Thailand
could have broader implications for similar activities in other LMICs and
future use of these mapping tools.
6. Integration of Findings from Phase I and II Studies

This study aimed to develop a conceptual framework to map health promotion capacity in LMICs. This section integrates the key findings from the two phases of the study: the Delphi study on development of the conceptual mapping framework and tool, and the case study which piloted the implementation of the framework and tool in a specific LMIC country context.

Based on a review of the international literature, a new mapping framework was developed and forwarded to a panel of global health promotion experts for their views on its suitability for use in LMICs in Phase I of the study. The experts took part in a consensus building process concerning the capacity mapping framework and a number of core capacity domains through an online Delphi method involving a questionnaire and a glossary of terms. The consultation comprised of a pilot study followed by two rounds of Delphi, in which up to 96 health promotion experts participated. In the Pilot and Round 1 of the Delphi, the mapping framework underwent a number of changes in response to participants’ feedback concerning the titles of domains and sub-domains, the number of sub-domains included, and overlap and repetition in the definition and description of domains and sub-domains. In Round 2, the experts took part in a consensus building process regarding the capacity mapping tool based on the agreed upon capacity domains and framework developed from Round 1. The mapping tool had 55 open and closed-ended questions covering four domains and 10 sub-domains. The main changes made to the mapping tool related to the domain Country Specific Context, which, although perceived to be quite an important domain, was considered difficult to capture adequately in the survey questionnaire items due to the complexity of the descriptions.

The changes to the framework domains made in different rounds of Phase I are presented in Table 6.1.
6. Integration of Findings from Phase I and II Studies

Table 6.1 Summary of changes to mapping framework in Phase I

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pilot</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants: 5/16</td>
<td>Participants: 96/723</td>
<td>Participants: 65/133</td>
<td></td>
</tr>
<tr>
<td>No. of domains: 4</td>
<td>No. of domains: 4</td>
<td>No. of domains: 4</td>
<td></td>
</tr>
<tr>
<td>No. of sub-domains: 15</td>
<td>No. of sub-domains: 18</td>
<td>No. of sub-domains: 10</td>
<td></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
<td><strong>Country Specific Context</strong></td>
<td><strong>Country Specific Context</strong></td>
<td><strong>Country Specific Context</strong></td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td>Historical Context</td>
<td>Historical Context</td>
<td>Environmental, historical, political, economic, social and cultural factors</td>
</tr>
<tr>
<td>Political Context</td>
<td>Political Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social and Cultural Context</td>
<td>Social Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Context</td>
<td>Cultural Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Economic Context</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
<td>Governance</td>
<td>Governance</td>
<td>Governance</td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td>Political Commitment</td>
<td>Political Commitment</td>
<td>Institutional Capacity</td>
</tr>
<tr>
<td>Leadership</td>
<td>Leadership</td>
<td>Vision and leadership</td>
<td></td>
</tr>
<tr>
<td>Partnership and Intersectoral Action</td>
<td>Ownership of Health Promotion Capacity Development</td>
<td>Transparency</td>
<td></td>
</tr>
<tr>
<td>Ownership</td>
<td>Health Promotion Systems Approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intersectoral Collaboration</td>
<td>Partnership for Health Promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
<td>Policy Environment</td>
<td>Policy Environment</td>
<td>Policy Environment</td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td>National Policies and Plans</td>
<td>National Policies and Plans</td>
<td>Healthy Public Policies</td>
</tr>
<tr>
<td>Policy Coherence</td>
<td>Policy Coherence</td>
<td>Policy Coherence</td>
<td></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
<td>Infrastructure</td>
<td>Infrastructure</td>
<td>Infrastructure</td>
</tr>
<tr>
<td><strong>Sub-domains</strong></td>
<td>Health Promotion Workforce</td>
<td>Programme Delivery</td>
<td>Health Promotion Delivery</td>
</tr>
<tr>
<td>Sustainable Financing</td>
<td>Health Promotion Workforce</td>
<td>Workforce</td>
<td></td>
</tr>
<tr>
<td>Programme Delivery</td>
<td>Performance Monitoring</td>
<td>Partnerships</td>
<td></td>
</tr>
<tr>
<td>Performance Monitoring</td>
<td>Sustainable Financing</td>
<td>Financing</td>
<td></td>
</tr>
<tr>
<td>Research and Knowledge Management</td>
<td>Research and Knowledge Management</td>
<td>Knowledge Development &amp; Management</td>
<td></td>
</tr>
</tbody>
</table>

The final mapping framework and tool developed from the Delphi survey, which was then piloted in the next phase of the study, consisted of 41 questions covering four domains and 10 sub-domains (Table 6.1). The participants found the domain Country Specific Context too complex to respond to in the online questionnaire. It was decided that a dialogue-based approach (interviewing) would be more suitable to collect information regarding this domain. In addition various minor changes were made to the domain names and descriptions. Governance and its sub-domains were modified to better represent an LMIC’s capacity to govern health promotion matters and these were included as the sub-domains Institutional Capacity, Vision and Leadership, and Transparency and Accountability. The resulting mapping framework and tool from Phase I was implemented in a LMIC on a pilot basis as part of the Phase II study.
In Phase II of the study, a multi-method approach was adopted to pilot the mapping framework and tool and to fine tune the mapping methodology. Thailand was selected as the case study country due to its recognised development of health promotion capacity at a country level. The findings of the Case Study are summarised in this chapter outlining the main strengths and weaknesses in the development of health promotion capacity within the Thai health system. The mapping data collection process in Phase II consisted of:

- Desk review to explore the country’s historical, political, socio-cultural and economic environments relevant to health promotion development
- Interviews with seven leaders and senior people involved in health promotion or public health development at the national level to elicit their views on the country specific contexts that influence health promotion development. These interviews were conducted as supplement to the desk review.
- Online questionnaire (mapping tool) to map capacity of the country based on the new mapping framework completed by 21 senior people involved in health promotion or public health development at the national level
- Face-to-face group discussion with nine national level key informants and stakeholders to explore the feasibility of implementation of the mapping process

The data collected through the Desk Review and the Interviews provided important information about the particular country specific contexts and environments in which national health promotion capacity developed in Thailand. The key events and historical and political landmarks in the development of health promotion were examined and the specific economic and sociocultural factors that shaped the development of health promotion in the country were explored. Exploration of these factors helped to understand and interpret how health promotion capacity development at the
country level had unfolded, and how priority issues in the implementation of health promotion policies and programmes had evolved.

The Country Specific Context domain was initially planned to cover the characteristics of a country that may have an influence on health promotion policies and capacity development efforts. In the earlier drafts of the framework separate sections were designed to capture the historical, social, cultural, economic and political factors influencing health promotion capacity development. These were later merged into a single section in the final tool as there was disagreement among the participants regarding how these factors were best defined and described (Table 6.1.). While the participants fully agreed that the various items in the questions should be included in the mapping process, there were differences in opinion regarding how best to represent these items. The themes in these questions included the type of political regime, and characteristics of the economy in the country. In the final tool that was piloted with the Thai participants, they were only asked to choose strengths and barriers to health promotion in their country from a list included in the survey tool. It was decided that the country specific context was best explored through the desk review and interview components of the data collection process.

The findings of the case study are summarised in Table 6.2 in terms of existing strengths and weaknesses in health promotion capacity in Thailand.
Table 6.2 Summary of findings of the Case Study on the basis of strengths and weaknesses in Thai health system to promote health promotion capacity

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country Specific Context</strong></td>
<td></td>
</tr>
<tr>
<td>Thailand is a Buddhist country with a history of many population movements from diverse cultural, linguistic, and religious backgrounds.</td>
<td>Currently the country is undergoing a strong political turmoil and unrest.</td>
</tr>
<tr>
<td>Thailand has achieved overall success in its poverty alleviation and was upgraded from a lower-middle income economy to an upper-middle income economy in 2011.</td>
<td>The gap between rich and poor has not narrowed. Social inequity remains one of the underlying causes of political unrest in Thailand in recent years.</td>
</tr>
<tr>
<td>Health developments have undergone many changes from curative services focus to broader social determinants of health approaches through various health promotion charters and declarations.</td>
<td>The burden of diseases is gradually shifting to NCDs, injuries and mental disorders linked with urbanization, internal migration and changes in social environment. This is putting demands on the country’s education, housing, health, and employment systems.</td>
</tr>
<tr>
<td>The country’s 1997 Constitution, focused on people’s rights to good health, resulting in a nationwide social movement for health promotion.</td>
<td>Country faces effects of globalisation in trade and financial markets. There is also increased influence of sex tourism due to poverty as a root cause.</td>
</tr>
<tr>
<td>The major landmark developments are adoption of the WHO’s Primary Health Care strategy to promote Health for All Thais in 1978, setting up of the health volunteer system and the Tobacco control movement in the early 1980s.</td>
<td>Demographics show an aging population with a declining annual population growth rate due to decreasing birth rate.</td>
</tr>
<tr>
<td>A mix of public and private health service providers supplies health services in Thailand. At community-level, primary health care is provided by health volunteers or by self-care.</td>
<td>Local governments play a limited role in health services. There is a need to reorient health programmes’ nature towards a primary prevention focus</td>
</tr>
<tr>
<td>Thailand has endorsed a range of UN conventions and treaties on human rights. Thailand also hosted the 6th Global Health Promotion Conference (Bangkok, 2005) and 21st IUHPE World Conference on Health Promotion (Pattaya, 2013).</td>
<td>The International NGOs and other organisations are more actively involved in implementing advocacy for human rights, equity and social justice than the government.</td>
</tr>
<tr>
<td>Health promotion developments take support of cultural and religious (Buddhist) traditions for advocacy and behaviour change.</td>
<td>The Government’s approach of ‘giving to people’ rather than empowering them (self-management) is perceived a barrier resulting in people ‘obeying’ the government rather than working with the government.</td>
</tr>
<tr>
<td>The language and socio-cultural contexts are different from South Asia, Asia and WPRO countries.</td>
<td>Key barriers in the economic environment are poverty, inequality, unemployment, GDP focused strategies, consumerism and materialism, effect on agriculture and disagreement on issues related to alcohol and tobacco trade.</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Institutional Capacity</strong></td>
<td></td>
</tr>
<tr>
<td>Strong political will is demonstrated through the Prime Minister’s support to deliver health promotion activities and the chairing of Board of Thai Health.</td>
<td>Decentralization of health sector is being politically delayed and is impacting on the local authorities that have the potential to develop/improve their own population health.</td>
</tr>
<tr>
<td>Key legislations and decisions which pushed the country’s health promotion agenda forward include the National Health Act (2007) and the Health Promotion Act (2001).</td>
<td>Law implementation is a weak area in the political system influenced by powerful lobbies. Key barriers are corruption, conflicts of interest, abuse of power by the politicians and more focus on financial/economic issues.</td>
</tr>
</tbody>
</table>
Thai Health Foundation is an autonomous institution dedicated to health promotion development. A lack of sharing of resources and outcomes by the Thai Health Foundation is reported.

In addition the MoPH has a health promotion unit, Health Promotion Bureau within the national public health system. The MoPH categorises health promotion under health education and communication. The health system focuses mostly on a personal care approach and disease diagnosis and treatment rather than employing a collective approach to empower communities.

**Vision and Leadership**

Leadership for health promotion is visible and effective and various organisations have clearly defined leadership functions including academia (questionnaire). Lack of capacity for leadership (interview), commitment, and participation of local leaders, is also reported.

There is a clear understanding of the rationale for health promotion (e.g. NCDs) and that health promotion is about prevention and goes beyond health issues. There is little understanding of health promotion approaches.

The Thai Health Foundation (2001) and the MoPH are the key institutions providing national vision and leadership responsibility for health promotion in Thailand. MoPH envision health promotion as service-based (services provision and individual-focused) rather than society/community-based (environment, policy, community action, etc.). MoPH’s decision to structure health promotion and health communication into one Unit is leading to the Health Promotion Bureau loosing coordination and power.

Health professionals are given the WHO’s ProLead trainings for health promotion leadership. The participants undergoing training for HP leadership through ProLead feel that a gap exists between how they are trained to understand HP and its perception in the health system in Thailand.

**Transparency and Accountability**

Information regarding funding and regulation of health promotion activities is accessible. Most information about health promotion funding and regulation available to health personnel is not generated to public.

Accountability of organisations for the implementation of health promotion interventions is clearly specified within the regulatory/governance framework. There is lack of lobbying with public authorities for health promotion development.

Government ensures that the organisations and institutions performing health promoting activities report their actions to the relevant higher authorities regularly. Decreased level of adherence to accountability and transparency by the government and its partners is reported.

Thai Health Foundation is required by law to report annually to the Cabinet/House of Representatives/the Senate, and is subject to an audit by the Auditor General. Corruption and lack of transparency is reported as a barrier to health promotion development.

**Policy Environment**

National Policies and plans

The WHO Country Cooperation Strategy 2012-2016 includes health promotion and healthy public policy as one of the seven priority areas consistent with the priorities of the Tenth National Health Strategy/Plan (2007-2011). Dominance of economic issues, political conflicts, lack of transparency, are considered barriers to policymaking for health promotion.

Health promotion is part of the overall health policy. Thai Health Foundation has a central role in developing the national strategic plan for health promotion. There is reported lack of diversity of stakeholders, lack of understanding of health in all policies and social determinants of health, lack of finances and domination of ‘opposition’ trade policies.

Policies include support for implementation of empowerment strategies for Thai people in rural areas. The policymaking process needs to be more participative to address national health promotion policy needs.
### 6. Integration of Findings from Phase I and II Studies

<table>
<thead>
<tr>
<th>Area</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A national plan exists to guide health promotion policymaking and implementation.</strong></td>
<td>Frequent changes in MOPH/government, lack of self-reliance, understanding of health promotion and lack of commitment are reported.</td>
</tr>
<tr>
<td><strong>There are clearly defined health promotion functions in the national health system.</strong></td>
<td>There is little evidence that evaluation and monitoring of health promotion policies feed into future policy developments.</td>
</tr>
<tr>
<td><strong>Policy Coherence</strong></td>
<td></td>
</tr>
<tr>
<td><strong>There is awareness that HiAP is a key element to bring about policy coherence by bridging different existing policies to complement or support each other.</strong></td>
<td>There is lack of understanding on translating ‘health in all policies’ into action.</td>
</tr>
<tr>
<td><strong>Mechanisms exist in the government to ensure that public policies support the attainment of national health promotion objectives.</strong></td>
<td>Lack of inter-sectoral action and policy coherence across sectors, in particular, trade and transport are reported.</td>
</tr>
<tr>
<td><strong>Health Promotion Infrastructure</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Health Promotion Delivery</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Planning, implementation, monitoring, evaluation and health impact assessment are included as delivery mechanisms for health promotion.</strong></td>
<td>There is lack of health promotion needs assessment at country and regional levels.</td>
</tr>
<tr>
<td><strong>There is a high level of awareness about all five action areas of Ottawa Charter (questionnaire).</strong></td>
<td>There is lack of understanding of five action areas (interview).</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist workforce for health promotion exist as staff working in Thai Health Foundation, health technical officers, and specific health promotion workers in Government agencies.</strong></td>
<td>There are no practitioners with dedicated posts or job descriptions, which contain the title health promotion. Health promotion jobs seem to be fully integrated into routine systems with health workers trained on health promotion actions.</td>
</tr>
<tr>
<td><strong>There are courses in which health promotion is a module, a subject or a part.</strong></td>
<td>There is no specific training in health promotion and available health promotion education and training is not sufficient. Lack of established curriculums for health promotion is contributing to a lack of health promotion workforce and capacity.</td>
</tr>
<tr>
<td><strong>The national health workforce classification mentions ‘promotion’ under the scope of work for public health generalists who are non-medical professionals with 4 years of university education in a public health bachelor’s degree.</strong></td>
<td>Health promotion education and training need to be targeted to policymakers and mid-level health managers in addition to practitioners.</td>
</tr>
<tr>
<td><strong>The WHO is involved in identifying competencies and standards for health promotion practice, and, developing short courses through regional office.</strong></td>
<td>Too much focus on service-based health promotion and ‘over-loaded’ jobs of community health personnel are key barriers to workforce development.</td>
</tr>
<tr>
<td><strong>Health promotion and public health practitioners are given priority for training and education in health promotion.</strong></td>
<td>Health service managers are not a priority for training in education in health promotion.</td>
</tr>
<tr>
<td><strong>Partnerships</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Thai Health plays a central role in working with multi-sectoral and international agencies like the WHO and VicHealth.</strong></td>
<td>Conflicts of interest exist between various sectors regarding agriculture, alcohol, tobacco, etc. with international trade organisations.</td>
</tr>
<tr>
<td><strong>Strong’ partnerships exist between health authorities and other sectors and NGOs.</strong></td>
<td>Currently health promotion is limited to the activities of MoPH within the healthcare services framework and there is a need for it to involve other sectors.</td>
</tr>
<tr>
<td><strong>In the national PHC programme a strong network of volunteers exist as community health workers covering all villages in Thailand.</strong></td>
<td>There is a need for participation from the rural area and local government utilising the strong health volunteers’ network.</td>
</tr>
</tbody>
</table>
### 6. Integration of Findings from Phase I and II Studies

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fewer international donors are involved in health development assistance either due to Thailand’s rise in development status (low to middle income) or due to repeated coups.</td>
</tr>
<tr>
<td>MoPH partners more frequently with other government sectors and intergovernmental organisations</td>
<td>MoPH partners less with civil society and NGOs. Partnerships are weak between national, regional and local levels, and between private organisations.</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td></td>
</tr>
<tr>
<td>Effective and sustainable strategy exists for financing national health promotion development, health in all policies and non-communicable diseases (NCDs). It is funded by dedicated ‘sin tax’ collected from producers and importers of alcohol and tobacco.</td>
<td>Financial resources need to be channelled from other relevant government sectors.</td>
</tr>
<tr>
<td>The costs of the curative approach acted as the main factor influencing the creation of Universal Health Care Coverage Policy, and the Thai Health fund.</td>
<td>Health promotion is a low priority with the Ministry of Finance. MoPH requests for budget for health promotion result in having money for one year only and even that is cut in case of any outbreak or emergency.</td>
</tr>
<tr>
<td>The government funds health promotion through the National Health Security Act, (2002) to carry out health promotion activities in health facilities in parallel with curative care.</td>
<td>There is deficiency of workforce which has capability to develop strategies to use the budget allocated for health promotion activities.</td>
</tr>
<tr>
<td>The Act also supports “Community Health Fund” at the sub-district level to finance health promotion activities.</td>
<td>There is less knowledge about international funding for health promotion.</td>
</tr>
<tr>
<td><strong>Knowledge Development and Management</strong></td>
<td></td>
</tr>
<tr>
<td>Universities and research institutes initiate and participate fully in health promotion research.</td>
<td>The uptake of health promotion research by the stakeholders for health promotion action and interventions is not clear.</td>
</tr>
<tr>
<td>Professional expertise within the universities and research institutes are capable of carrying out health promotion monitoring activities and interpret outcomes and trends.</td>
<td>There is no local research to support five action areas of health promotion.</td>
</tr>
</tbody>
</table>

In the case of Thailand, the mapping of the domain Country Specific Context brings to light how socio-demographic characteristics of a country can impact on health promotion development including; population changes, the burden of diseases, the effects of globalisation and issues of human rights. The mapping illustrated how specific health issues are prioritised in Thailand and are given importance in the national health plans and policies. The mapping also focused on the history of the country to show how the health sector evolved, what key global strategies were adopted and how the health system was structured accordingly. Through the combined forces of a social movement and political will, policymakers were motivated to design policies that lead to the introduction of health promotion programmes and strategies based on the action areas laid out in the Ottawa Charter (WHO, 1986) and other health promotion charters and declarations. The mapping process identified how Thailand adapted its health promotion strategies and
programmes to local needs, taking into account the country specific social, cultural and economic environments.

Other key themes which emerged from mapping the Country Specific Context domain were the importance of the level of understanding about health promotion among national and international stakeholders, and the importance of health literacy as a bridge between the stakeholders and broader society’s understanding about health promotion. The benefit of reducing health expenditures by expanding health promotion approaches was also highlighted, as was the enactment of legislation on health promotion issues. The role of international agencies and donors’ responses to a country’s health promotion needs also emerged as being an important influencing factor. Overall, the main barriers affecting the broader development of health promotion at a country level were identified as being; poverty, inequality, unemployment, GDP focused strategies, consumerism and materialism, the effect of agriculture and disagreement on issues related to alcohol and tobacco trade. The decentralization of the health sector was also perceived as being politically delayed and thereby impacting on the health promotion capacity of local authorities and their potential to improve the health of their local populations.

Overall, gaps in health promotion capacity were identified as including the lack of suitable health promotion workforce capacity, the need for more stable financing, and developing more participatory policy approaches and greater intersectoral commitment.

The final mapping framework included the domains Governance, Policy Environment, and Health Promotion Infrastructure and 10 sub-domains. The accompanying mapping tool consisted of 41 open and close-ended questions. The data from the mapping tool identified a number of themes relevant to LMICs from the participants’ feedback, which are not sufficiently covered by existing mapping tools. These themes could be added in future mapping tools either as a domain or sub-domain.
Service-based health promotion: A number of participants made a distinction between ‘service or individual-based health promotion’ compared to health promotion focused on wider environment including policy, community action, to prevent disease and reduce risk factors. In Thailand, disease prevention was seen as being mainly focused on infectious diseases through vaccination, sanitation, etc. by the service providers. Thus, health promotion is perceived to be part of medicine, as an individual-focused health action. The ‘newer’ concept of health promotion that addresses factors like the environment, including smoking, alcohol consumption, exercise, unhealthy food, etc., was regarded as not being widely acknowledged. This new way of thinking about health and health promotion, addressing the general population with risk behaviours, and the role of health promoting environments was not seen as being widely understood in the society.

The feedback from the participants suggests that health promotion is still focused on individual and lifestyle factors in Thailand. This indicates a gap between research and programme implementation where public health programmes are still struggling to adopt health promotion strategies within the development agenda. According to a comment made by one of the study participants, some key stakeholders understand health promotion in a ‘health promotion care service’ context rather than in the social movement context which includes health in all policies. This is linked to the second point below regarding the understanding of health promotion by policymakers and politicians who were perceived as still considering health promotion as a ‘service’ provided in hospitals and clinics.

Understanding of health promotion: This is reported as a key barrier in advancing health promotion in Thailand. The importance of language is highlighted as participants commented that Thai people understand health promotion better when translated into their own language. Politicians and other national and international stakeholders were reported as having a lack of understanding about health promotion. Structural processes were also
6. Integration of Findings from Phase I and II Studies

seen as being related to this too as the activities of the MoPH were perceived as limiting health promotion to health education and communication activities. In other instances health promotion was reported to be ‘confused and overlapped’ with political dialogue, advocacy, communication, and public communication and there are varying levels of understanding of the concept of health promotion among various stakeholders. Absence of a ‘health in all policies’ strategy in ‘research and operations’ is also considered as a barrier to understanding health promotion while ‘scholars, health personnel, and some health activists’ are perceived as among the stakeholders who have a clear understanding of health promotion.

Health literacy and communication: Health literacy and health communication emerged as key themes from the analysis that future mapping tools need to include a greater focus on. These were found to help in understanding health promotion and bridging cultural and social obstacles in the implementation of health promotion programmes. A participant viewed them as useful concepts to use in addressing behaviour issues which may be difficult to understand (or be acceptable) in the East.

As the mapping exercise was a pilot activity, participants were asked to suggest dimensions of capacity which they found missing and could be added to the framework. Suggestions for new domains by the participants included:

- Governance: engagement by civil society, need for a flexible management system and strong commitment by the public (or public sector)
- Policy Environment: realisation of people at the community level that policies are not formulated by the elite class, lobbying of policymakers, and understanding of health in all policies.
- Infrastructure: empowerment of the local volunteers, health literacy and autonomy of the health promotion unit.
Several issues regarding the future use of capacity mapping tools were addressed in the discussion group. Different stakeholders have different perspectives and the capacity mapping tools need to be inclusive of these diverse views. In addition, health promotion covers a wide range of activities and the mapping strategies need to include coverage of the continuum of health promotion approaches and the different stages of development of health promotion policies and programmes at a given time in a country. The mapping tools should be able to record dynamic and multiple dimensions of the health promotion capacity domains, keeping in view the evolving nature of health promotion.

In terms of data analysis, consideration needs to be given to how the different types of information collected from the different data collection processes are combined to present results. The data from the mapping tools need to be cross-related and interpreted within the country specific context. Therefore, the findings from the survey need to be interpreted within the context of the data deriving from the participatory interviews and group discussions and vice versa. Likewise, the desk review process can also help with validating data derived from the other mapping tools. Further guidance on data analysis and interpretation will also help to guide the optimal use of the findings.

Regarding the use of the mapping tools, the tools can be used for policy advocacy, and as a resource to guide and empower personnel and institutions in developing health promotion planning processes. The tools need to have a built-in ‘learnability’ especially with regards to how the data can be used by the workforce in developing health promotion capacity in the health system, using a whole systems approach. Special consideration must be given to the use of language and the cross-cultural comprehension and interpretation of health promotion concepts in order to facilitate a better understanding of the mapping process and its constituent elements.
7. Discussion

7.1 Introduction
This study set out to explore the specific contextual factors that influence country level health promotion capacity in an LMIC context and aimed to develop a capacity mapping conceptual model and data collection process that addressed these factors. This chapter will discuss the implications of the study findings and will consider the specific value of the new mapping framework and tools in comparison with other existing tools, with particular reference to their application in the context of LMICs.

As outlined earlier, this study had a number of specific research objectives, all of which have been met, including:
- Conducting a review of the international literature concerning conceptual frameworks and methodologies for health promotion capacity mapping and identifying a conceptual model and set of core domains suitable for mapping health promotion capacity in LMIC contexts.
- Achieving consensus among a panel of global health promotion experts regarding a conceptual framework and a proposed set of core capacity domains for mapping health promotion capacity in LMIC contexts.
- Developing a capacity mapping process and set of data collection tools, based on the consensus building process, suitable for use in an LMIC context.
- Testing the mapping framework and data collection tools within an LMIC context.
- Making recommendations for research and practice, based on the study findings, regarding the development and implementation of health promotion capacity mapping in LMIC settings.

The study builds on and extends the earlier the work of the WHO on health promotion capacity mapping (Catford, 2005; Lin & Fawkes, 2005;
Mittelmark et al., 2006; WHO, 2010e). It also takes into consideration the work of Aluttis et al. (Aluttis, Chiotan, Michelsen, Costongs, & Brand, 2013) that was conducted in the European context. A mapping framework and questionnaire tool were developed through a review of the international literature, and a consensus building exercise using Delphi technique. The mapping framework and tool, was tested in a selected LMIC, Thailand, employing a case study design. The mapping methodology included a questionnaire, a desk review, semi-structured telephone interviews and a face-to-face group discussion with national level key informants. The mapping was successful in gathering relevant information on the country-specific context and existing development of health promotion infrastructure in Thailand.

The final capacity mapping conceptual framework consisted of four domains - Governance, Policy Environment, Infrastructure, and Country Specific Context. Each domain, except the Country Specific Context, was further themed into 10 sub-domains as follows:

3. Infrastructure: Health Promotion Delivery, Workforce, Partnerships, Financing, and Knowledge Management
4. Country Specific Context

The final capacity mapping framework and data collection tools have a number of unique features that make a specific contribution to the literature on health promotion capacity development globally. From the outset this study had an explicit focus on developing a conceptual framework that would be suitable for use in LMIC contexts. The majority of existing mapping tools are either developed in HIC contexts or are developed as generic frameworks that could be used across countries. This study sought
to embrace a LMIC perspective from the outset and this was accomplished through adopting a number of specific steps in the development of the study.

The review of the international literature included a focus on the international development literature alongside the public health and health promotion literature in order to identify capacity domains that would be particularly relevant to the development context in LMICs. In addition, the development of the framework and tool was based on a consensus building process with a panel of global health promotion experts with particular experience of working in a LMIC context. This was to ensure that the content of the mapping framework and tools would be meaningful and appropriate to LMIC contexts.

The process of developing the framework and tool also sought to build on the strengths of existing capacity mapping frameworks and tools and where possible to address identified weaknesses. These are outlined further in this chapter. There was a particular effort made to incorporate country specific contextual factors in the mapping framework and tool, in order to capture those country level factors that influence and shape the development of health promotion within the challenging contexts of many LMICs. As the findings from this study show, the inclusion of this county specific lens is a critical component in the overall mapping process and is particularly important in analysing and interpreting the data from a specific country perspective.

The framework and tool were piloted in a LMIC in order to explore the specific practical and methodological issues that arise when mapping health promotion capacity in LMICs and these are discussed further in this chapter. Likewise, how the mapping process could be used to guide and inform future health promotion development at the country level was also explored.

The result is a capacity mapping conceptual framework and data collection process that was developed specifically for use in a LMIC context and was
successfully applied and tested at a country level. This is an important addition to the global health promotion literature in view of the paucity of current research on health promotion capacity mapping and development in LMIC contexts. The specific value of the mapping framework and tool developed in this study, together with the specific issues that arose in the data collection process and the wider implications of the findings, will now be discussed further in the context of the current literature.

7.2 Comparison with existing frameworks and tools
The literature review highlighted the paucity of research on health promotion capacity developments in LMICs. The double burden of communicable and non-communicable diseases and the challenges of globalisation (CSDH, 2008), present a complex situation in terms of setting health promotion objectives in LMICs. Policy experts indicate the need to include the social determinants of health, such as poverty, social and economic rights, social justice and environment, in the broader development agenda and public health policies of LMICs (Lethbridge, 2001). While some studies point to the need for the development of health promotion capacity and infrastructure in LMICs (Battel-Kirk & Barry, 2010; Catford, 2005; Sparks, 2007) the literature is not clear on what are the specific needs of health promotion capacity development in LMICs.

In this study, capacity domains suitable for use in LMICs were identified from the available literature in health promotion, public health and international health development (Section 2.6). The common capacity domains identified were governance, policy, workforce, information and monitoring systems, infrastructure and partnership. Through the inclusion of literature from areas such as international and human development, key health promotion related issues like human rights, ownership, policy coherence, health promotion system approach, etc. were considered during selection of capacity domains. The domains were defined and described in an accompanying Glossary.
In this study, the existing literature regarding the development and implementation of capacity mapping tools across the globe was examined by identifying six existing frameworks and tools from health promotion literature. Out of these six, two were from Australian and Canadian health systems (country level initiatives) and four from the WHO regional initiative on health promotion capacity mapping (Catford, 2005). These were analysed for strengths and weaknesses to inform the mapping strategy adopted in the study. The analysis examined these tools from various perspectives: domains covered, terminology, structure, format, theory, approach used to implement (systems approach, participative, dialogue-based), methodology, evidence base, validity / reliability, etc. A summary of the strengths and weaknesses of these frameworks and tools is shown in Table 7.1.
Table 7.1 Strengths and weaknesses of health promotion capacity mapping frameworks and tools

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NSW, Australia</strong></td>
<td></td>
</tr>
<tr>
<td>theory based indicators (quality focussed)</td>
<td>does not address capacity issues at regional/national levels</td>
</tr>
<tr>
<td>top down and bottom up approach</td>
<td>lacks health promotion capacity infrastructure assessment</td>
</tr>
<tr>
<td>comprehensive coverage for assessing multi-level workforce capacity</td>
<td>lack of a qualitative methodology</td>
</tr>
<tr>
<td>emphasis on problem solving through learning</td>
<td>requires experienced health promotion practitioners to execute</td>
</tr>
<tr>
<td>tested for validity and reliability</td>
<td>project still in development (lack of literature on evaluation)</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td></td>
</tr>
<tr>
<td>structured approach</td>
<td>tools in development stage</td>
</tr>
<tr>
<td>mix of qualitative and quantitative methods</td>
<td>personnel and time required to map</td>
</tr>
<tr>
<td>multi-sectoral and participative methodology</td>
<td>cultural and language barriers</td>
</tr>
<tr>
<td>dialogue based process and stakeholders’ consensus building (enhances reliability)</td>
<td>lack of availability of data in some domains (especially health promotion financing)</td>
</tr>
<tr>
<td>reports describe methodological limitations</td>
<td>country contextual factors not well reflected in the methodologies</td>
</tr>
<tr>
<td>systems approach of a country’s health promotion system</td>
<td>no indication of cost of implementation</td>
</tr>
<tr>
<td>capacity analysed with comparison to human development indicators</td>
<td></td>
</tr>
<tr>
<td>evidence based use of tool in other countries</td>
<td></td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td></td>
</tr>
<tr>
<td>theory-based</td>
<td>practice focused only</td>
</tr>
<tr>
<td>well-structured survey</td>
<td>reliability and consistency tests not conducted</td>
</tr>
<tr>
<td>face validity and acceptability with practitioners and managers established</td>
<td></td>
</tr>
</tbody>
</table>

Based on this review of the existing frameworks and tools, the following key issues were identified as needing to be addressed in the new framework:

- The mapping framework and tool for LMICs need to be supported by evidence and informed by theory
- Country contextual factors should be well reflected in the methodology including issues such as language and cultural barriers
- The mapping process should be participative and include a dialogue-based processes involving a wide spectrum of stakeholders
The mapping data collection process should be based on a mixed methods approach

The mapping tool should be reliable and valid

This study was successful in addressing these points and in addition, the findings highlighted a number of other key areas that had specific relevance for LMICs. The subsequent sections in this chapter describe how the development of the new mapping framework and tools in this study sought to address the shortcomings of the existing tools along with some additional themes that emerged during the development of the mapping process and their implication for future research. The selection of capacity domains, development of the mapping framework and tools, and implementation of the mapping process in Thailand, took all these factors into account in this study.

7.3 Evidence and theory informed mapping

This study sought to contribute to the existing literature on health promotion capacity mapping frameworks and tools by exploring the application of a conceptual model and mapping tool within a specific LMIC context through use of a multi-method mapping process. The mapping methodology includes a template for conducting a desk review prior to the mapping activity, a detailed mapping survey instrument, and a dialogue-based participatory process conducted with key stakeholders including interviews and group workshops with senior level national health promotion experts.

The study gained important insight into the country level factors that influence health promotion development both at the level of policy and supportive legislation, socio-economic and political developments and key cultural factors and social movements in Thailand. The mapping questionnaire, supplemented by a dialogue-based process of interviewing key health promotion experts, highlighted areas within the country’s broader development which influence and shape the nature of health promotion activities. The study also identified the existing strengths and gaps in the
country’s governance, policymaking and programme implementation structures and mechanisms. This information can be utilised at the national level to develop strategies to further strengthen capacity in areas that are weaker and to build on the country’s strengths to improve the health of its population.

This study adds to the existing evidence on health promotion capacity mapping at country level in LMICs. Health promotion capacity mapping is an activity carried out by the WHO at regional level since 2005. The last report published by the WHO reported on the mapping of the EMRO region in 2010 (WHO, 2010e). While country level mapping was done in a number of WHO member countries, there are no publications that are publically available on mapping in individual countries. Neither is there any published evidence on the utilisation of the mapping results for health promotion development or capacity development in any LMIC. Many global development and health agencies have emphasised the importance of health promotion development in LMICs but there are few published reports on current efforts for strengthening country level health promotion capacity development. The case study in Thailand serves as an example of how country level capacity mapping can be conducted and how the data could be used to inform future capacity development.

The study focused on capacity mapping as an important tool in supporting both global and national agencies in carrying out initial situation assessments in countries where health promotion is lacking or deficient or in developing stages. The findings of the study are an addition to the growing awareness, and emerging evidence, that health promotion is a sustainable approach for LMICs. This can play a vital role in addressing the social determinants of health through strengthening health promotion programmes and capacity development (CSDH, 2008; WHO, 2009a, 2009g). International networks and institutions can support the development of health promotion capacity. However, developments need to be embedded
and strengthened at the local and national levels, as part of the process of mainstreaming health promotion into policy and practice. This study fills this gap by illustrating how a capacity mapping process can produce valuable data at a country level of those specific factors need to be addressed in order to bring health promotion to the forefront of development process in LMICs.

The study shows that in Thailand, community health promotion developments have successfully utilised the value of local knowledge and traditional culture in translating or adapting health promotion objectives to a culturally appropriate context. These community-based assets could lead to the discovery of innovative ways of addressing community and local health concerns. The data collection tools are sufficiently flexible to allow for modification to suit a particular country’s needs.

The study allows inclusion of elements in the mapping process such as human rights, equity, freedom and social justice within the country context and governance which remain the ultimate aims of progressive health systems worldwide. As the world is becoming more globalised, health issues are becoming similar in HICs and LMICs e.g., the rise of non-communicable diseases. Many LMICs have a long tradition of health development (Sparks, 2013) and health promotion is well placed to address contextual issues of political, sociocultural and economic nature which lie outside the realm of health sector.

7.4 **Country specific contextual factors**

This study set out to map capacity areas beyond infrastructure by addressing the country-specific context, governance and policymaking issues relevant to capacity development. The WHO defines health promotion infrastructure as ‘human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide health promotion response to health issues and challenges’ (WHO, 1998). The new framework and mapping tools embrace a whole
7. Discussion

A systems perspective that includes mapping social movements, historical landmarks in health development, assessing the situation in the country regarding human rights, and the effects of existing political paradigms and conflicts. This information is gathered through a participative process.

The study shows that including contextual factors in the mapping process can have multiple uses for both national and global stakeholders. With the growing evidence of the potential contribution of health promotion to poverty alleviation, health equity and decreasing the burden of diseases, especially non-communicable diseases (include key refs here), capacity mapping becomes an important activity for LMICs. The stakeholders can utilise the mapping tools to assess the national and local situation to help implement health promoting programmes and initiatives. A capacity mapping process provides stakeholders and decision-makers at various levels with an initial assessment of existing assets and gaps in health promotion capacity, including governance, policymaking, and infrastructure. This assessment can facilitate the necessary planning for strengthening the health system and related cross-sectoral structures for implementing health promotion initiatives targeted at priority areas. The mapping of existing capacities serves as the starting point for developing country level health promotion policies and plans to address priority health issues.

The study shows that the mapping process needs to address the national and local capacity needs. Many LMICs lack health promotion policies especially at national levels. The information collected in the mapping process can be utilised to support policymaking at all levels. The mapping of the existing situation can inform policy development by identifying areas where health promotion action is needed. Governance, policy, infrastructure and the country-specific context for health promotion constitute the basic elements of the health promotion system at a country level. The mapping framework and tool provides data and information for considering how to strengthen a
country’s capacity in these areas through a whole-system approach involving a participatory process with key stakeholders. The data collected from the mapping provides a base for health promotion knowledge development. Knowledge Management consists of using this knowledge to develop capacity for health promotion research, information systems, performance improvement, evaluation and monitoring to promote health and strengthen national health system.

The mapping process in the study provides information about the country’s existing assets, strengths and resources to build on and promote health at various levels. In the health promotion capacity literature the terms ‘strength’ and ‘asset’ are used interchangeably and the latter is used more in the case of workforce, community development or social capital (J. McLean, 2011; S. McLean, Feather, & Butler-Jones, 2005; S. McLean et al., 2004). In this study, from a health promotion perspective, strengths and assets are considered as the positive potential which a country possesses to promote health promotion, encompassing all the capacity domains, including workforce and leadership. A popular model presented by Morgan (2007), in the context of failing policies with regards to health inequities in Europe, utilises asset mapping to fill the gap (A. Morgan, 2014; A. Morgan & Ziglio, 2007). Using a salutogenic approach, Morgan highlights an important difference between disease prevention and ‘creation of health’ and advocates for identifying health promoting assets across all domains of health determinants. He defines a health asset as ‘any factor (or resource), which enhances the ability of individuals, groups, communities, populations, social systems and/or institutions to maintain and sustain health and well-being and to help to reduce health inequities’ (A. Morgan & Ziglio, 2007). While the authors refer to enhancing the ability of populations and systems, the concept at present is focused more on community development and not at a country level. Nevertheless, a salutogenic perspective on country level asset mapping could augment the mapping activity for health promotion capacity development.
Country level capacity mapping needs to be an essential and initial part of health promotion capacity development in order to provide the stakeholders with an assessment of what strengths and gaps exist and where the focus for development needs to be. Linked to this is the fostering of a better understanding about health promotion, which a capacity mapping process can contribute to by serving as a learning process. The need for this was very clearly illustrated in the present study. The capacity mapping process can also be an effective strategy for identifying health promotion capacity and resources outside the health sector.

7.4.1 Contribution to health systems in LMICs
Health promotion plays a vital role in strengthening health systems in LMICs. It has paved the way in changing how health is perceived and understood, both within and outside the health sector. This has been instrumental in shifting the focus from medically focused activities to broader strategies addressing the social determinants of health. At the core is the change in the understanding of health in various settings in public health and non-health sectors. Many countries are adopting health promotion strategies as sustainable actions to address health and development issues but many health promotion efforts fail to become sustainable because insufficient resources are provided in a short to medium time frame (Swerissen & Crisp, 2004; Whelan et al., 2014). Sustainable development and sustainable health promotion action is one of the ethical values underpinning health promotion core competencies for health promotion professionals (Dempsey, Battel-Kirk, & Barry, 2011). Health promotion provides a strong evidence-based foundation for sustainable development programmes through multisectoral action and advocacy for implementation of healthy public policies (Delobelle, Fisher, & Corbin).

This mapping process developed in this study acknowledges the importance of sustainable health promotion strategies and looks at capacity development as a part of sustainable approach for addressing existing and
emerging health promotion issues in LMICs. This is reflected in the mapping questionnaire under the domains of Health Promotion Delivery, Country Specific Context and Financing (Question numbers 34 and 37 in Appendix N). Understanding the importance of sustainable health promotion, especially by policymakers, researchers and practitioners, is crucial for health development (WHO, 1986) and demands an understanding of health promotion concepts and how they are positioned within the broader public health framework. Capacity mapping can also assist in increasing this understanding at a country level and also supports the process of embedding health promotion into mainstream health policy and service delivery. Other issues relevant to health systems strengthening in LMICs is that mapping methods are capable of addressing issues beyond the conventional scope of health systems, through multisectoral, participative and a Health in All Policies approaches.

In this study the terms ‘country level’ and ‘national’ have been used interchangeably but it is important to understand the difference between the uses of these terms. The term ‘national’, as defined by (Mittelmark, Perry, Wise, Lamarre, & Jones, 2007), refers to sovereign states and includes regions other than sovereign states that have been delegated the main responsibility for health promotion. Further exploration of the terms highlights the complexity surrounding the issue, and therefore, it was decided to use the term ‘country level’ for ease in understanding. However, the matter is important with regards to determining the level at which the contextual factors, particularly political and economic contexts, influence health promotion development in LMICs.

This also include the issue of selection of suitable terminology like ‘LMIC’ among other terms like ‘developing countries’, ‘third world countries’, ‘least developed countries’, etc. Most international approaches (United Nations, World Bank) utilise an income-oriented approach to collect data on health status of countries, which conflicts with the concept of capacity
particularly in the case of health promotion. For the purpose of this study the term ‘LMIC’ is used following the World Bank classification. This also links with the role of international development through various agencies, inter-governmental organisations (UN, World Bank, etc.) within the national development framework of LMICs, which cannot be overlooked. Issues like ‘aid dependency’, ‘aid effectiveness’ and the role of donor organisations in LMICs make country situations more complex by influencing the existing structures and mechanisms in positive or negative ways (MacLachlan, McAuliffe, & Carr, 2010; Moyo, 2009). This could help in understanding the contexts that influence policy and programme development for health promotion in LMICs.

Another accompanying issue is whether health promotion is a concept which is suited to the needs of LMICs. The concept originally emerged from the context of ‘industrialised countries’ but took into account similar concerns in all other regions especially in the health promotion charters and declarations succeeding the Ottawa Charter (McPhail-Bell, Fredericks, & Brough, 2013). This highlights the need to include the discourse of international development within the capacity mapping discussion especially when considering LMICs. Health promotion has multidisciplinary foundations and it is still an evolving field. This gives it ample scope to address the contexts in which various concepts, strategies and interventions evolve. The findings from the present study support the need for further research to elucidate the socio-cultural and political factors influencing the development of health promotion in countries which are or were e.g., colonised, countries with ongoing political conflicts, war and epidemics, rather than imposing approaches and interventions from more developed countries.

A key question that arises from the study findings: can capacities which are health promoting, but ‘hidden’ in non-health sectors (community workers, parents, teachers, social workers, primary health care workers etc.), be
capitalised by the health systems in LMICs and how can national health promotion be enabled to use this capacity from the non-health sectors? This issue is very much at the core of adopting a Health in All Policies (HiAP) approach (WHO, 2013). The concept of HiAP or Healthy Public Policies emerged from the health promotion movements in 1980s. At the 8th Global Conference on Health Promotion at Helsinki, Finland, the WHO issued The Helsinki Statement on Health in All Policies which states that ‘HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity’ (WHO, 2013). With regards to LMICs, health is prioritized as a shared goal of public policy in the national development plans, and requires ‘strong institutional capacities and accountability mechanisms’ (Cook, Zhang, & Yi; WHO, 2013). HiAP, through partnerships with non-health sectors, can mobilise and optimise the potential of hidden health promotion capacities for national capacity development. This could be achieved through developing leadership and technical expertise, both of which are included in the mapping framework and tools in this study.

Linked to this is the issue of lack of ‘well-defined’ health promotion components which may not exist or may not be labelled as health promotion. These capacities may be difficult to capture, especially if there is not a clear understanding of what constitutes health promotion and how other sectors can contribute, as was found in the present study. However, within the health sector some of these capacities could be identified through the questions included under the sub-domains of Institutional Capacity and Workforce (See Appendix N, Question numbers 2 - 6, and 23 – 30). A similar issue was reported by (Lin & Fawkes, 2005), that countries following the Ottawa Charter (WHO, 1986) framework for health promotion capacity development may well have different capacities developed outside the health sector. This, coupled with limited resources for health promotion within the health sector, can reflect a capacity profile,
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.

A single mapping protocol cannot be used in different contexts, situations and countries. The capacity domains which are common to existing mapping frameworks and tools are health promotion infrastructure, policy and to a certain extent, governance (Section 2.5). The themes (items in the questionnaire) covered in these domains reflect a HICs perspective and cater well to the health promotion needs to this group of countries. In addition, these tools lack a focus on the country specific contexts which lie at the core of understanding capacity mapping, especially in the case of LMICs. Differing cultural, social, economic and political conditions require different levels and types of capacity for effective health promotion and need to be interpreted in considering those contexts. This is also influenced by the health priorities that are set in different countries.

The mapping framework and tools developed in this study could be used for mapping health promotion capacity in many countries worldwide. What makes this mapping process specific for LMICs are the details within the themes covered in the questionnaire items, together with the dialogue-based processes (interviews, discussion group) and desk review which have an explicit focus on mapping the country specific contexts. The mapping process needs to capture and assess the country level factors which can promote health promotion capacity in LMICs: participative policy making and health promotion delivery, transparency and accountability, policy coherence, financing of health promotion, and most importantly the contexts that influence policies and delivery, taking into consideration historical, political, economic, and sociocultural environments.

7.4.2 Understanding health promotion and mapping
A central issue faced during the development of the conceptual framework for mapping health promotion capacity at the country level was to portray
the nature and scope of health promotion which would be easily understood by the respondents. This included issues such as defining health promotion, its concepts and principles, where it is positioned within the health system, and what approach is taken to implement its strategies. The challenge of understanding the concept of health promotion is reported to be faced by researchers (De Leeuw, 1989), policymakers and practitioners (McKinlay et al., 2005) alike. Being a multi-disciplinary field (Bunton, Macdonald, & Macdonald, 2003; Edmondson & Kelleher, 2000; Orme, de Viggiani, Naidoo, & Knight, 2007), different countries interpret health promotion concepts according to their specific contexts. To develop the capacity mapping framework, public health and health promotion literature was not found adequate to address the health promotion capacity needs of LMICs. A multidisciplinary approach, which allowed for integrating health promotion within the broader national development agenda, was adopted for the development of the mapping framework in this study.

The global health promotion literature envisages health promotion as an ‘approach’ embedded within public health. According to the WHO, health promotion, through its holistic and intersectoral approach, acts as a ‘vehicle’ for public health to address the social determinants of health and is embedded as a ‘component’ within public health policies and programmes to reduce the burden of priority public health problems and inequities (WHO, 2009g). A lack of capacity at a country level to put health promotion into practice is considered as a gap that threatens and limits the realization of ‘public health goals’ (WHO, 2009g). Statements like these lack ‘concreteness’ in positioning health promotion in the broader frameworks of the health system and health sector. This ambiguity around the positioning of health promotion within the health system creates confusion and can generate a lack of understanding among various stakeholders. In the case of Thailand, health promotion is seen on one hand as a public health programme within the Ministry of Health, which is more individual focused, and service based confined to hospitals and clinics. On the other hand, the
autonomous institutions like to see it as an intervention to build healthy public policies, involving multiple sectors.

The study found that the progress towards mainstreaming health promotion within a country’s broader development agenda is a slow process especially in the case of LMICs where most are still grappling with predominantly medical and preventive approaches. Historically health promotion is borne out of WHA resolutions (42.44, 51.12, 55.23) in the ‘spirit of Alma Ata’ (Catford, 2005). The WHA acknowledges that health promotion’s crucial role in all areas of public health represents a ‘powerful policy lever’ and urges the health promotion community to drive health promotion into the mainstream of public health practice. In converting WHA resolutions into concrete actions, the WHO Member States are expected to acknowledge the essential role of health promotion by clearly delineating the application of health promotion implementation strategies across all public health programmes and integrated into health policy implementation, and not be implemented as a fragmented and isolated programme area’ (WHO, 2009g). These resolutions promoted the Ottawa Charter as a ‘worldwide source of guidance and inspiration for health promotion’. Catford was of the view that this Charter, being an important source, should be complimented with ‘innovative and authoritative advice’ particularly for LMICs (Catford, 2005). The selection of capacity domains in this study, specifically in relation to Governance and Policy Environment, aimed to address these factors and to depict health promotion and its principles in accordance with the global health promotion literature.

The mapping process and methods suggested in the study acknowledge that while the ‘flexibility’ within health promotion indicates the potential to accommodate and identify suitable capacity domains from a wide variety of disciplines, it also emphasises a need to ‘demarcate’ its scope especially when it comes to positioning health promotion within public health. From a values perspective, which was found to be of key importance in mapping
capacity in LMICs, health promotion has well defined ‘principles’ (WHO, 2009e) very much at par with international and human development. These principles, especially those on human rights, equity and social justice, lie at the core of health promotion plans (Dempsey et al., 2011). To develop a fertile policy ground for health promotion where human rights, social justice and equity can be nurtured is a priority for any LMIC to be able to achieve its development goals. The conceptual framework and the mapping tool developed in this study particularly focused on these development issues in an effort to address the health promotion capacity from a more whole-system perspective. The mapping tool is capable of collecting relevant data on these core issues through the capacity domains of Governance, Policy Environment and sub-domains addressing equity, freedom and rights, transparency, accountability and participation. The mapping methodology is designed to collect information which can provide insight into the country’s development as well as how these can contribute to the development of health promotion.

This study takes into consideration an understanding of health promotion’s significant role in global health diplomacy. The study portrays health promotion as an essential component of national and global health governance, particularly in the areas of promoting health literacy and community empowerment and mobilization. The study’s emphasis on intersectoral action and a Health in All Policies approach (Questions 7 and 14 in Appendix N) can help locate and channel resources within the non-health sectors towards the improvement of population health and development. The mapping tools, as instruments for advocacy, highlight the importance of understanding and mapping these elements for the stakeholders.

It is important to assess the level of understanding of health promotion of the experts in the country where health promotion capacity is being mapped. This affects, in turn, how the key informants understand what is being asked
of them during the mapping activity and thus influences the quality of information being collected. Many countries are striving to develop a better understanding of the concepts of health promotion, especially those who want to develop or incorporate health promotion policies into the health system or implement programmes. While agencies like the WHO provide guidelines and technical support, it is essential for a country to produce its own qualified health promotion staff and professionals to conduct local research and programme planning. The professionalisation of health promotion practice in LMICs could mean that practitioners can interact, compete and collaborate with other health professionals on an equal footing (Nyamwaya, 1996). This need for advocacy in support of health promotion at all levels could be addressed by global health promotion organisations like the IUHPE through its conferences, publications and various global activities.

Health promotion is also often equated with health education and this issue influences the understanding of health promotion in many countries. Some common issues faced during implementation of capacity mapping include the fact that Government personnel in LMICs may be more involved in the delivery of health education programmes, the workforce is skilled in information/communication/education strategies rather than advocacy, and partnerships are primarily engaged around programme development and delivery rather than healthy public policy (Lin & Fawkes, 2005). This was also the case in Thailand where some participants reported a similar perception, which was noted as an obstacle to health promotion development. This is not unique to LMICs in that in the United States health promotion is frequently equated with health education (E. H. Howze, Auld, Woodhouse, Gershick, & Livingood, 2009).

The mapping process takes the stance that health education is a component of health promotion. In most situations health education is equated with health information particularly in clinical settings. To engage in health
education, information needs to be accompanied with a change of perspective and insight into how actions or beliefs need to change. For health education to result in health promotion, action on this information needs to occur. These concepts are well reflected in the accompanying Glossary of terms provided with the mapping tools. The Glossary serves as a database of definitions and explanations of various terms like advocacy, health promotion action, health education, etc. to help participants understand the perspective well according to the existing global standards and literature. This constitutes an important dimension of mapping to bring ‘visibility’ to the concepts and practice of health promotion with regards to under estimation of health promotion capacity assessments due to frequent use of terminology that is more suitable for administrators and health bureaucrats as compared to that of the Ottawa Charter.

7.5 Mapping as dialogue-based and participative process
The mapping carried out by this study was participative and dialogue-based in nature. It focused on ‘sharing information’ with the aim of learning about and strengthening health promotion capacity. At the country level, ideally the participants need to join from a broad range of stakeholders – international, regional, national, local, academia, research, policy, practice, public, private, non-government, health and non-health sectors including the civil society.

The study differs from the methodology adopted by the WHO by involving a wide range of stakeholders from areas such as research, academia, policy, practice, public, private, etc. In the WHO mapping process, the key informants are usually the WHO staff from the regional offices that provide preliminary information and data from relevant WHO reports (Lin & Fawkes, 2005). The questionnaires are then sent to contact persons in each country in the region who use various approaches to collect information from senior health promotion staff, international and intergovernmental organisations, MOH personnel, etc. This approach creates a gap and risks making mapping a top-down activity. In terms of LMICs, a process like
mapping needs to be a participative and empowering and calls for a local mapping strategy to be utilised according to the country’s health promotion needs.

During the development of the framework and tool in this study, both national and global stakeholders, were kept in view. One of the main reasons that the mapping process revealed a wide range of issues was the breadth and diversity of views and information received from the participants coming from a diverse range of backgrounds. Some personnel from IGOs (intergovernmental organisations), ministries of health and NGOs were found to be difficult to contact or not able to provide relevant information due to the policies of the organisations in which they were employed. This was experienced both in Phase I and II of this study. Because of the nature of the information, and the fact that the mapping was being conducted at national level involving senior officials, processes like these require prior permissions and approvals. This can be quite time consuming but is important in ensuring that the information collected will be relevant and valid.

Usually health promotion is not a key focus in LMICs, and even in a country like Thailand with a good track record of health promotion, capacity mapping was not perceived as a common practice among the national stakeholders. A good collaboration is necessary between the national stakeholders and the global organisation that is carrying out the mapping. There needs to be a balance between the agenda of the global organisation and the national aims for health promotion in the recipient country. A good representation of key stakeholders is of vital importance especially from the non-health sectors, NGOs and the civil society. Even if the activity is financed by an external agency, the country needs to have ownership of the process and be able to use the findings according to their national aims and not feel obliged to follow the agency’s timeline or agenda.
Historically mapping tools have been used or sponsored by global agencies (GTZ- SfDM, 2005; UNDP, 1998, 2007). In LMICs, global agencies are more likely to conduct the mapping, as has been done by the WHO in the past. There is no evidence that a country has taken its own initiative to map health promotion capacity. This leads to several issues: global and national stakeholders may have different agendas, and a number of issues arise regarding ownership of information and policy coherence. In addition, there is limited available evidence of how the findings of the regional and country level capacity mapping undertaken by the WHO (Lin & Fawkes, 2005; Mittelmark et al., 2006; WHO, 2010c) have been used to strengthen regional or country level.

7.6 Static vs dynamic capacity
An important part of the feedback received from the case study was the perceived inability of the mapping tool to capture the changes in capacity. Health promotion capacity is evolving and capacity development has to respond continuously to the changing health promotion landscape including; changes in socio-economic and political situations; levels of development of various health promotion strategies, policies and programmes; rapid changes in communication and information technology, knowledge development and the increasing influence of globalisation. The health promotion literature and the existing tools for capacity mapping produce a ‘point-in-time assessment’ of capacity. These assessments or blueprints may lose their relevance over time. Institutions and governments need to adjust quickly to changing environments both domestically and globally. The mapping tools should be robust enough to be able to assess the national health promotion capacity in the context of changing demands, including determining the ability of a country’s health promotion capacity development to respond to changing circumstances. This will require the development of more dynamic and adaptive capacity mapping tools and systems that can be implemented in a more flexible manner.
7. Discussion

7.7 Tiered approach for capacity mapping
Country level mapping is not a quick process but requires a considerable time to complete. Time consuming activities include identifying stakeholders, engaging stakeholders in the process, getting the questionnaire completed by the necessary key informants, undertaking desk review and getting buy-in to a participatory process by key leaders at the national level. The WHO developed two versions of the mapping tool, short and expanded, and the stakeholders were asked to choose which one they wanted to complete (Lin & Fawkes, 2005; WHO, 2010e). The mapping tools in this study do not make this distinction. The participants of the discussion group suggested that the tool could be designed in such a tiered format: (1) a mapping tool for LMICs with developed health promotion policies or institutions, and, (2) a mapping tool for LMICs without a health promotion policy or institution. These suggestions were made due to the fact that the questions regarding various existing policies and infrastructure become inapplicable if a country does not have those in place. This is an issue which can be considered in future developments of the mapping tools.

7.8 Methodological strengths and limitations
A wide range of methodologies have been used for mapping health promotion capacity as outlined in the literature review. This study adopted a mix of approaches building on the earlier work of the WHO Europe and Western Pacific regional offices. The literature advocates developing models of best practice and constructing typologies of capacity that are suited to various purposes by examining the concept of capacity across different countries through a combination of qualitative and quantitative methods, such as the triangulation approach that was used in Europe (Mittelmark et al., 2006).

The present study achieved its objectives by employing a mixed methods approach. Phase I of the study comprised of developing a conceptual framework and a tool for mapping health promotion capacity at country level in an LMIC context. These were developed through a comprehensive
literature review and a consensus building process through two rounds of Delphi consultation among global and national health promotion experts. In Phase II the mapping tool was tested in an LMIC, Thailand, employing a case study approach which consisted of a desk review of policy developments, key informant interviews, online questionnaire and a face-to-face discussion group with key stakeholders. The study started with a global health promotion reference point and developed a conceptual framework to closely focus on at the country level in LMICs. Then taking the country level as a reference point the mapping framework and the tools were tested with senior level national stakeholders.

The use of the mixed method approach is identified as a key strength of this study. The approach utilised a consultative process, not found commonly in research, to understand health promotion capacity mapping in LMICs. The consultations were conducted at both a global (Phase I) and national (Phase II) level. In addition, the case study provided an opportunity to test the findings from the consultative processes. The study was conducted in a phased manner and each phase built on the previous phase. The diversity of methods employed, capacity mapping issues covered, and the range of study participants from various backgrounds enriched the findings of the study.

The main limitation of the study was its inability to capture fully the range of issues that are pertinent for health promotion capacity in LMICs contexts worldwide. Many issues like governance, transparency, policy coherence, country specific contexts, and country level health promotion capacity are not well researched in the health promotion area but are found to be the main elements for capacity development in LMICs. The case study research would have benefitted from a more detailed and in-depth mapping process in the field, ideally from more than one LMIC at differing levels of development. Being a doctoral study, however, there were practical constraints of resources and time, which limited the scope and breadth of the study.
Another key limitation of the study was the sampling frame that could be used, both in Phase I and II of the study. The level of engagement required that senior global and national stakeholders should have sufficient expertise, interest and commitment to be involved in the consultations. Officials from ministries, intergovernmental organisations (UN including the WHO), international and national NGOs were the key people who were expected to respond to the invitations to contribute to the study. People working at these levels and organisations are not easily accessible and may not have sufficient permission to provide the information required in the mapping process. This is one of the main reasons for the low response rate in both the phases of the study. A preferred way to conduct this kind of activity would be to perform a stakeholders’ analysis and invest time in selecting a core group of experts with relevant experience. The selection of a single country due to resources and time constraints was also a limitation. While a comparison between LMICs at different stages of development could not be conducted, Thailand as a country with a track record of effective health promotion strategies, does pave the way for conducting similar studies in other LMICs.

7.8.1 Sampling
As already highlighted, access to accurate information regarding issues like underlying mechanisms in policy making, resource allocation, etc. could only be available for some stakeholders. In addition, not all information is readily available such as details about workforce and financing. Accurate information is key to successful mapping. At this stage of development, it might be suggested that specific themes in mapping like workforce, policy, financing could be targeted to people who are actually involved in the process and can give reliable response to the queries.

This issue is also further complicated in countries where health promotion activities are merged in the public health system and job descriptions of personnel do not sufficiently describe specific health promotion
responsibilities. In addition, the personnel in various organisations at national level cannot respond to mapping questionnaires without prior permission from higher authorities (unless the mapping questionnaire is routed from the higher authorities to relevant employees). This issue holds vital importance in the case of IGOs (WHO and other UN agencies) and international agencies which can strongly influence national development activities in LMICs. One suggestion to address this issue during data collection in an LMIC could be to invest more time in forming a core stakeholders’ group and gaining their commitment before disseminating the questionnaire.

7.8.2 Questionnaire
The questionnaire in this mapping study, which used a mix of open and closed-ended questions, was developed through a consensus building process involving global health promotion experts and their consensus was recorded in the analysis section. The main issues which were faced during the development of the questionnaire revolved around language and terminology, which are discussed in the next heading.

It was desired that the questionnaire be designed similar to the WHO’s mapping tool where all questions are of rating scale type. The WHO mapping tool (WHO, 2010e) has 37 rating scale items and one close-ended question. (Lin & Fawkes, 2005) identified issues with several of the questions, to which the respondents found it difficult to respond. These included issues with; scoring, terminology, use of compound questions, complexity, etc. During the questionnaire development process in the present study it was found that question formats other than rating scales had to be included. The WHO mapping tool only records the level of development of a particular capacity dimension (fully implemented, partially implemented, actioned, under development, being considered and, not currently actioned). This limits the ability of the tool to collect information required to assess dimensions of capacity development not visible in the mainstream mapping processes. For instance, a comment box
was added with each question in addition to the answer choices so that participants can raise issues other than the ones asked, if relevant.

### 7.8.3 Terminology

The health promotion capacity literature contains various terms to denote capacity ‘areas’: dimensions, domains, components, themes, etc. In some literature these terms are used interchangeably (Aluttis et al., 2014). One of the meanings of word ‘domain’ in Merriam-Webster Dictionary is ‘an area of knowledge or activity’. The word ‘dimension’ is ‘a measurement in one direction’. The study has followed Catford’s style of describing the capacity areas i.e. domains and sub-domains (Catford, 2005).

The study developed and regularly updated a Glossary of commonly used terms that were sent to the participants during the different stages of data collection (Appendix Q). Some respondents commented on the terminology used in the questionnaire. This could be due to the fact that they did not refer to the Glossary, though it was clearly mentioned in the invitation and attached, or that some terms were not clearly explained in the Glossary. After each stage the Glossary was updated. Presently, the Glossary contains a list of terms used in the online questionnaire and information sheets in alphabetical order. The Glossary can play a vital role in informing the stakeholders regarding health promotion concepts and approaches and related issues. In future, the Glossary could be further developed to include two sections on operational definitions and terms (for use in the mapping process) and general terms aiming at improving participants’ understanding of health promotion.

In terms of global health promotion capacity mapping, or country level mapping in non-English speaking countries, the preferred method is to translate the mapping questionnaire so that stakeholders at various levels, including employees working in health promotion programmes (especially in the ministries), civil society representatives, local NGOs, etc. can respond
to the mapping exercise in their own language. In that case, the added issues of translation cost and time will have to be considered.

### 7.8.4 Analysis and Validation of the Findings

The study employed multiple methods for searching and gathering data including the literature review, case study desk review, interviews, online questionnaire, group discussion etc. The study utilised both quantitative and qualitative approaches to collect and analyse data e.g. data analysis of the online questionnaire. The data from these diverse methods were triangulated in order to identify the key themes emerging from a process of convergence of information (Creswell & Miller, 2000). Information on the institutions responsible for health promotion policy making in Thailand, for example, were compared in the desk review, key informant interviews and the online questionnaire.

The closed-ended Likert scale questions were analysed for reliability and checked for internal consistency using Cronbach's alpha. The study was carried out in detailed work phases comprised of developing and planning the research questions, sampling, data collection, process notes, transcripts, and methods of data analysis. The analysis of findings was mostly restricted to analysing qualitative data as thematic analysis. Basic quantitative data analysis in terms of frequencies and means was also conducted. The capacity mapping data from Thailand gave a clear picture of where the essential policies, institutions, programmes and practices lie, to guide recommendations about what remedial measures are desirable.

In Phase I of the study the development of the mapping framework and tool posed a number of challenges. A key limitation noted in Round 1 during the consensus building of international experts on a set of capacity domains was the ‘ceiling effect’, indicating the tendency of respondents to rate the capacity domains at the higher end suggesting skewed distribution of the answers. It is not clear from the analysis whether this relates to the questionnaire’s inability to convey clearly the meaning of domains for
which the agreement was sought or that the participants actually did give high scores to the proposed capacity domains. Regarding the clarity of meanings of various capacity domains, it needs to be mentioned here that throughout the three Delphi rounds (pilot, Round 1 and Round 2) every effort was made to improve the clarity of the terms used as the definitions and the descriptions of the capacity domains were revised and updated, in light of the participants’ comments, in various versions of the Glossaries. In the findings of the Round 1, the existing understanding and lack of research of domains from a LMIC perspective was also highlighted. Furthermore, as mapping for LMICs is an evolving process, and this study being a pilot study, the scope is open to re-modification of the capacity domains descriptions which may better fit the mapping process needs in LMICs.

In Phase II of the study the reliability of the mapping tool was tested through calculating the internal consistency of the tool question items. Questions 34 and 35 on Financing and Knowledge Development and Management respectively were found to have low Cronbach’s Alpha while all other questions had good internal consistency. The standard practice suggests that these questions be removed from the mapping tool. Here it needs to be mentioned that the low internal consistency in items of these questions could be due to variation in the responses of the participants. Each question item in these questions provides useful information regarding financing and knowledge development and management situation in Thailand and these can be reported individually. As these domains are essential components of the core domain Infrastructure it is suggested that the question items be modified and strengthened to improve the internal consistency. In future the possibility of test-retest reliability and construct validity can be added to the data analysis.

In some instances, e.g., on the issue of Thai practitioners including five action areas of the Ottawa Charter in their practice, the data from the online questionnaire was found to be in contradiction with the findings from the
key informant interviews. In such cases, it is important to attempt to validate the accuracy of the information from the various sources and to determine which is the most accurate version. This is not always a straightforward process and may require a more layered approach to both data collection and analysis.

The mapping process highlighted the contextual issues in health promotion and health promotion capacity development which comprised of historical, political, economic and sociocultural contexts in which health promotion capacity developments take place in Thailand. In addition, health promotion capacity in Thailand was mapped with regards to structures and mechanisms of health promotion governance, policymaking and infrastructure. The analysis can be compared with the country’s overall development status globally or regionally to determine health promotion’s role in country’s progress.

The implementation of the mapping tool in Thailand was a pilot exercise. The next stage would entail presenting the findings and determining with the key stakeholders how the data could be used to enhance capacity development. The results of the mapping exercise could be presented in the form of a spidergram diagram as part of a more detailed country report. However, due to the limitations of this doctoral study the next stage could not developed in this study. However, consideration was given to how the overall mapping process could be improved and a number of recommendations will now be outlined.

7.9 Summary
The specific value of the new mapping framework and tools developed in this study were discussed in the context of existing tools for use in LMICs. The chapter considered the shortcomings of other mapping frameworks and tools, as found in the literature review, and demonstrates how the new framework and tools overcome these. These shortcomings included a lack of evidence support and theory-base, country contextual factors especially
language and cultural barriers, local stakeholder participation, dialogue-based approach, mixed method approach and reliability and validity of data collection tools. This study adds to the existing evidence of country level mapping by developing a new framework, tools and method to map capacity in LMICs building on the work done previously and employing a multi-method approach. The selected mapping domains, are set to address areas of specific relevance to LMICs, encompassing governance, policy environment and the context in which country level health promotion developments take place. The mapping tools designed in the study serve multiple functions of assessing existing health promotion capacity, policy advocacy, and promoting awareness of concepts and principles of health promotion in a participative and dialogue-based method involving a wide range of stakeholders. The study findings highlight that capacity mapping can play a positive role in countries which are struggling with health promotion development by providing a base of information and a platform on which to build capacity, adopting asset mapping and a Health in all Policies approaches. The key challenges faced in the development of the capacity mapping tools for LMICs were the lack of a capacity framework for health promotion which addresses the specific health promotion needs of LMICs, including an understanding of the diversity of social and cultural environments, language barriers and use of terminology around defining and describing various health promotion capacity domains in LMIC contexts.

*Perspectives for inclusion in mapping in LMIC context*

The study findings revealed some key perspectives that need to be taken on board for future capacity mapping exercises in LMICs. These can be kept in view in defining the goals of capacity mapping and also are closely linked to the understanding of health promotion in LMICs. Health promotion capacity mapping in LMICs context:

- is a process with multiple aspects, linking with the country’s overall development goals and should be in line with national and global health promotion aims and objectives
- lays foundations for developing national health promotion policies, plans and programmes
- is a process involving learning, sharing and participation
- is an empowering process

LMICs context for health promotion

The study findings highlighted some emerging issues specific to health promotion capacity in LMICs which need to be explored further to strengthen country level capacity development activities. These key areas are health promotion governance, policy coherence, HIAP, ownership, and systems approach. These areas are addressed in the data collection tools in the study but require updating in light of new literature and research. The data collection tools could be further refined and applied in other LMICs with more challenging situations including, war, conflicts, epidemics, etc. This would require further dedicated efforts supported by financial and human resources.

Country level vs global level mapping

The mapping framework and the process suggested in the study could be employed as an extension of the WHO capacity mapping specifically for LMICs. There is no evidence of an LMIC utilising a mapping strategy to strengthen health promotion. Global agencies like the WHO and the IUHPE can play a vital role in bringing this awareness to their Member States and networks. Another issue is ownership of the mapping process, which can only be brought about by involving the local stakeholders and not only the Ministry of Health personnel. This type of ownership can only result when local stakeholders are able to conduct mapping with a responsibility and accountability in their own system rather than for a donor or an international agency. From a global perspective, mapping is a process carried out for regions, involving many countries, by the organisations like the WHO and IUHPE. Key issues to keep in view in this situation are participation, transparency and granting suitable ownership to the country being mapped.
A wide spectrum of stakeholders, individuals, groups and organisations, from international, regional, national, local, academia, research, policy, practice, public, private, non-government, health and non-health sectors including the politicians and civil society need to be a part of the mapping process. It is important to carry out an analysis of who the stakeholders are in terms of influence (positive or negative), and develop strategies to get the most effective support and engagement possible for the mapping process. These stakeholders would need to be clearly appraised of the objectives of the mapping process, the procedures involved, time frame of the process and its results.

Data collection and feedback

The data collection processes should include use of dialogue-based approaches such as workshops, face-to-face interviews and focus groups. The dialogue-based methods help in bringing to light issues that cannot be covered by the desk review or the questionnaire. The feedback from the participants is useful in reflecting the situation on the ground and helps in making effective recommendations. The collected information and the stakeholders’ feedback would need to be analysed and documented. Finally, the results of the mapping need to be fed back to the key stakeholders and a list of key recommendations identified.

7.10 Recommendations for Future Research

Based on the findings of this study and the issues discussed in this chapter, the following recommendations are made for improving the process of capacity mapping in LMIC contexts. A staged process for conducting the health promotion capacity mapping in an LMIC context is proposed, utilising the mapping framework developed in this study together with an operational framework for utilising the data from the mapping process. Figure 7.1 shows the stages of the mapping process that are proposed.
7.11 Conclusion
The findings from this study show that developing and implementing a capacity mapping framework and data collection process is a feasible and useful activity which can guide health promotion policymakers and stakeholders in understanding health promotion capacity development and how it can be strengthened within an LMIC context. The framework developed in this study addresses the health promotion capacity needs in LMIC contexts and includes capacity areas that are specific to LMICs, which can complement existing mapping tools. Capacity mapping for LMICs requires suitable consideration of specific contextual factors that influence health promotion capacity in the LMIC context.
Health promotion plays a key role in the attainment of good health and health equity through empowerment, intersectoral action and healthy public policies which create sustainable action for health. Health promotion is a distinct approach which has the capability to address health issues beyond the health sector ensuring equity, rights and social justice through healthy public policies. Country level capacity mapping, as an integral part of national health promotion development, can be a source of guidance for national health promotion stakeholders for policy development and programme implementation. Global and national health promotion stakeholders, at various levels, from the health and non-health sectors can benefit from the country level capacity mapping by using the data and information collected to develop effective health promotion plans and strategies. The key characteristics of a successful capacity mapping process are openness, transparency, a participative approach with due consideration of conflicts of interests, sharing experiences instead of solely providing information, and an overall data collection and dissemination process that is aimed at improving the health of the populations in line with global health promotion goals.
REFERENCES


References


References


Export Date 8 January 2013

**References**


Mahmood, S. (2009). *National capacity building in health promotion in Pakistan – A case study.* (MA Health Promotion), National University of Ireland, Galway, Galway.


References


Vichayanrat, T., Steckler, A., & Tanasugarn, C. (2013). Barriers and facilitating factors among lay health workers and primary care providers to promote children’s oral health in Chon Buri province,


## APPENDIX A: Summary of methodologies, domains and sub-domains, and strengths and weaknesses of mapping frameworks and tools reviewed in the literature review

<table>
<thead>
<tr>
<th>Title of tool</th>
<th>NSW, Australia</th>
<th>Catford</th>
<th>WHO EURO/IUHPE</th>
<th>WHO WPR</th>
<th>WHO EMRO</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methodology</strong></td>
<td>Indicators for Health Promotion Capacity</td>
<td>National Health Promotion Capacity Wheel</td>
<td>HPSource.net</td>
<td>National Health Promotion Capacity Mapping</td>
<td>Health Promotion Capacity Mapping</td>
<td>Health Promotion Capacity Checklist</td>
</tr>
<tr>
<td><strong>Capacity Domains/Dimensions/Levels</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Survey, semi-structured interviews and historical timelines 3 checklists 63 items and space for reflection, evidence and comments</td>
</tr>
</tbody>
</table>

### National policies and plans
- National leadership
- Joined up government
- Programme delivery

### System infrastructure and resources
- Knowledge development
- Implementation
- Information dissemination for healthcare professionals
- Programmes and strategies
- Professional workforce

### Policies and plans pertaining to health promotion
- Core of expertise in health promotion
- Collaborative mechanisms within government
- Programme delivery
- Partnership among nongovernmental organizations, private sector and government
- Professional development

### Environmental level:
- Policies and political will
- Public opinion
- Ideas and other resources
- Supportive organisations

### Organizational level:
- Commitment
- Resources
- Culture
- Structures

### Individual level:
- Knowledge
- Skills
- Commitment
- Resources

### Four domains
1. **SYSTEM GOVERNANCE**
   - Governance
2. **Policy environment**
3. **SYSTEM INPUTS**
4. **Framework of programs and Services IMPACTS**

### OUTCOMES
- Improved Quality of life, Health and Wellbeing

### Four domains
1. **SYSTEM GOVERNANCE**
   - Governance
2. **Policy environment**
3. **SYSTEM INPUTS**
4. **Framework of programs and Services IMPACTS**

### IMPACTS
- Changes to determinants of health

### OUTCOMES
- Improved Quality of life, Health and Wellbeing

### Four domains
1. **SYSTEM GOVERNANCE**
   - Governance
2. **Policy environment**
3. **SYSTEM INPUTS**
4. **Framework of programs and Services IMPACTS**

### IMPACTS
- Changes to determinants of health

### OUTCOMES
- Improved Quality of life, Health and Wellbeing
## Strengths

- Theory-based indicators (quality focussed)
- Top down and bottom up approach
- Comprehensive coverage for assessing one-to-one, group, organisation, inter-organisation/coalition and community capacity
- Emphasis on problem solving through learning
- Tested for validity and reliability

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured approach to health promotion capacity assessment (systems approach, engaging people operating at multiple levels in scoping capacity strengths and weaknesses to help shape system development agendas, which might not be the case in some countries where these voices are not heard routinely (Fawkes &amp; Lin, 2007)).</td>
<td></td>
</tr>
<tr>
<td>Mix of qualitative and quantitative methods undertaken for capacity assessment of the region and countries in the region.</td>
<td></td>
</tr>
<tr>
<td>Multi-sectoral and participative methodology</td>
<td></td>
</tr>
<tr>
<td>Involves stakeholders’ consensus building (enhances reliability) through application of a dialogue based process</td>
<td></td>
</tr>
<tr>
<td>Some reports on mapping describe various methodological limitations with regards to question construction, language and concepts, availability of and access to information and issues in analysis of data.</td>
<td></td>
</tr>
<tr>
<td>Requires a whole systems view of a country’s health promotion system</td>
<td></td>
</tr>
<tr>
<td>National capacity is analysed with comparison to human development: expenditure on health as a % of GDP, GDP of a country, Human Development Index and Life Expectancy Index.</td>
<td></td>
</tr>
<tr>
<td>Japan and Korea are good examples of application of a European methodology in Asia that identify vital issues surrounding application of a tool developed for a ‘western audience’ utilised in Asia though more ‘fine-tuned’ tools are needed (Nam &amp; Engelhardt, 2007)</td>
<td></td>
</tr>
</tbody>
</table>

- Theory-based
- Well-structured survey
- ‘Road tested’ for face validity and acceptability with practitioners and managers
<table>
<thead>
<tr>
<th>Weaknesses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does not address capacity issues at regional/national policy levels</td>
<td>• The WHO tools are in the development stage therefore a fair</td>
<td>• Practice focused</td>
</tr>
<tr>
<td>(essentially it is settings- or situations-based within an organisation</td>
<td>amount of focus is on tool development rather than what</td>
<td>• Has not been subjected to user satisfaction</td>
</tr>
<tr>
<td>/community)</td>
<td>capacity needs are being met through the use of tool.</td>
<td>ratings, inter-rater reliability testing or internal consistency</td>
</tr>
<tr>
<td>• Only addresses workforce capacity and not health promotion capacity</td>
<td>• There were concerns about time constraints during the dialogue</td>
<td>scores.</td>
</tr>
<tr>
<td>infrastructure (for that Hawe recommends work of Miller and Richards</td>
<td>based approaches (one-day workshops) to become familiar with</td>
<td></td>
</tr>
<tr>
<td>and their colleagues, USA)</td>
<td>others’ experience and expertise, to achieve a trusting rapport</td>
<td></td>
</tr>
<tr>
<td>• Lack of a qualitative methodology</td>
<td>to encourage the sharing and questioning of opinions and</td>
<td></td>
</tr>
<tr>
<td>• Only to be used by experienced health promotion practitioners</td>
<td>experiences; and to debate and negotiate assessments.</td>
<td></td>
</tr>
<tr>
<td>• Project still in development (lack of literature on evaluation)</td>
<td>• Misunderstandings and conceptual misinterpretations of health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>promotion due to cultural and language barriers in case of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Japan and Korea (Nam &amp; Engelhardt, 2007) where tools were</td>
<td></td>
</tr>
<tr>
<td></td>
<td>unable to identify the country’s health promotion capacity as</td>
<td></td>
</tr>
<tr>
<td></td>
<td>expected.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Some methodological limitations identified by authors:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>questionnaire design and construction, the time available for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>data to be collected for country-level capacity assessments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and lack of availability of data in some domains (especially</td>
<td></td>
</tr>
<tr>
<td></td>
<td>health promotion financing)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Flexibility of methodology exists for use at regional levels,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>contextual factors are not well reflected in the questionnaires</td>
<td></td>
</tr>
<tr>
<td></td>
<td>or other methods employed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No indication of cost of implementation</td>
<td></td>
</tr>
</tbody>
</table>

293
# APPENDIX B: Table of groups of capacity levels, domains and components

<table>
<thead>
<tr>
<th>Broad Capacity Domains</th>
<th>System Governance</th>
<th>Policy Environment</th>
<th>System Infrastructure and Resources</th>
<th>System Outputs</th>
<th>Impact</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity Components</td>
<td>Governance</td>
<td>System Inputs</td>
<td>Framework of programs and Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strategic vision and Leadership</td>
<td>Partnership among NGOs, private sector and government</td>
<td>Health sector policies and plans</td>
<td>Core of expertise in health promotion</td>
<td>Programs designed to improve the health of populations</td>
<td>Changes to determinants of health</td>
</tr>
<tr>
<td></td>
<td>Mandate for health promotion</td>
<td>Collaborative mechanisms within government</td>
<td>Healthy public policy and plans</td>
<td>External environment</td>
<td>Professional development</td>
<td>Programme delivery</td>
</tr>
<tr>
<td>Leadership &amp; Governance</td>
<td>Joined up government</td>
<td>Policies and plans pertaining to health promotion</td>
<td>Specific National context</td>
<td>Professional workforce</td>
<td>Sustainable financing</td>
<td>Programme delivery</td>
</tr>
<tr>
<td>National leadership</td>
<td>National partnerships</td>
<td>Politics, policies and priorities</td>
<td>National structures</td>
<td>Workforce</td>
<td>Funding</td>
<td>Programmes and strategies</td>
</tr>
<tr>
<td>Strategic visioning</td>
<td>Partnerships</td>
<td>National policies and plans</td>
<td>Workforce learning</td>
<td>Health promotion financing</td>
<td>Organisation management</td>
<td>Performance management systems</td>
</tr>
<tr>
<td>Visioning the future</td>
<td>Institutional links and relationships</td>
<td>Professional support and supervision</td>
<td>Physical resources</td>
<td>Decision making tools and models</td>
<td>Monitoring and/or surveillance</td>
<td>Access to information</td>
</tr>
<tr>
<td>Relationships</td>
<td>Professional development opportunities</td>
<td>Specialist advice</td>
<td>Planning and implementation</td>
<td>Access to information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance monitoring</td>
<td>Administrators</td>
<td>System thinking</td>
<td>Knowledge development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Human resources</td>
<td>Intelligence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate and Post Graduate degrees</td>
<td>Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

294
APPENDIX C: WHO mapped regions/countries with HDI ranking

*VH=Very High Human Development (same as developed, category added in 2011),
H=High Human Development, M=Medium Human Development, L=Low Human
Development (Source: HDR UNDP, 2010)
NA = results not available (Total countries mapped are 71 excluding Cook Islands,
Samoa, Occupied Palestinian territory, Oman and Bhutan)

<table>
<thead>
<tr>
<th>Tool Source</th>
<th>Country</th>
<th>Year</th>
<th>HD Status</th>
<th>HDI 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO WPR</td>
<td>Australia</td>
<td>2005</td>
<td>VH</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Brunei Darussalam</td>
<td>2005, 2007</td>
<td>VH</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>China</td>
<td>2005</td>
<td>M</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Cook Islands</td>
<td>2005</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fiji</td>
<td>2005</td>
<td>M</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Japan</td>
<td>2005</td>
<td>VH</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Republic of Korea</td>
<td>2005</td>
<td>VH</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Lao PDR</td>
<td>2005</td>
<td>M</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td>Malaysia</td>
<td>2005</td>
<td>H</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Mongolia</td>
<td>2005</td>
<td>M</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>New Zealand</td>
<td>2005</td>
<td>VH</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Papua New Guinea</td>
<td>2005, 2007</td>
<td>L</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>2005, 2007</td>
<td>M</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Samoa</td>
<td>2005</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Singapore</td>
<td>2005</td>
<td>VH</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Tonga</td>
<td>2005</td>
<td>H</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>Viet Nam</td>
<td>2005</td>
<td>M</td>
<td>113</td>
</tr>
<tr>
<td>WHO EUR</td>
<td>Austria</td>
<td>2005</td>
<td>VH</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Armenia</td>
<td>2005</td>
<td>H</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Belgium</td>
<td>2005</td>
<td>VH</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Czech Republic</td>
<td>2005</td>
<td>VH</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Denmark</td>
<td>2005</td>
<td>VH</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Estonia</td>
<td>2005</td>
<td>VH</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Finland</td>
<td>2005</td>
<td>VH</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>France</td>
<td>2005</td>
<td>VH</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Georgia</td>
<td>2005</td>
<td>H</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Germany</td>
<td>2005</td>
<td>H</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Greece</td>
<td>2005</td>
<td>VH</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Hungary</td>
<td>2005</td>
<td>VH</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Iceland</td>
<td>2005</td>
<td>VH</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Ireland</td>
<td>2005</td>
<td>VH</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Israel</td>
<td>2005</td>
<td>VH</td>
<td>15</td>
</tr>
<tr>
<td>Country</td>
<td>Year</td>
<td>Region</td>
<td>Code</td>
<td>Risk</td>
</tr>
<tr>
<td>----------------------</td>
<td>------</td>
<td>--------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Italy</td>
<td>2005</td>
<td>VH</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>2005</td>
<td>H</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>2005</td>
<td>M</td>
<td>109</td>
<td></td>
</tr>
<tr>
<td>Latvia</td>
<td>2005</td>
<td>H</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Luxembourg</td>
<td>2005</td>
<td>VH</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Moldova</td>
<td>2005</td>
<td>M</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>2005</td>
<td>VH</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Norway</td>
<td>2005</td>
<td>VH</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>2005</td>
<td>VH</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>2005</td>
<td>VH</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Romania</td>
<td>2005</td>
<td>H</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Russia</td>
<td>2005</td>
<td>H</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Slovakia</td>
<td>2005</td>
<td>VH</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Slovenia</td>
<td>2005</td>
<td>VH</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>2005</td>
<td>VH</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>2005</td>
<td>VH</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td>2005</td>
<td>VH</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Tajikistan</td>
<td>2005</td>
<td>M</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2005</td>
<td>VH</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>2010</td>
<td>M</td>
<td>125</td>
<td></td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>2010</td>
<td>M</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Bahrain</td>
<td>2010</td>
<td>VH</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>2010</td>
<td>H</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2010</td>
<td>L</td>
<td>155</td>
<td></td>
</tr>
<tr>
<td>Yemen</td>
<td>2010</td>
<td>L</td>
<td>133</td>
<td></td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>2010</td>
<td>VH</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Occupied Palestinian territory</td>
<td>2010</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morocco</td>
<td>2010</td>
<td>M</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>Lebanon</td>
<td>2010</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egypt</td>
<td>2010</td>
<td>M</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>Islamic Republic of Iran</td>
<td>2010</td>
<td>H</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Libyan Arab Jamahiriya</td>
<td>2010</td>
<td>H</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Sudan</td>
<td>2010</td>
<td>L</td>
<td>154</td>
<td></td>
</tr>
<tr>
<td>Oman</td>
<td>2010</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>2010</td>
<td>H</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>2005</td>
<td>L</td>
<td>129</td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td>2005</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>2005</td>
<td>M</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Year</td>
<td>Gender</td>
<td>Rank</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>------</td>
<td>--------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>2005</td>
<td>M</td>
<td>108</td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>2005</td>
<td>M</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>2005</td>
<td>L</td>
<td>132</td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>2005</td>
<td>L</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2005</td>
<td>M</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>2005</td>
<td>M</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>2005</td>
<td>M</td>
<td>120</td>
<td></td>
</tr>
</tbody>
</table>
**APPENDIX D: Criteria for developing the database of health promotion experts**

<table>
<thead>
<tr>
<th></th>
<th><strong>International</strong> (Name of organisation, Country, City, Web-link, email address)</th>
<th><strong>National</strong> (Name of organisation, Country, City, Web-link, email address)</th>
<th><strong>Individuals</strong> (Country, Name of expert, Job/position, Department, City, email address)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Professional Health Promotion associations</td>
<td>Global network of professionals like IUHEALTH PROMOTIONE include memberships from government bodies, universities, institutes, NGOs and individuals across continents to strengthen the capacities of countries to promote health.</td>
<td>Regional Vice Presidents and focal persons</td>
</tr>
<tr>
<td>2</td>
<td><em>Intergovernmental Organisations (IGOs)</em></td>
<td>Play a key role in Health Promotion development through health systems governance, policy remit, priority setting, resource mobilization and capacity development in developing* countries. E.g. WHO, UNICEF, World Bank, etc.</td>
<td>Health Promotion focal persons in Head and Regional Offices</td>
</tr>
<tr>
<td>3</td>
<td><em>International Non-governmental (INGOs)</em></td>
<td>Play a key role in Health Promotion development through health systems governance, policy remit, priority setting, resource mobilization and capacity development in developing* countries. E.g. DFID, CIDA, etc.</td>
<td>Health Promotion focal persons in Head and Regional Offices</td>
</tr>
<tr>
<td>4</td>
<td><em>State level organisations, units, departments in Ministries of Health in developing countries</em></td>
<td>Researchers, policymakers, advisors and practitioners from the health sector in developing* countries are an important source of information about national health policy development and programme implementation for Health Promotion capacity development.</td>
<td>Health Promotion focal persons for a country or region</td>
</tr>
<tr>
<td>5</td>
<td><em>Research bodies</em></td>
<td>Universities or research institutes are responsible for advancing Health Promotion development and strengthening its capacity through disseminating their results by teaching, publication or collaboration with national and international agencies.</td>
<td>Researchers with interest in Health Promotion capacity development</td>
</tr>
<tr>
<td>6</td>
<td><em>Foundations and think tanks</em></td>
<td>Independent quasi-government bodies influencing national policies through Health Promotion research and advocacy.</td>
<td>Focal persons</td>
</tr>
<tr>
<td>7</td>
<td><em>National non-governmental organisations (NGOs) in developing countries</em></td>
<td>Volunteer, not-for-profit organisations which form coalitions with governments and other organisations to mobilise resources for Health Promotion.</td>
<td>Programme managers</td>
</tr>
<tr>
<td>8</td>
<td>Authors</td>
<td>Research articles, books and organisational reports (published and internal) are an important source of contacting experts writing about Health Promotion capacity and development.</td>
<td>Authors with publications relevant to the study</td>
</tr>
<tr>
<td>9</td>
<td>Personal contacts</td>
<td>Experts’ contacts from previous WHO and IUHEALTH PROMOTIONE studies conducted by the researcher and colleagues</td>
<td></td>
</tr>
</tbody>
</table>
The term ‘developing countries’ are described as countries which are not included in the ‘very high human development index’ category by the Human Development Reports, United Nations Development Programme (UNDP HDR, n.d.).

Only those organisations will be included which have a specialised unit for Health Promotion development at global, regional or state/country levels.

Experts from the WHO and IUHEALTH PROMOTION will be selected from lists of experts from previous studies conducted by the researcher and colleagues after seeking formal approvals.

Authors of publications will be searched using keywords ‘health promotion’, ‘capacity’ and ‘developing countries’. These searches will be conducted in databases: EBSCO, Web of Knowledge, ScienceDirect, SCOPUS, PsycINFO, Google Scholar, Google Books and Amazon.com. The publications will be sought from the year 2005 onwards and will also include the ones referenced in the literature review of this study.
APPENDIX E: List of Medium and Low Human Development Countries
(UNDP, 2011)

<table>
<thead>
<tr>
<th>Medium Human Development</th>
<th>Low Human Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>95. Jordan</td>
<td>142. Solomon Islands</td>
</tr>
<tr>
<td>96. Algeria</td>
<td>143. Kenya</td>
</tr>
<tr>
<td>97. Sri Lanka</td>
<td>144. São Tomé and Príncipe</td>
</tr>
<tr>
<td>98. Dominican Republic</td>
<td>145. Pakistan</td>
</tr>
<tr>
<td>99. Samoa</td>
<td>146. Bangladesh</td>
</tr>
<tr>
<td>100. Fiji</td>
<td>147. Timor-Leste</td>
</tr>
<tr>
<td>101. China</td>
<td>148. Angola</td>
</tr>
<tr>
<td>102. Turkmenistan</td>
<td>149. Myanmar</td>
</tr>
<tr>
<td>103. Thailand</td>
<td>150. Cameroon</td>
</tr>
<tr>
<td>104. Suriname</td>
<td>151. Madagascar</td>
</tr>
<tr>
<td>105. El Salvador</td>
<td>152. Tanzania (United Republic of)</td>
</tr>
<tr>
<td>106. Gabon</td>
<td>153. Papua New Guinea</td>
</tr>
<tr>
<td>107. Paraguay</td>
<td>154. Yemen</td>
</tr>
<tr>
<td>108. Bolivia (Plurinational State of)</td>
<td>155. Senegal</td>
</tr>
<tr>
<td>109. Maldives</td>
<td>156. Nigeria</td>
</tr>
<tr>
<td>110. Mongolia</td>
<td>157. Nepal</td>
</tr>
<tr>
<td>111. Moldova (Republic of)</td>
<td>158. Haiti</td>
</tr>
<tr>
<td>112. Philippines</td>
<td>159. Mauritania</td>
</tr>
<tr>
<td>113. Egypt</td>
<td>160. Lesotho</td>
</tr>
<tr>
<td>114. Occupied Palestinian Territory</td>
<td>161. Uganda</td>
</tr>
<tr>
<td>115. Uzbekistan</td>
<td>162. Togo</td>
</tr>
<tr>
<td>116. Micronesia (Federated States of)</td>
<td>163. Comoros</td>
</tr>
<tr>
<td>117. Guyana</td>
<td>164. Zambia</td>
</tr>
<tr>
<td>118. Botswana</td>
<td>165. Djibouti</td>
</tr>
<tr>
<td>119. Syrian Arab Republic</td>
<td>166. Rwanda</td>
</tr>
<tr>
<td>120. Namibia</td>
<td>167. Benin</td>
</tr>
<tr>
<td>121. Honduras</td>
<td>168. Gambia</td>
</tr>
<tr>
<td>122. Kiribati</td>
<td>169. Sudan</td>
</tr>
<tr>
<td>123. South Africa</td>
<td>170. Côte d'Ivoire</td>
</tr>
<tr>
<td>124. Indonesia</td>
<td>171. Malawi</td>
</tr>
<tr>
<td>125. Vanuatu</td>
<td>172. Afghanistan</td>
</tr>
<tr>
<td>126. Kyrgyzstan</td>
<td>173. Zimbabwe</td>
</tr>
<tr>
<td>127. Tajikistan</td>
<td>174. Ethiopia</td>
</tr>
<tr>
<td>128. Viet Nam</td>
<td>175. Mali</td>
</tr>
<tr>
<td>129. Nicaragua</td>
<td>176. Guinea-Bissau</td>
</tr>
<tr>
<td>130. Morocco</td>
<td>177. Eritrea</td>
</tr>
<tr>
<td>131. Guatemala</td>
<td>178. Guinea</td>
</tr>
<tr>
<td>132. Iraq</td>
<td>179. Central African Republic</td>
</tr>
<tr>
<td>133. Cape Verde</td>
<td>180. Sierra Leone</td>
</tr>
<tr>
<td>134. India</td>
<td>181. Burkina Faso</td>
</tr>
<tr>
<td>135. Ghana</td>
<td>182. Liberia</td>
</tr>
<tr>
<td>136. Equatorial Guinea</td>
<td>183. Chad</td>
</tr>
<tr>
<td>137. Congo</td>
<td>184. Mozambique</td>
</tr>
<tr>
<td>138. Lao People's Democratic Republic</td>
<td>185. Burundi</td>
</tr>
<tr>
<td>139. Cambodia</td>
<td>186. Niger</td>
</tr>
<tr>
<td>140. Swaziland</td>
<td>187. Congo (Democratic Republic of the)</td>
</tr>
<tr>
<td>141. Bhutan</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX F: Information for Delphi Pilot Participants

Conceptual Framework for Health Promotion Capacity Mapping in Developing Countries

Background
Health promotion is increasingly being adopted globally as an approach to tackle health inequities and the determinants of health. The Ottawa Charter for Health Promotion states that ‘Health promotion is the process of enabling people to increase control over, and to improve, their health’ (WHO, 1986). Many developed countries have Health Promotion goals and processes embedded in national policies, objectives and targets or have stand-alone Health Promotion policies. However many developing countries are lagging behind. Literature shows wide differences in the understanding of key concepts of Health Promotion and lack of a functional Health Promotion infrastructure in the majority of developing countries around the globe (Battel-Kirk & Barry, 2010).

The health potential of nations can improve through their ability to refocus health systems to include the promotion of health (WHO, 2009c). Developing national capacity for Health Promotion strengthens health systems in supporting, protecting and improving the health of disadvantaged populations. Health Promotion capacity development can be defined as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective Health Promotion for strengthening national health system (modified from Smith, Tang & Nutbeam, 2006).

In developing countries, closing the Health Promotion capacity gap and mainstreaming Health Promotion in health systems is a global health development challenge. This research study is being undertaken to understand this capacity gap at the national level in developing countries. The study builds on the work of the World Health Organisation on the assessment of existing regional and national capacity in Health Promotion (Catford, 2005; Lin & Fawkes, 2005; Mittelmark et al., 2006; WHO, 2010e). At the national level, the objective of capacity mapping includes identifying the extent to which essential policies, institutions, programmes and practices are in place, and to guide recommendations about what remedial measures are desirable (Mittelmark et al., 2006). This study aims to develop, test and refine a framework to map Health Promotion capacity in developing countries. The framework will lead to the development of a tool that can be used to map Health Promotion capacity at a national level.

Conceptual Framework

The figure below summarises the proposed conceptual framework for Health Promotion capacity mapping in developing countries. The framework consists of four broad domains A-D (National Context, Governance, Policy Environment and Infrastructure) and fifteen sub-domains. These have been identified from the existing literature on Health Promotion capacity development. The domains are further described in the proceeding text.
Domains

The list of broad domains (A – D) and sub-domains (A1, B8, D15, etc.) are the main content of the online questionnaire for Round 1 of the Delphi process (provided in a link in the email). In the questionnaire you will be requested to rate each of the sub-domains on a scale of 1 to 10, with 1 being the least relevant and 10 being the most relevant to Health Promotion capacity mapping in developing countries. You will also be invited to suggest other domains, change the wording, or provide further comment on the explanations provided. Also if you think any of these domains are extremely good or, at the other extreme, counterproductive, you will be requested to outline your reasons.

A: Country Specific Context
Country specific context includes the environmental or contextual factors in the country such as history (e.g. colonial history), economic stability, political systems and socio-cultural variables\(^\text{22}\) which influence the settings within which the Health Promotion capacity development takes place. Understanding these influences is necessary in order to design a context-sensitive Health Promotion system that will assist stakeholders in interpreting findings accurately according to a country’s needs.

---

Appendices

<table>
<thead>
<tr>
<th>A1</th>
<th>Historical context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the historical context clarifies the role of Health Promotion within the country’s broader development as a long-term process of structural societal transformation. For the purpose of Health Promotion capacity mapping this could include drivers and events that bring about increases in Health Promotion infrastructure, such as government papers on achieving Health for All, adoption of the Ottawa Charter, and steps taken towards development of healthy public policies, together with other important historical landmarks.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A2</th>
<th>Political context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political processes in developing countries change constantly, particularly with changes of government. In these countries health policies are often analysed without studying the political context that determines them. Health promotion recognises that peace, shelter, food, income, a stable ecosystem, sustainable resources, social justice and equity are basic pre-requisites for health and this implies a major redistribution of resources in terms of power and wealth.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A3</th>
<th>Social and cultural context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social context can be defined as the combined characteristics of the social environment, including institutional structures, social stratification, cultural and behavioural norms, and everyday life experiences that shape and legitimize the ways in which people interpret and respond to different situations. The WHO Commission on the Social Determinants of Health state that health and health equity should be a fundamental result of all social policies. In developing countries health problems are largely rooted in the social conditions in which people live and require structural measures to address them. It is important to understand the influence of culture in order to identify the processes that cause social and health inequities by shaping institutions (family, education systems, politics, legislation, etc.). Implementation of Health Promotion initiatives demands sensitivity to cultures. Very often culture is a missing component in many health models. Cultural and language barriers have been identified as important considerations for the development of Health Promotion in developing countries.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A4</th>
<th>Economic context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic growth gives the opportunity to provide resources to invest in improvement of the lives of the populations including the poor. Often economic growth does not match the level of population growth giving rise to poverty and unemployment. A core debate essential to Health Promotion development in developing countries is whether economic growth is a means to achieve health outcomes or health a means to boost economic development?</td>
<td></td>
</tr>
</tbody>
</table>

economic policies use the resources generated from economic development to invest in raising the living standards of low-income groups. In developing countries Health Promotion capacity mapping can play a special role in reducing poverty by addressing resource allocation issues which is often politised in developing countries. Another related issue to address is the categorisation of countries into low and middle income categories, resulting in a loss of focus on aspects of disadvantaged populations and groups.

B: Governance
Governance is defined as a system of values, policies and institutions by which society manages economic, political and social affairs through interactions within and among the state, civil society and private sector. Governance and policy are structural determinants of health that shape the socioeconomic and political context of the various health interventions within the country. Mainstreaming Health Promotion into health systems and policy processes require governments to exercise political will, to regulate, legislate, invest, and demand coordination on specific issues and priorities. In terms of Health Promotion capacity development, governance provides answers to the questions ‘what should the national Health Promotion system do’, ‘how should it work and with what resources’ and ‘what measures should be taken to assess whether it achieves its goals and objectives’. Governance is not an activity limited to a government but also defines the relationship between government and other stakeholders outside of government.

B5 Political Commitment
A political statement of intent defines the scope and purpose of a Health Promotion system in the country and helps set government aims for promoting health, outline the values to guide policy and establish structures to develop and implement policy. The higher the ownership e.g. Minister, Prime Minister, President – the greater the commitment expressed as a statement in the National Development Policy / Plan or an act of Parliament. A legal framework facilitates establishment and sustainability of Health Promotion in a country. The WHO commission on Social Determinants of Health urges the member states to tackle health inequities within and across countries through legislation and regulation to mainstream health equity in all policies.

B6 Leadership
Health Promotion leadership is the ability to contribute to the development of a shared vision and strategic direction for health promotion action. At the national level this is demonstrated by the political and professional core of expertise for Health Promotion including the Ministry of Health’s ability to deliver on Health Promotion objectives depicted in the Ottawa Charter for Health Promotion, an identifiable Health Promotion unit / department within the Ministry, or a group described differently but with similar explicitly stated functions and external advisers both within and outside government e.g. a

---


Health Promotion Foundation. This also entails technical leadership in surveillance, intervention design, evaluation research, and policy and practice development. Health Promotion leadership encompasses activities that go beyond the health system to influence the main determinants of health (e.g., education, poverty, environment), and other factors that are external to the health system, but which either foster or constrain its effectiveness.

**B7 Ownership**
Ownership is defined as a country’s exercise of control and command over development activities. According to the UNDP national ownership needs to be the default setting for capacity development. Excessive dependence on aid constrains a developing country from exercising policy autonomy which could impact on Health Promotion development activities. True ownership exists when a developing country chooses an alternative that is not granted by the international aid community in conformity with the prescription or guideline of the international aid community. In the context of sustainable Health Promotion development this involves two types of capacities: donor management and policy autonomy and content (for details see glossary).

**B8 Partnerships and Intersectoral action**
Health sectors in developing countries need to work in collaboration with other sectors to raise awareness of the co-benefits of acting together for policies that promote health. Effective policy development and implementation of Health Promotion priorities depend on coordination within the Ministry of Health and across national government. These include existing inter- and multi-sectoral collaborations in the form of formal institutional linkages across NGOs, civil society, private and government sectors. Intersectoral action can also arise from the community level via advocating for policy change and participatory activities influencing a whole of government approach. A prime focus of mapping should be identifying the potential for engaging health and non-health sectors in developing countries through a participatory decision-making system, where all key partners are involved in priority-setting. For example action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies.

**C: Policy Environment**
A supportive policy environment is the foundation to scale up effective, sustainable Health Promotion interventions. Healthy public policy puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. National Health Promotion policy and other healthy public policies and plans should reflect why the policy is being developed and how it fits within the broader development goals of equity and social justice. Furthermore, evaluation of these policies is a core activity within the Health Promotion capacity development framework.


C9 National Policies and Plans
Health Promotion is positioned as an essential, effective approach in policy making for health equity. Health Promotion strategies could be embedded within the national health policy or as a standalone national Health Promotion policy or reflected as healthy public policies across government sectors. Capacity mapping under this domain can include application of Health Promotion charters, stakeholders’ participation in policy making, existing processes which assess Health Promotion development needs (prioritisation), use of evidence-based decision making tools and models, plans to implement policies and readily accessible published strategies for health improvement. Policy emphasis of health programmes in the developing countries often change the with respect to fluctuations in the resource availability especially when dependent on foreign aid.

C10 Policy Coherence

D: Infrastructure
The development of sustainable infrastructure is a basic requirement for Health Promotion systems. While developed countries have shown a considerable improvement, many developing countries have an uncertain status with regards to infrastructure and organisational development required for strengthening Health Promotion capacity. WHO. (2005). The Bangkok charter for health promotion in a globalized world. Geneva, Switzerland: World Health Organization. 

D11 Health Promotion Workforce
Achieving a critical national mass of competent Health Promotion professionals

requires a long term human resource strategy. At a national level this workforce includes Health Promotion practitioners, specialists by virtue of their dedicated training, specialist functions or experience in Health Promotion in both health and non-health sectors and generalists, whose primary profession or area of study may be something different, but whose responsibilities include promoting health. A competent workforce needs to have necessary knowledge, skills and abilities in translating policy objectives and current research knowledge into effective action tailored to the social, cultural, economic and political context and realities of population groups, settings and communities\textsuperscript{43}. The workforce should also include national-level advanced education and training programmes, professional association/s for Health Promotion practitioners, policy makers and researchers to produce a health workforce capable of delivering Health Promotion interventions.

D12 Sustainable financing
Sustainable financing is needed to allocate sufficient resources and incentives to create and sustain effective Health Promotion structures and strategies. Many developing countries have predominantly private means of financing healthcare as opposed to public means. Also bi- and multilateral health funding and health financing are closely knit areas in developing countries. Mapping Health Promotion financing should also include intersectoral approaches used by the country to locate and channel resources within health and non-health sectors to finance Health Promotion capacity for effective programme delivery.

D13 Programme Delivery
The capacity to deliver effective Health Promotion interventions includes the delivery structures and mechanisms for health promotion priorities at national and/or subnational levels.\textsuperscript{43} This could be a suitably defined organisational unit responsible and accountable for Health Promotion actions including capacity development at various implementation levels. Capacity to develop effective workforce capacity, participation strategies, organisational forms (primary healthcare, community-based, etc.), intersectoral partnerships, advocacy and programme evaluation system are few elements of a successful Health Promotion programme delivery mechanism.\textsuperscript{44,45}

D14 Research and Knowledge Management
Research and evaluation builds evidence for implementing Health Promotion interventions. Research capacity is built by improving the overall skills of researchers and providing networking opportunities for researchers. Connecting Health Promotion research to policy and practice (knowledge translation) puts knowledge to work and increases the impact of Health Promotion and public health programmes.

D15 Performance Monitoring
Health Promotion performance monitoring includes national-level research and evaluation, and information systems to track and report on health indicators relevant to health promotion policy, priorities and programmes.\textsuperscript{46} A national


Health Promotion development programme’s performance is linked to the overall health system performance. With regular cycles of feedback, stakeholders and practitioners can make plans for improving their strategies, practices and the system supports that they need. Information systems are needed to track and report on health indicators relevant to Health Promotion policy, priorities and programmes to analyse implementation failures and to gain insight into short and longer term priorities and mechanisms for building Health Promotion capacity.

### Glossary

<table>
<thead>
<tr>
<th>Capacity Development (Health Promotion)</th>
<th>Development of knowledge, skills, commitment, structures, systems and leadership to enable effective Health Promotion for strengthening national health system. Modified (Smith et al., 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity mapping (National Health Promotion)</td>
<td>National Health Promotion capacity mapping is a strategy to assess a country’s existing knowledge, skills, commitment, structures, systems and leadership to develop Health Promotion capacity for strengthening national health system. Modified (Smith et al., 2006)</td>
</tr>
<tr>
<td>A strategy for collecting information on health promotion policies, infrastructures and practices. Modified (<a href="http://www.healthpromotion-source.net">www.healthpromotion-source.net</a>)</td>
<td>A strategy to find untapped, unrecognised and missing resources for the purpose of Health Promotion capacity development. Modified (Dato et al., 2002; LaFond &amp; Brown, 2003)</td>
</tr>
<tr>
<td>Conceptual framework</td>
<td>A framework that links capacity-related inputs, processes, outputs, and outcomes to performance of a system, organization, health personnel, or community. (LaFond &amp; Brown, 2003)</td>
</tr>
<tr>
<td>Delphi Technique / Method</td>
<td>A method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem (Linstone &amp; Turoff, 1975)</td>
</tr>
<tr>
<td>Development</td>
<td>See ‘Human Development’</td>
</tr>
<tr>
<td>Donor management</td>
<td>Capacity to own the relationship with the donor community and requiring leadership in policy dialogue, coordination of diverse requests, selectively adopting donor advice, handling friction with diplomatic grace, and so on (Shimomura &amp; Ohno, 2005)</td>
</tr>
</tbody>
</table>
| Inequality vs. Inequity in health | **Health inequalities** are differences in health between groups of people. These differences might be due to non-modifiable factors such as age or sex, or modifiable factors such as socioeconomic status. **Health inequities** refer to the subset of health inequalities that are systematic, socially produced (and therefore modifiable) and unfair (WHO, 2010p)  
Human poverty is defined as impoverishment in multiple dimensions—deprivations in a long and healthy life, in knowledge, in a decent standard of living, in participation. Impoverishment is further defined as ‘to lack or be denied adequate resources to participate meaningfully in society’ (Krieger, 2001)  
**Social inequalities in health:** Health disparities between population groups defined by social characteristics such as wealth, education, occupation, racial or ethnic group, sex, rural or urban residence, and social conditions of the places where people live and work (C. J. Murray, 2001). |
| Ethnicity | The sense of identity an individual has based on common ancestry, national, religious, tribal, linguistic, or cultural origins. It generally implies that there are shared values, lifestyles, beliefs, and norms among those claiming affiliation to a specific ethnic group (Huff & Kline, 1999) |
| Evaluation | Evaluation is the systematic examination and assessment of features of a programme or other intervention in order to produce knowledge that different stakeholders can use for a variety of purposes (Rootman et al., 2001) |
| Health action | Any set of activities whose primary intent is to improve or maintain health (C. J. L. Murray & Frenk, 2000) |
| Health Promotion | The process of enabling people to increase control over, and to improve their health. Health promotion represents a comprehensive social and political process, which not only includes actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. The Ottawa Charter (18) identifies three basic strategies for health promotion:  
- advocacy for health to create the essential conditions for health  
- enabling all people to achieve their full health potential  
- mediating between the different interests in society in the pursuit of health.  
These strategies are supported by five priority action areas for health promotion:  
- Build healthy public policy  
- Create supportive environments for health  
- Strengthen community action for health  
- Develop personal skills, and  
- Re-orient health services (Smith et al., 2006) |
| Health Promotion outcomes | Health promotion outcomes are changes to personal characteristics and skills, and/or social norms and actions, and/or organizational practices and public policies which are attributable to a health promotion activity. (WHO, 1998) |
| Health system | Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health (WHO Regional Office for Europe, 2008)  
All the organizations, institutions, and resources that are devoted to producing health actions (WHO, 2000) |
| Human development | Creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests (and) thus about expanding the choices people have to lead lives that they value (UNDP, 2000).

Human development is the process of enlarging people’s choices. Their three essential choices are to lead a long and healthy life, to acquire knowledge and to have access to the resources needed for a decent standard of living. Additional choices, highly valued by many people, range from political, economic and social freedom to opportunities for being creative and productive and enjoying personal self—respect and guaranteed human rights (OECD, 2007).

| Human rights | A concept that presumes that all people ‘are born free and equal in dignity and rights’ and provides a universal frame of reference for deciding questions of equity and social justice (Krieger, 2001)

| Intersectoral action (for health) | Refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector (PAHO/WHO, 2000).

| Performance (Health system) | A broader conceptual approach to measuring performance by explicitly using non-health care determinants, health care, and contextual information to give a clearer picture of population health (Arah, Westert, Hurst, & Klazinga, 2006)

| Policy | It is the expressed intent of an institution (government, corporation, volunteer group, etc.) to act strategically to attain specified goals (Rootman et al., 2001)

| Policy autonomy | Policy autonomy and content are concerned with owning development policies. This requires the capacity to identify national development goals, set coherent and realistic action plans and timetables, execute them without delay, respond to unforeseen situations, and so on........Intra-governmental coordination is required for owning policy autonomy and content (Shimomura & Ohno, 2005).

| Poverty | A human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights (UN, 2001)

Human poverty is defined as impoverishment in multiple dimensions—deprivations in a long and healthy life, in knowledge, in a decent standard of living, in participation. Impoverishment is further defined as ‘to lack or be denied adequate resources to participate meaningfully in society’(Krieger, 2001)

| Programme | Intervention, initiative or action aimed at promoting health (Rootman et al., 2001)

| Social determinants of health | Refer to both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action (Krieger, 2001)

The social conditions in which people live and work (CSDH, 2008)

| Sustainability | It is the capacity of the system to continue its normal activities well into the future (USAID, 2007) |
APPENDIX G: Delphi Pilot Questionnaire

Introduction

Please refer to the document 'Conceptual Framework for Health Promotion Capacity Mapping in Developing Countries' attached to the email when completing this questionnaire. The questions will relate to the capacity domains mentioned in the document.

The questionnaire has 6 pages containing 16 rating scale questions on the proposed broad domains and subdomains as following:

Broad capacity domains
Sub-domains for 'Country specific context'
Sub-domains for 'Governance'
Sub-domains for 'Policy environment'
Sub-domains for 'Infrastructure'

You will be requested to rate each domain on a scale of 1 to 10, with 1 being the least relevant and 10 being the most relevant to Health Promotion capacity mapping in developing countries. You are invited to suggest other domains, change the wording, or provide further comment on the explanations provided. Also if you think any of these domains are extremely good or, at the other extreme, counterproductive, you are requested to outline your reasons.

If you have any queries about the questionnaire please continue to complete it and refer to Samir Mahmood at s.mahmood1@nuigalway.ie for further clarification. If a query relates to a lack of clarity in the conceptual framework itself please comment on this in the space provided.

Please answer all the questions as your opinion is very important to this study. All responses are confidential.

I appreciate your taking the time to participate in this survey.
*To start the questionnaire fill in your name or email in the box below and then click 'Next'
Proposed Broad Domains

The proposed broad Health Promotion capacity domains for developing countries are Country Specific Context, Governance, Policy Environment and Infrastructure. The domains’ relationship with each other and the sub-domains is presented in the draft framework diagram below.

A: Country Specific Context

Country specific context includes the environmental or contextual factors in the country such as history (e.g. colonial history), economic stability, political systems and socio-cultural variables which influence the settings within which the Health Promotion capacity development takes place. Understanding these influences is necessary in order to design a context-sensitive Health Promotion system that will assist stakeholders in interpreting findings accurately according to a country’s needs.

Please rate each broad capacity domain (A, B, C and D - see diagram above) on its relevance to the conceptual framework on the provided scale of 1 to 10, with 1 being the least relevant and 10 being the most relevant to Health Promotion capacity mapping in developing countries.

A: Country Specific Context
<table>
<thead>
<tr>
<th>Country Specific Context</th>
<th>Comment</th>
</tr>
</thead>
</table>

**B: Governance**

Governance is defined as a system of values, policies and institutions by which society manages economic, political and social affairs through interactions within and among the state, civil society and private sector. Governance and policy are structural determinants of health that shape the socioeconomic and political context of the various health interventions within the country. Mainstreaming Health Promotion into health systems and policy processes require governments to exercise political will, to regulate, legislate, invest, and demand coordination on specific issues and priorities. In terms of Health Promotion capacity development, governance provides answers to the questions ‘what should the national Health Promotion system do’, ‘how should it work and with what resources’ and ‘what measures should be taken to assess whether it achieves its goals and

<table>
<thead>
<tr>
<th>Governance</th>
<th>Comment</th>
</tr>
</thead>
</table>

**C: Policy Environment**

A supportive policy environment is the foundation to scale up effective, sustainable Health Promotion interventions. Healthy public policy puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. National Health Promotion policy and other healthy public policies and plans should reflect why the policy is being developed and how it fits within the broader development goals of equity and social justice. Furthermore, evaluation of these policies is a core activity within the Health Promotion capacity development framework.
Policy  Environment

Comment

D: Infrastructure

The development of sustainable infrastructure is a basic requirement for Health Promotion systems. While developed countries have shown a considerable improvement, many developing countries have an uncertain status with regards to infrastructure and organisational development required for strengthening Health Promotion capacity. At the national level Health Promotion infrastructure includes human and material resources, organizational and administrative structures, knowledge management and information systems which facilitate country-wide Health Promotion response to health issues and challenges. Particularly in case of developing countries the role of pre-existing public health infrastructure in the development of Health Promotion infrastructure needs to be explored as well as existing opportunities for a productive Health Promotion-Public Health partnership.

Comment

Sub-domains for 'Country Specific Context'

A1: Historical context

Understanding the historical context clarifies the role of Health Promotion within the country’s broader development as a long-term process of structural societal transformation. For the purpose of Health Promotion capacity mapping this could include drivers and events that bring about increases in Health Promotion infrastructure, such as government papers on achieving Health for All, adoption of the Ottawa Charter, and steps taken towards development of healthy public policies, together with other important historical landmarks.
Political context

Political processes in developing countries change constantly, particularly with changes of government. In these countries health policies are often analysed without studying the political context that determines them. Health promotion recognises that peace, shelter, food, income, a stable ecosystem, sustainable resources, social justice and equity are basic pre-requisites for health and this implies a major redistribution of resources in terms of power and wealth.

Social context

Social context can be defined as the combined characteristics of the social environment, including institutional structures, social stratification, cultural and behavioural norms, and everyday life experiences that shape and legitimize the ways in which people interpret and respond to different situations. The WHO Commission on the Social Determinants of Health state that health and health equity should be a fundamental result of all social policies. In developing countries health problems are largely rooted in the social conditions in which people live and require structural measures to address them. It is important to understand the influence of culture in order to identify the processes that cause social and health inequities by shaping institutions (family, education systems, politics, legislation, etc.). Implementation of Health Promotion initiatives demands sensitivity to cultures. Very often culture is a missing component in many health models. Cultural and language barriers have been identified as important considerations for the development of Health Promotion in developing countries.
Economic growth gives the opportunity to provide resources to invest in improvement of the lives of the populations including the poor. Often economic growth does not match the level of population growth giving rise to poverty and unemployment. A core debate essential to Health Promotion development in developing countries is whether economic growth is a means to achieve health outcomes or health a means to boost economic development? Healthy economic policies use the resources generated from economic development to invest in raising the living standards of low-income groups. In developing countries Health Promotion capacity mapping can play a special role in reducing poverty by addressing resource allocation issues which is often politicised in developing countries. Another related issue to address is the categorisation of countries into low and middle income categories, resulting in a loss of focus on aspects of disadvantaged populations and groups.

A political statement of intent defines the scope and purpose of a Health Promotion system in the country and helps set government aims for promoting health, outline the values to guide policy and establish structures to develop and implement policy. The higher the ownership e.g. Minister, Prime Minister, President – the greater the commitment expressed as a statement in the National Development
Policy / Plan or an act of Parliament. A legal framework facilitates establishment and sustainability of Health Promotion in a country. The WHO commission on Social Determinants of Health urges the member states to tackle health inequities within and across countries through legislation and regulation to mainstream health equity in all policies.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political Commitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

B6: Leadership

Health Promotion leadership is the ability to contribute to the development of a shared vision and strategic direction for health promotion action. At the national level this is demonstrated by the political and professional core of expertise for Health Promotion including the Ministry of Health’s ability to deliver on Health Promotion objectives depicted in the Ottawa Charter for Health Promotion, an identifiable Health Promotion unit / department within the Ministry, or a group described differently but with similar explicitly stated functions and external advisers both within and outside government e.g. a Health Promotion Foundation. This also entails technical leadership in surveillance, intervention design, evaluation research, and policy and practice development. Health Promotion leadership encompasses activities that go beyond the health system to influence the main determinants of health (e.g., education, poverty, environment), and other factors that are external to the health system, but which either foster or constrain its effectiveness.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment
B7: Ownership

Ownership is defined as a country’s exercise of control and command over development activities. According to the UNDP national ownership needs to be the default setting for capacity development. Excessive dependence on aid constrains a developing country from exercising policy autonomy which could impact on Health Promotion development activities. True ownership exists when a developing country chooses an alternative that is not granted by the international aid community in conformity with the prescription or guideline of the international aid community. In the context of sustainable Health Promotion development this involves two types of capacities: donor management and policy autonomy and content.

Ownership

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

B8: Partnerships and Intersectoral Action

Health sectors in developing countries need to work in collaboration with other sectors to raise awareness of the co-benefits of acting together for policies that promote health. Effective policy development and implementation of Health Promotion priorities depend on coordination within the Ministry of Health and across national government. These include existing inter- and multi-sectoral collaborations in the form of formal institutional linkages across NGOs, civil society, private and government sectors. Intersectoral action can also arise from the community level via advocating for policy change and participatory activities influencing a whole of government approach. A prime focus of mapping should be identifying the potential for engaging health and non-health sectors in developing countries through a participatory decision-making system, where all key partners are involved in priority-setting. For example action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies.
Partnerships and Intersectoral Action

Comment

Sub-domains for 'Policy Environment'

C9: National Policies and Plans

Health Promotion is positioned as an essential, effective approach in policy making for health equity. Health Promotion strategies could be embedded within the national health policy or as a standalone national Health Promotion policy or reflected as healthy public policies across government sectors. Capacity mapping under this domain can include application of Health Promotion charters, stakeholders’ participation in policy making, existing processes which assess Health Promotion development needs (prioritisation), use of evidence-based decision making tools and models, plans to implement policies and readily accessible published strategies for health improvement. Policy emphasis of health programmes in the developing countries often change with respect to fluctuations in the resource availability especially when dependent on foreign aid.

National Policies and Plans

Comment

C10: Policy Coherence

The OECD defines policy coherence as the systematic promotion of mutually reinforcing policy actions across government departments and agencies creating synergies towards achieving the defined objective. The Bangkok Charter called for policy coherence, increased investment and a commitment to Health Promotion across all of government, the development community, civil society and the private sector. Health Promotion policies can be effective only if there is coherence around
central values and principles at all governance levels. Mutually supportive policies across a wide range of economic, social and environmental issues improve the health of populations, maintain a healthy workforce and reduce poverty. This also puts an obligation on the developed countries to ensure that their own policies have a positive health impact on developing nations.

Policy Coherence

Comment

Sub-domains for 'Infrastructure'

D11: Health Promotion Workforce

Achieving a critical national mass of competent Health Promotion professionals requires a long term human resource strategy. At a national level this workforce includes Health Promotion practitioners, specialists by virtue of their dedicated training, specialist functions or experience in Health Promotion in both health and non-health sectors and generalists, whose primary profession or area of study may be something different, but whose responsibilities include promoting health. A competent workforce needs to have necessary knowledge, skills and abilities in translating policy objectives and current research knowledge into effective action tailored to the social, cultural, economic and political context and realities of population groups, settings and communities. The workforce should also include national-level advanced education and training programmes, professional association/s for Health Promotion practitioners, policy makers and researchers to produce a health workforce capable of delivering Health Promotion interventions.
D12: Sustainable Financing

Sustainable financing is needed to allocate sufficient resources and incentives to create and sustain effective Health Promotion structures and strategies. Many developing countries have predominantly private means of financing healthcare as opposed to public means. Also bi- and multilateral health funding and health financing are closely knit areas in developing countries. Mapping Health Promotion financing should also include intersectoral approaches used by the country to locate and channel resources within health and non-health sectors to finance Health Promotion capacity for effective programme delivery.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sustainable Financing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

D13: Programme Delivery

The capacity to deliver effective Health Promotion interventions includes the delivery structures and mechanisms for health promotion priorities at national and/or subnational levels. This could be a suitably defined organisational unit responsible and accountable for Health Promotion actions including capacity development at various implementation levels. Capacity to develop effective workforce capacity, participation strategies, organisational forms (primary healthcare, community-based, etc.), intersectoral partnerships, advocacy and programme evaluation system are few elements of a successful Health Promotion programme delivery mechanism.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programme Delivery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment
D14: Research and Knowledge Management

Research and evaluation builds evidence for implementing Health Promotion interventions. Research capacity is built by improving the overall skills of researchers and providing networking opportunities for researchers. Connecting Health Promotion research to policy and practice (knowledge translation) puts knowledge to work and increases the impact of Health Promotion and public health programmes.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and Knowledge Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment

D15: Performance Monitoring

Health Promotion performance monitoring includes national-level research and evaluation, and information systems to track and report on health indicators relevant to health promotion policy, priorities and programmes. A national Health Promotion development programme’s performance is linked to the overall health system performance. With regular cycles of feedback, stakeholders and practitioners can make plans for improving their strategies, practices and the system supports that they need. Information systems are needed to track and report on health indicators relevant to Health Promotion policy, priorities and programmes to analyse implementation failures and to gain insight into short and longer term priorities and mechanisms for building Health Promotion capacity.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment
Feedback (for the pilot participants only)

Please comment on any ambiguities, difficulty in questions (including any unnecessary question/s), time taken to complete the questionnaire, overall readability or on any other aspect of the survey which you would like to highlight as a pilot participant.

Please send any further feedback to s.mahmood1@nuigalway.ie.
APPENDIX H: Invitation email Delphi Round 1

Dear (full name of participant),

I wish to invite you to join a panel of experts to contribute to developing a conceptual framework for Health Promotion capacity mapping in developing countries. You have been selected in view of your expertise in the area relevant to this research study. This study is being conducted in the World Health Organisation Collaborating Centre for Health Promotion Research in the National University of Ireland at Galway, Ireland entitled ‘National Health Promotion Capacity Mapping in Developing Countries’. The study is overseen by Prof Margaret Barry, the head of the department.

You are invited to participate in a Delphi consultation in developing a framework for mapping Health Promotion capacity in developing countries. There will be two rounds of consultation and each round will require rating and commenting on a set of proposed capacity domains through an online questionnaire. You can also suggest new domains if required.

The suggested capacity framework, instructions to participate and a glossary is accessible online at this link: http://goo.gl/O8f3r . If you are not able to access the document online for any reason, please email me.

You can contact me at my email (samir.mahmood@nuigalway.ie) or call me at +353 (0)91 495040. I would be glad to provide assistance and answer to any queries regarding the study and the Delphi consultation.

If you would like to participate in the two-round Delphi process please proceed by clicking on the link to the online questionnaire below:

Link to the Round 1 online questionnaire: http://www.surveymonkey.com/s/DB3P5W8

If for some reason you cannot participate in this consultation please forward this email to another suitable colleague or expert.

Please note that the Round 1 of the Delphi consultation will close by the end of January 2012.

Thank you.

Yours sincerely,

Samir Mahmood

Dr Samir Mahmood | PhD Research Fellow | Discipline of Health Promotion | School of Health Sciences | University Road, National University of Ireland, Galway, Galway, Ireland | E-mail: samir.mahmood@nuigalway.ie | Direct Line: +353 (0)91 495040 | HPDC (Health Promotion Research Centre) Web: http://www.nuigalway.ie/hpdc | HPDC is a designated WHO (World Health Organisation) Collaborating Centre for Health Promotion Research
APPENDIX I: Information for Delphi participants Round 1
Conceptual Framework for Health Promotion Capacity Mapping in Developing Countries

Background

Health promotion is increasingly being adopted globally as an approach to tackle health inequities and the determinants of health. The Ottawa Charter for Health Promotion states that ‘Health promotion is the process of enabling people to increase control over, and to improve, their health’ (WHO, 1986). Many developed countries have Health Promotion goals and processes embedded in national policies, objectives and targets or have stand-alone Health Promotion policies. However many developing countries are lagging behind. Literature shows wide differences in the understanding of key concepts of Health Promotion and lack of a functional Health Promotion infrastructure in the majority of developing countries around the globe (Battel-Kirk & Barry, 2010).

The health potential of nations can improve through their ability to refocus health systems to include the promotion of health (WHO, 2009c). Developing national capacity for Health Promotion strengthens health systems in supporting, protecting and improving the health of disadvantaged populations. Health Promotion capacity development can be defined as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective Health Promotion for strengthening national health system (modified from Smith, Tang & Nutbeam, 2006).

In developing countries, closing the Health Promotion capacity gap and mainstreaming Health Promotion in health systems is a global health development challenge. This research study is being undertaken to understand this capacity gap at the national level in developing countries. The study builds on the work of the World Health Organisation on the assessment of existing regional and national capacity in Health Promotion (Catford, 2005; Lin & Fawkes, 2005; Mittelmark et al., 2006; WHO, 2010e).
At the national level, the objective of capacity mapping includes identifying the extent to which essential policies, institutions, programmes and practices are in place, and to guide recommendations about what remedial measures are desirable (Mittelmark et al., 2006). This study aims to develop, test and refine a framework to map Health Promotion capacity in developing countries. The framework will lead to the development of a tool that can be used to map Health Promotion capacity at a national level.

**Conceptual Framework**

The figure below summarises the proposed conceptual framework for Health Promotion capacity mapping in developing countries. The framework consists of four domains 1 to 4 (National Context, Governance, Policy Environment and Infrastructure) and 18 sub-domains. These domains and sub-domains have been identified from the existing literature on Health Promotion capacity development.
Description
Each domain and sub-domain is described briefly in bold text below. Only some domains have an extended description in italicised text (highlighted).

Country Specific Context

Country specific context includes the environmental or contextual factors in the country such as history (e.g. colonial history), economic stability, political systems and socio-
cultural variables which influence the design and development of context-sensitive Health Promotion systems.

**Historical context**

The historical context comprise of the landmarks within the country’s history of broader development processes that contribute to increases in national Health Promotion infrastructure (knowledge, skills, commitment, structures, systems and leadership) including government papers on achieving Health for All, adoption of the Ottawa Charter, steps taken towards development of healthy public policies, etc.

**Political context**

Political traditions comprising of economic and social policies determine the level of equalities/inequalities in the state. Implementation of equitable public policies is critical for Health Promotion action and contributes to the reconstruction of health systems.

Political processes change constantly, particularly with changes of government. In developing countries health policies are often analysed without studying the political context that determines them.

**Social context**

Social context is defined as the combined characteristics of the social environment, including institutional structures, social stratification, and everyday life experiences that shape and legitimize the ways in which people interpret and respond to different situations. Health systems are a reflection of achievements of the society and indicate the quality of life of its members through respecting their freedom, dignity, privacy, and autonomy.

---


Cultural context

Culture is defined as a learned, non-random, systematic behaviour that is transmitted from person to person and from generation to generation—a tool which defines reality for its members. Health and Health Promotion is perceived differently in various cultures. Cultural and language barriers have been identified as important considerations for the development of Health Promotion in developing countries.

Economic context

Healthy economic policies of a country use the resources generated from economic development to invest in raising the living standards of populations. In developing countries Health Promotion capacity development can play a special role in reducing poverty by addressing resource allocation issues which is often politicised in developing countries.

Often economic growth does not match the level of population growth giving rise to poverty and unemployment. A core debate essential to Health Promotion development in developing countries is whether economic growth is a means to achieve health outcomes or health a means to boost economic development.

Another related issue to address is the categorisation of countries into low and middle income categories, resulting in a loss of focus on aspects of disadvantaged populations and groups.

Governance

Governance is a structural determinant of health defined as a system of values, policies and institutions to manage a country's economic, political and social affairs through interactions within and among the state, civil society and private sector. Governance for health and health equity require mainstreaming Health Promotion into policy

---

processes and health systems. It requires governments to exercise political will to regulate, legislate, invest, and demand coordination on specific issues and priorities and to reorient health services and systems in both the developing and the developed countries.

Political Commitment

A political statement of intent defines the scope and purpose of a Health Promotion system in the country and helps government set aims for promoting health, outline the values to guide policy and establish structures to develop and implement policy.

The WHO commission on Social Determinants of Health urges the member states to tackle health inequities within and across countries through legislation and regulation to mainstream health equity in all policies.\textsuperscript{57} The higher the ownership e.g. Minister, Prime Minister, President – the greater the commitment expressed as a statement in the National Development Policy / Plan or an act of Parliament. The accompanying legal framework facilitates the establishment and sustainability of Health Promotion in a country.

Leadership

Health Promotion leadership is the ability to contribute to the development of a shared vision and strategic direction for health promotion action.\textsuperscript{58} At the national level this is demonstrated by the political and professional core of expertise for Health Promotion including the Ministry of Health’s ability to deliver on Health Promotion objectives, an identifiable Health Promotion unit / department and external advisers within and outside government.\textsuperscript{59}

This also entails technical leadership in surveillance, intervention design, evaluation research, and policy and practice development. Health Promotion leadership encompasses activities that go beyond the health system to influence the main determinants of health (e.g., education, poverty, environment), and


other factors that are external to the health system, but which either foster or constrain its effectiveness. Health Promotion Foundations in various countries are an example of such leadership.

Ownership of health promotion capacity development

Ownership is defined as a country’s exercise of control and command over development activities. Excessive dependence on aid constrains a developing country from exercising policy autonomy which could impact on Health Promotion development activities.

True ownership exists when a developing country chooses an alternative that is not granted by the international aid community in conformity with the prescription or guideline of the international aid community. In the context of sustainable Health Promotion development this involves two types of capacities: policy autonomy and donor management (defined in the glossary).

Health promotion systems approach

Health Systems are defined as all the activities whose primary purpose is to promote, restore, or maintain health. A Health Promotion system is built on stable, basic infrastructure (finance, workforce, resources, information systems and organisational and intersectoral teams and partnerships) harnessed through governance and consequent policy and planning frameworks. It includes the personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.

Intersectoral collaboration

---


An intersectoral collaboration for Health Promotion is defined as a recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone. This includes the intra- and multi-sectoral collaborations in the form of formal institutional linkages across NGOs, civil society, private and government sectors.

For example, action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Intersectoral action can also arise from the community level via advocating for policy change and participatory activities influencing a whole of government approach.

Partnership for health promotion

A partnership for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes. A prime focus for capacity mapping should be identification of the potential for engaging health and non-health sectors in developing countries through a participatory decision-making system, where all key partners are involved in priority-setting.

Policy environment

Supportive policy environments scale up effective, sustainable Health Promotion interventions. National Health Promotion policy, national health policy, and other public policies and plans should reflect why the policy is being developed and how it fits within the broader development goals of equity and social justice.

Healthy public policy puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. In addition, evaluation of these policies is a core activity within the Health Promotion capacity development framework. Effective policy development and implementation of Health Promotion priorities depend on coordination within the Ministry of Health and across national government.

National policies and plans

---

National government policies and plans include Health Promotion priorities which conform to the underlying concepts of the five Ottawa Charter strategies68. This domain includes national plans for application of Health Promotion charters, stakeholders’ participation in policy making, existing processes which assess Health Promotion development needs, use of evidence-based decision making tools and models, plans to implement policies and readily accessible published strategies for health improvement.

Health Promotion strategies could be embedded within the national health policy, as a standalone national Health Promotion policy or reflected as healthy public policies across government sectors.

While Health Promotion is positioned as an essential, effective approach in policy making for health equity, policy emphasis of health programmes in the developing countries often change with respect to fluctuations in the resource availability especially when dependent on foreign aid.

Policy coherence

Health Promotion policies require coherence around central values and principles at all governance levels.69 It is defined as the systematic promotion of mutually reinforcing policy actions across government departments and agencies creating synergies towards achieving the defined objective.70

The Bangkok Charter called for policy coherence, increased investment and a commitment to Health Promotion across all of government, the development community, civil society and the private sector.71 Mutually supportive policies across a wide range of economic, social and environmental issues improve the health of populations, maintain a healthy workforce and reduce poverty. This also puts an obligation on the developed countries to ensure that their own policies have a positive health impact on developing nations.72

---

68 Build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, and, reorient health services.
Infrastructure

At the national level Health Promotion infrastructure includes human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide Health Promotion response to health issues and challenges.

The development of sustainable infrastructure is a basic requirement for Health Promotion systems. While developed countries have shown a considerable improvement, many developing countries have an uncertain status with regards to infrastructure and organisational development required for strengthening Health Promotion capacity. In the developing countries the role of pre-existing public health infrastructure in the development of Health Promotion infrastructure needs to be explored as well as existing opportunities for a productive Health Promotion-Public Health partnership.

Health promotion workforce

A competent Health Promotion workforce needs to have necessary knowledge, skills and abilities in translating policy objectives and current research knowledge into effective action tailored to the social, cultural, economic and political context and realities of population groups, settings and communities. At a national level this includes practitioners, specialists by virtue of their dedicated training, specialist functions or experience in Health Promotion in both health and non-health sectors and generalists, whose primary profession or area of study may be something different, but whose responsibilities include promoting health.

Achieving a critical national mass of competent Health Promotion professionals requires a long term human resource strategy. The workforce should also include national-level advanced education and training programmes, professional association/s for Health Promotion practitioners, policy makers and researchers to produce a health workforce capable of delivering Health Promotion interventions.

Sustainable financing

Sustainable financing means allocation of sufficient resources and incentives to create and sustain effective Health Promotion structures and strategies. This includes the intersectoral approaches used by the country to locate and channel

---

resources within health and non-health sectors to finance Health Promotion capacity for effective programme delivery.

Additional issues to include in the mapping process are bi- and multi-lateral health funding and health financing which are closely knit areas in the developing countries. These countries also have a predominantly private means of financing healthcare as opposed to public means.

Programme Delivery

National Health Promotion programme delivery includes the delivery structures and mechanisms for health promotion priorities at national and/or subnational levels. This could be a suitably defined organisational unit responsible and accountable for Health Promotion actions including capacity development at various implementation levels.

Research and Knowledge Management

Knowledge management can be defined as process of organising what is known and then using this in a variety of capacities to improve Health Promotion systems. Appropriate evaluation and research methods used in partnership with stakeholders determine the reach, impact and effectiveness of Health Promotion action.

Research capacity is built by improving the overall skills of researchers and providing networking opportunities for researchers. Connecting Health Promotion research to policy and practice puts knowledge to work and increases the impact of Health Promotion and public health programmes.

Performance Monitoring

This includes national-level research and evaluation, and information systems to track and report on health indicators relevant to health promotion policy, priorities and programmes. A national Health Promotion development programme’s performance is linked to the overall health system performance.

Stakeholders and practitioners can make plans for improving their strategies, practices and the system supports that they need through regular cycles of feedback. Information systems are needed to track and report on health indicators relevant to Health Promotion policy, priorities and programmes to

---


Analyse implementation failures and to gain insight into short and longer term priorities and mechanisms for building Health Promotion capacity.

How to fill the online Questionnaire?

- The aim of this consultation is to reach an international experts’ agreement on the proposed Health Promotion capacity mapping framework for developing countries. Through the questionnaire you will be able to comment on the framework and its domains, suggest other domains, suggest change in terminology used, or further comment on the explanations provided.
- The online questionnaire has been created on the survey software www.surveymonkey.com.
- The Round 1 questionnaire of the Delphi process will comprise of rating scale questions on the domains, sub-domains and their description.
- You will be requested to rate each domain and sub-domain on a five-point scale: Strongly Disagree, Disagree, Uncertain, Agree, and Strongly Agree.
- If you ‘Strongly Disagree’ or ‘Disagree’ with any core domain or a sub-domain, and believe it should be removed, you will be expected to give your reasons in the comments box.
- If you have any queries about the questionnaire please do not hesitate to contact me at s.mahmood1@nuigalway.ie, or call at +353 (0) 91 495040 for further clarification.
- Important: Once you start, you can re-enter the questionnaire at any time to update your responses. Please note that you must use the same computer to fill your responses.
- If for some reason you are unable to respond to the questionnaire, please forward the email with the survey link to suitable colleagues or people you know who can contribute to the study.

Glossary

<table>
<thead>
<tr>
<th>Capacity Development (Health Promotion)</th>
<th>Development of knowledge, skills, commitment, structures, systems and leadership to enable effective Health Promotion for strengthening national health system. Modified</th>
</tr>
</thead>
</table>
| Capacity mapping (National Health Promotion)                   | National Health Promotion capacity mapping is a strategy to assess a country’s existing knowledge, skills, commitment, structures, systems and leadership to develop Health Promotion capacity for strengthening national health system. Modified (Smith et al., 2006)  
A strategy for collecting information on health promotion policies, infrastructures and practices. Modified (www.hp-source.net) |
<table>
<thead>
<tr>
<th>Conceptual framework</th>
<th>A framework that links capacity-related inputs, processes, outputs, and outcomes to performance of a system, organisation, health personnel, or community. (LaFond &amp; Brown, 2003)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delphi Technique / Method</td>
<td>A method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem (Linstone &amp; Turoff, 1975)</td>
</tr>
<tr>
<td>Development</td>
<td>See ‘Human Development’</td>
</tr>
<tr>
<td>Donor management</td>
<td>Capacity to own the relationship with the donor community and requiring leadership in policy dialogue, coordination of diverse requests, selectively adopting donor advice, handling friction with diplomatic grace, and so on (Shimomura &amp; Ohno, 2005)</td>
</tr>
<tr>
<td>Inequality vs. Inequity in health</td>
<td><strong>Health inequalities</strong> are differences in health between groups of people. These differences might be due to non-modifiable factors such as age or sex, or modifiable factors such as socioeconomic status. <strong>Health inequities</strong> refer to the subset of health inequalities that are systematic, socially produced (and therefore modifiable) and unfair (WHO, 2010p) Human poverty is defined as impoverishment in multiple dimensions—deprivations in a long and healthy life, in knowledge, in a decent standard of living, in participation. Impoverishment is further defined as ‘to lack or be denied adequate resources to participate meaningfully in society’(Krieger, 2001) <strong>Social inequalities in health:</strong> Health disparities between population groups defined by social characteristics such as wealth, education, occupation, racial or ethnic group, sex, rural or urban residence, and social conditions of the places where people live and work (C. J. Murray, 2001).</td>
</tr>
<tr>
<td>Intersectoral action for health</td>
<td>Intersectoral action for health refers to actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health equity outcomes or on the determinants of health or health equity (Peake et al., 2008).</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>The sense of identity an individual has based on common ancestry, national, religious, tribal, linguistic, or cultural origins. It generally implies that there are shared values, lifestyles, beliefs, and norms among those claiming affiliation to a specific ethnic group (Huff &amp; Kline, 1999)</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Evaluation is the systematic examination and assessment of features of a programme or other intervention in order to produce knowledge that different stakeholders can use for a variety of purposes (Rootman et al., 2001)</td>
</tr>
<tr>
<td>Health (Promotion) action</td>
<td>Any set of activities whose primary intent is to improve or maintain health (C. J. L. Murray &amp; Frenk, 2000)</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>The process of enabling people to increase control over, and to improve their health. Health promotion represents a comprehensive social and political process, which not only includes actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. The Ottawa Charter (18) identifies three basic strategies for health promotion: • advocacy for health to create the essential conditions for health • enabling all people to achieve their full health potential • mediating between the different interests in society in the pursuit of health. These strategies are supported by five priority action areas for</td>
</tr>
</tbody>
</table>
### Health Promotion outcomes

Health promotion outcomes are changes to personal characteristics and skills, and/or social norms and actions, and/or organisational practices and public policies which are attributable to a health promotion activity. (WHO, 1998)

### Health system

Within the political and institutional framework of each country, a health system is the ensemble of all public and private organisations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health (WHO Regional Office for Europe, 2008)

All the organisations, institutions, and resources that are devoted to producing health actions (WHO, 2000)

### Human development

Creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests (and) thus about expanding the choices people have to lead lives that they value (UNDP, 2000).

Human development is the process of enlarging people’s choices. Their three essential choices are to lead a long and healthy life, to acquire knowledge and to have access to the resources needed for a decent standard of living. Additional choices, highly valued by many people, range from political, economic and social freedom to opportunities for being creative and productive and enjoying personal self—respect and guaranteed human rights (OECD, 2007).

### Human rights

A concept that presumes that all people ‘are born free and equal in dignity and rights’ and provides a universal frame of reference for deciding questions of equity and social justice (Krieger, 2001)

### Intersectoral action (for health)

Refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector (PAHO/WHO, 2000).

### Performance (Health system)

A broader conceptual approach to measuring performance by explicitly using non-health care determinants, health care, and contextual information to give a clearer picture of population health (Arah et al., 2006)

### Policy

It is the expressed intent of an institution (government, corporation, volunteer group, etc.) to act strategically to attain specified goals (Rootman et al., 2001)

### Policy autonomy

Policy autonomy and content are concerned with owning development policies. This requires the capacity to identify national development goals, set coherent and realistic action plans and timetables, execute them without delay, respond to unforeseen situations, and so on........Intra-governmental coordination is required for owning policy autonomy and content (Shimomura & Ohno, 2005).

### Poverty

A human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights (UN, 2001)

Human poverty is defined as impoverishment in multiple dimensions—deprivations in a long and healthy life, in knowledge, in a decent standard of living, in participation.
Impoverishment is further defined as 'to lack or be denied adequate resources to participate meaningfully in society' (Krieger, 2001)

| Programme | Intervention, initiative or action aimed at promoting health (Rootman et al., 2001) |
| Social determinants of health | Refer to both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action (Krieger, 2001) The social conditions in which people live and work (CSDH, 2008) |
| Sustainability | It is the capacity of the system to continue its normal activities well into the future (USAID, 2007) |
APPENDIX J: Delphi Round 1 Questionnaire

Health Promotion Capacity Mapping in Developing Countries

Introduction

Thank you for starting the Round 1 of the consultation on Health Promotion capacity Mapping in developing countries.

The details about the proposed framework and the domains are provided in the document 'Conceptual Framework for Health Promotion Capacity Mapping in Developing Countries' which was sent to you as a link in the email. Or you can copy this URL in your browser's address bar to access the document now: http://goo.gl/08F3r

The aim of this consultation is to reach an international experts’ agreement on the proposed Health Promotion capacity mapping framework for developing countries. Through the questionnaire you will be able to comment on the framework and its domains, suggest other domains, suggest change in terminology used, or further comment on the explanations provided.

Please note the following:

• This questionnaire comprises of rating scale questions about the domains, sub-domains and their description.

• You will be requested to rate each domain and sub-domain on a five-point scale: Strongly Disagree, Disagree, Uncertain, Agree, and Strongly Agree.

• If you 'Strongly Disagree' or 'Disagree' with any core domain or a sub-domain, and believe it should be removed, you will be expected to give your reasons in the comments box.

• If you have any queries about the questionnaire please do not hesitate to contact me at samir.mahmood@nuigalway.ie, or call at +353 (0) 91 495040 for further clarification.

• Important: Once you start, you can re-enter the questionnaire at any time to update your responses. Please note that you must use the same computer to fill your responses.

• If for some reason you are unable to respond to the questionnaire, please forward the email with the survey link to suitable colleagues or people you know who can contribute to the study.

Please also note that your responses including your name, email address or IP address will be confidential. The results of this study will be used for scholarly purposes only.

*1. To start the questionnaire fill in your name or email in the box below and then click 'Next'. Please note that this information is required to proceed further.

Name: _______________________________

Email Address: _______________________

2. Country where you work? (optional) _______________________________

Domain 1: Country Specific Context

This page contains the rating scale questions about the domain 'Country Specific Context' and related sub-domains: Historical Context, Political Context, Social Context, Cultural Context and Economic Context.
3. Country specific context

Country specific context includes the environmental or contextual factors in the country such as history (e.g. colonial history), economic stability, political systems and socio-cultural variables which influence the design and development of context-sensitive Health Promotion systems.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country specific context</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

4. Historical Context

The historical context comprise of the landmarks within the country's history of broader development processes that contribute to increases in national Health Promotion infrastructure (knowledge, skills, commitment, structures, systems and leadership) including government papers on achieving Health for All, adoption of the Ottawa Charter, steps taken towards development of healthy public policies, etc.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical context</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

5. Political Context

Political traditions comprising of economic and social policies determine the level of equalities/inequalities in the state. Implementation of equitable public policies is critical for Health Promotion action and contributes to the reconstruction of health systems.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political context</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments
Appendices

Health Promotion Capacity Mapping in Developing Countries

6. Social context

Social context is defined as the combined characteristics of the social environment, including institutional structures, social stratification, and everyday life experiences that shape and legitimize the ways in which people interpret and respond to different situations. Health systems are a reflection of achievements of the society and indicate the quality of life of its members through respecting their freedom, dignity, privacy, and autonomy.

<table>
<thead>
<tr>
<th>Social context</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Comments

7. Cultural Context

Culture is defined as a learned, non-random, systematic behaviour that is transmitted from person to person and from generation to generation - a tool which defines reality for its members. Health and Health Promotion is perceived differently in various cultures. Cultural and language barriers have been identified as important considerations for the development of Health Promotion in developing countries.

<table>
<thead>
<tr>
<th>Cultural context</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Comments

8. Economic Context

Healthy economic policies of a country use the resources generated from economic development to invest in raising the living standards of populations. In developing countries Health Promotion capacity development can play a special role in reducing poverty by addressing resource allocation issues which is often politicised in developing countries.

<table>
<thead>
<tr>
<th>Economic context</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Comments
Health Promotion Capacity Mapping in Developing Countries

9. Please provide any general comment on Domain 1: Country Specific Context.

Governance

This page contains the rating scale questions about the domain 'Governance' and related sub-domains: Political Commitment, Leadership, Ownership of Health Promotion Capacity Development, Health Promotion Systems Approach, Intersectoral Collaboration and Partnership for Health Promotion.

10. Governance

Governance is a structural determinant of health defined as a system of values, policies and institutions to manage a country's economic, political and social affairs through interactions within and among the state, civil society and private sector. Governance for health and health equity require mainstreaming Health Promotion into policy processes and health systems. It requires governments to exercise political will to regulate, legislate, invest, and demand coordination on specific issues and priorities and to reorient health services and systems in both the developing and the developed countries.

<table>
<thead>
<tr>
<th>Governance</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Comments

11. Political Commitment

A political commitment or statement of intent defines the scope and purpose of a Health Promotion system in the country and helps government set aims for promoting health, outline the values to guide policy and establish structures to develop and implement policy.

<table>
<thead>
<tr>
<th>Political Commitment</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

Comments
Appendices

### Health Promotion Capacity Mapping in Developing Countries

#### 12. Leadership

Health Promotion leadership is the ability to contribute to the development of a shared vision and strategic direction for health promotion action. At the national level this is demonstrated by the political and professional core of expertise for Health Promotion including the Ministry of Health's ability to deliver on Health Promotion objectives, an identifiable Health Promotion unit / department and external advisers within and outside government.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

#### 13. Ownership of Health Promotion Capacity Development

Ownership is defined as a country's exercise of control and command over development activities. Excessive dependence on aid constrains a developing country from exercising policy autonomy which could impact on Health Promotion development activities.

<table>
<thead>
<tr>
<th>Ownership of Health Promotion Capacity Development</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

#### 14. Health Promotion Systems Approach

Health Systems are defined as all the activities whose primary purpose is to promote, restore, or maintain health. A Health Promotion system is built on stable, basic infrastructure (finance, workforce, resources, information systems and organisational and intersectoral teams and partnerships) harnessed through governance and consequent policy and planning frameworks. It includes the personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.

<table>
<thead>
<tr>
<th>Health Promotion Systems Approach</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments
Health Promotion Capacity Mapping in Developing Countries

15. Intersectoral Collaboration

An intersectoral collaboration for Health Promotion is defined as a recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone. This includes the intra- and multi-sectoral collaborations in the form of formal institutional linkages across NGOs, civil society, private and government sectors.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intersectoral Collaboration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

16. Partnership for Health Promotion

A partnership for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes. A prime focus for capacity mapping should be identification of the potential for engaging health and non-health sectors in developing countries through a participatory decision-making system, where all key partners are involved in priority-setting.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership for Health Promotion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

17. Please provide any general comment on Domain 2: Governance.

Domain 3: Policy Environment

This page contains the rating scale questions on the domain Policy Environment and related sub-domains: National Policies and Plans, and Policy Coherence.
## Health Promotion Capacity Mapping in Developing Countries

### 18. Policy Environment

Supportive policy environments scale up effective, sustainable Health Promotion interventions. National Health Promotion policy, national health policy, and other public policies and plans should reflect why the policy is being developed and how it fits within the broader development goals of equity and social justice.

<table>
<thead>
<tr>
<th>Policy Environment</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 19. National Policies and Plans

National government policies and plans include Health Promotion priorities which conform to the underlying concepts of the five Ottawa Charter strategies. This domain includes national plans for application of Health Promotion charters, stakeholders’ participation in policy making, existing processes which assess Health Promotion development needs, use of evidence-based decision making tools and models, plans to implement policies and readily accessible published strategies for health improvement.

<table>
<thead>
<tr>
<th>National Policies and Plans</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 20. Policy Coherence

Health Promotion policies require coherence around central values and principles at all governance levels. It is defined as the systematic promotion of mutually reinforcing policy actions across government departments and agencies creating synergies towards achieving the defined objective.

<table>
<thead>
<tr>
<th>Policy Coherence</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 7
Health Promotion Capacity Mapping in Developing Countries

21. Please provide any general comment on Domain 3: Policy Environment.

Domain 4: Infrastructure

This page contains the rating scale questions on the domain Infrastructure and related sub-domains: Health Promotion Workforce, Sustainable Financing, Programme Delivery, Research and Knowledge Management, and Performance Monitoring.

22. Infrastructure

At the national level Health Promotion infrastructure includes human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide Health Promotion response to health issues and challenges.

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments

23. Health Promotion Workforce

A competent Health Promotion workforce needs to have necessary knowledge, skills and abilities in translating policy objectives and current research knowledge into effective action tailored to the social, cultural, economic and political context and realities of population groups, settings and communities. At a national level this includes practitioners, specialists by virtue of their dedicated training, specialist functions or experience in Health Promotion in both health and non-health sectors and generalists, whose primary profession or area of study may be something different, but whose responsibilities include promoting health.

<table>
<thead>
<tr>
<th>Health Promotion Workforce</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments
24. Sustainable Financing

Sustainable financing means allocation of sufficient resources and incentives to create and sustain effective Health Promotion structures and strategies. This includes the intersectoral approaches used by the country to locate and channel resources within health and non-health sectors to finance Health Promotion capacity for effective programme delivery.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustainable Financing</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

25. Programme Delivery

National Health Promotion programme delivery includes the delivery structures and mechanisms for health promotion priorities at national and/or subnational levels. This could be a suitably defined organisational unit responsible and accountable for Health Promotion actions including capacity development at various implementation levels.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Delivery</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

26. Research and Knowledge Management

Knowledge management can be defined as process of organising what is known and then using this in a variety of capacities to improve Health Promotion systems. Appropriate evaluation and research methods used in partnership with stakeholders determine the reach, impact and effectiveness of Health Promotion action.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and Knowledge Management</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments
Health Promotion Capacity Mapping in Developing Countries

27. Performance Monitoring

This includes national-level research and evaluation, and information systems to track and report on health indicators relevant to health promotion policy, priorities and programmes. A national Health Promotion development programme’s performance is linked to the overall health system performance.

<table>
<thead>
<tr>
<th>Performance Monitoring</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. Please provide any general comment on Domain 4: Infrastructure.

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
</table>
APPENDIX K: Revised definitions of capacity domains

<table>
<thead>
<tr>
<th>Domain name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country specific context</strong></td>
<td>The environmental, historical, political, economic, social and cultural factors which influence the development of health promotion capacity in a country.</td>
</tr>
<tr>
<td><strong>Health promotion governance</strong></td>
<td>A system of values, policies and institutions to manage the country’s health promotion development within and among the state, civil society and private sector.</td>
</tr>
<tr>
<td><strong>Institutional capacity</strong></td>
<td>Institutional capacity refers to the governments’ ability to define the scope and purpose of health promotion system in the country, outline the values to guide health promoting policies, set aims for promoting health and establish structures to develop and implement policy.</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Health promotion vision expresses goals that are worth striving for and incorporates shared health promotion ideals and values.</td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td>Ability to contribute to the development of the vision and strategic direction for health promotion action to deliver on national health promotion objectives.</td>
</tr>
<tr>
<td><strong>Transparency</strong></td>
<td>Transparency in health promotion activities is a set of rules that allow those affected by administrative decisions, business transactions or charitable work to know the basic facts, figures, mechanisms and the processes involved in national health promotion development.</td>
</tr>
<tr>
<td><strong>Policy environment</strong></td>
<td>Health promotion policy environment refers to national structures and mechanisms which enable formulation and implementation of national health promotion policy, national health policy, and healthy public policies and plans in form of health promotion interventions and action across all sectors.</td>
</tr>
<tr>
<td><strong>National policies and plans</strong></td>
<td>National policies and plans for health promotion consist of national health promotion policy, national health policy, and healthy public policies and plans to set health promotion goals, provide guidelines for health promotion practice, and framework for health promotion action across all sectors.</td>
</tr>
</tbody>
</table>

### Policy coherence

Policy coherence for health promotion is defined as the systematic promotion of mutually reinforcing policy actions across government departments and all other stakeholders creating synergies towards achieving the defined health promotion objectives.\(^{83}\)

### Infrastructure

Health Promotion infrastructure consists of human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide health promotion response to health issues and challenges.\(^{84}\)

### Health promotion delivery

National health promotion delivery includes the structures and mechanisms for health promotion priorities at national and/or subnational levels responsible and accountable for health promotion actions including support for inter-sectoral partnerships.\(^{85}\)

### Workforce

The availability and development of qualified human resources with sufficient skills and knowledge to deliver essential health promotion action.\(^{86}\)

### Partnerships

Health promotion partnerships refer to relationship between various partners in the health and non-health sectors (donors, development agencies, NGOs, civil society, private and government sectors) to work towards a set of shared outcomes towards strengthening health promotion system in a country.\(^{87}\)

### Financing

This refers to transparent and sustainable source of public financing for health promotion priorities at national or subnational levels including direct government allocations, hypothecated taxes, or through social/health insurance.\(^{88}\)

### Knowledge development and management

Health promotion knowledge development refers to developing a body of knowledge and evidence base to support policymaking at all levels.\(^{89}\) Knowledge management consists of using this knowledge to develop capacity for health promotion research, information systems, performance improvement, evaluation and monitoring to strengthen national health system.

---


APPENDIX L: Email for Delphi participants Round 2

Dear (full name of participant)

Thank you for participating earlier this year in a Delphi consultation on the development of a Health Promotion Capacity Mapping Framework for developing countries. By way of follow-up, I am pleased to forward a summary of the findings from Round One of the Delphi consultation. Your feedback, along with that of the other participants, is analysed and presented as a brief report at Link 1 below:

Link 1: (http://goo.gl/ths4M) Round One Analysis Report

We are now ready to commence Round Two of the consultation, and your expert views on a revised Health Promotion Capacity tool, would be much appreciated. Based on the Round One feedback and a review of the literature, the mapping tool has been developed further. The tool consists of open and closed-ended questions and, as before, you are requested to rate on a 5 point scale each question in terms of its relevance for inclusion in the tool. You can access the questionnaire, for a ready reference, to read and print before completing it online by clicking on the Link 2 below.

Link 2: (http://goo.gl/rgRnd) Round 2 Questionnaire

Please note that the questionnaire is for your preview only, as it is an ongoing study, and not for circulation.

To participate in the second round of the Delphi process please proceed by clicking on this link:
Link to online questionnaire: http://www.surveymonkey.com/s/KTDZHTL
You can contact me at my email (samir.mahmood@nuigalway.ie) or call me at +353 (0)91 495040. I would be glad to provide assistance and answer to any queries regarding the study and the Delphi consultation.

Closing date: Round Two of the Delphi consultation will close on 31st May 2012.

Thank you.

Yours sincerely,

Samir Mahmood

Dr Samir Mahmood | PhD Research Fellow | Discipline of Health Promotion | School of Health Sciences | University Road, National University of Ireland, Galway, Galway, Ireland
E-mail: samir.mahmood@nuigalway.ie | Direct Line: +353 (0)91 495040 |
World Health Organisation) Collaborating Centre for Health Promotion Research
Web: http://www.nuigalway.ie/hprc
APPENDIX M: Health Promotion Capacity Mapping Tool

(This document is a copy of the online questionnaire. Printing and/or reading this document before starting the online questionnaire will help you better understand the scope of the Health Promotion Capacity Mapping Tool you are being requested to rate)

This questionnaire is comprised of a proposed Health Promotion Capacity Mapping Tool to assess country-wide health promotion capacity in developing countries. The questions have been adapted from the literature\(^{90}\) and the your comments from the first round of the Delphi consultation.

The questionnaire is divided into three parts:

1. **Part one** consists of questions regarding information such as your name, email, etc.

2. **Part two** consists of the proposed Health Promotion Capacity Mapping Tool. You will be required to rate and comment on (55) closed and open-ended questions (Q1 – Q55). The rating will be based on a 5-point Likert scale (Strongly Disagree, Disagree, Uncertain, Agree and Strongly Agree). You are requested to suggest changes to the questions if needed, suggest new question(s) or provide any other comments related to the questions (on content, terminology, format, etc.). If you 'Strongly Disagree' or 'Disagree' with any question and/or believe it should be removed, you are requested to give your reason(s) in the comments box. You are required to rate all questions in this part of the questionnaire.

---

\(^{90}\) Source of various questions in the tool:

3. **Part three** consists of questions on your opinion about the tool as a whole, your comments on any specific aspects of the tool, and any suggestions to improve the tool.

4. **Important:** If you plan to complete the questionnaire in more than one sitting, please use the same computer. You can re-enter the survey anytime from where you last saved your responses. To save your responses always click the 'Next' button at the end of each page of the questionnaire. You can also review your responses on the previous pages by clicking the ‘Prev’ button at the end of each page.

Please note that your personal details, data collected from this questionnaire and any other correspondence related to your feedback on the study will be kept strictly confidential.

**Part 1**

Participants’ details: Name, email and area of expertise in health promotion (optional)

**Part 2**

*Important: In this section, please respond by rating the questions on their suitability for inclusion in the Health Promotion Capacity Mapping Tool for developing countries and give relevant comments.*

**Country Specific Context for Health Promotion**

>The Country Specific Context describes the environmental, historical, political, economic, social and cultural factors which influence the development of health promotion capacity in a country (adapted from Brown, L, LaFond, A, & Macintyre, K, 2001).

<table>
<thead>
<tr>
<th>Q1.</th>
<th>What term is most commonly used in your country for activities to improve health?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Health Promotion</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Health Education</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Public Health</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Other (please specify)</strong></td>
</tr>
<tr>
<td></td>
<td>Do you agree that Q1 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
</tr>
</tbody>
</table>

354
### Q2. Which of the following terms are you most comfortable using? Please suggest any other:
- Developing country
- Third World country
- Low or middle income country
- Least or medium developed country
- Low resource country
- Suggest any other term

Do you agree that Q2 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
- Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:

### Q3. Which of the following landmarks in the history of national health system development in your country have contributed to increase health promotion infrastructure (i.e. knowledge, skills, commitment, system and leadership):
- Government papers on achieving Health for All/Primary Health Care
- Adoption of the Ottawa Charter (WHO, 1986)
- Steps taken towards development of healthy public policies
- Other (please specify)

Do you agree that Q3 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
- Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:

### Q4. How would you characterise the political regime in your country?
- established democracy
- transitional regime: substantial democratization over the past fifteen years
- still largely undemocratic, even if some opening-up has occurred
- Other (please specify)

Do you agree that Q4 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
- Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:

### Q5. How would you characterise your country’s economy?
- mature market economy (i.e., fully liberalized and open; steady competition; moderately affluent)
- a reforming economy “marketizing” at a steady pace (i.e., largely liberalized and open; growing competition; moderately

Do you agree that Q5 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
- Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:
### Q6
What do you consider to be the most important assets or strengths of your country in relation to building capacity for health promotion? 1 = not important, 2 = low importance, 3 = moderate importance, 4 = high importance, 5 = very high importance:
- Community knowledge, tradition and culture
- Eagerness to learn and to build capacity
- Low cost infrastructure leading to more sustainable health promotion capacity development
- Political commitment
- Commitment of the existing workforce
- Strong leadership provided by key individuals and organisations
- Links to regional and global networks
- Civil society partnerships (e.g., multiple levels of government, NGOs and community organisations)
- Other (please specify)

Do you agree that Q6 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:

### Q7
In your country what are the main barriers which affect its capacity to deliver interventions that improve population health:
- War
- Tyranny
- Poverty
- Social inequalities
- Intolerance
- Economic transitions
- Political transitions
- Language and culture

Do you agree that Q7 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:
Health Promotion Governance

*Health Promotion Governance is defined as a system of values, policies and institutions to manage the country’s health promotion development within and among the state, civil society and private sector* (adapted from Olowu & Sako, 2002).

The components of health promotion governance are:

*B1. Institutional Capacity*
*B2. Vision and Leadership*
*B3. Transparency*

B1. Institutional Capacity

*Institutional Capacity refers to a government’s ability to define the scope and purpose of the health promotion system in the country, outline the values to guide health promoting policies, set aims for promoting health, and establish structures to develop and implement policy.*
### Q9
Which of the following best describes the current situation in your country? Please choose from one of the options below:

- The country has 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
- The country has a unit/section/department or a group described differently but which performs functions relating to health promotion
- The country has no designated health promotion unit/section/centre/department or a group within the national Ministry of Health

<table>
<thead>
<tr>
<th>Do you agree that Q9 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

### Q10
Please rate the following statements about health promotion in your country:

- National health authorities are able to assess the needs of the population for health promotion
- There is an established designated authority with a clear mandate for health promotion e.g., Ministry of Health.
- There is a political commitment to issues relating to health promotion
- Essential health promotion and public health functions of the national health system are clearly defined
- Health promotion strategies are integrated into the practice of health care services
- Policy making in health and other sectors contributes to national health promotion goals and objectives
- National and regional mechanisms are in place to provide technical assistance and improve health promotion actions at local level
- Mechanisms and structures are in place within the health care services to respond to the needs and priorities of more disadvantaged or vulnerable groups

<table>
<thead>
<tr>
<th>Do you agree that Q10 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

### B2. Vision and Leadership

*Health Promotion Vision* expresses goals that are worth striving for and incorporates shared health promotion ideals and values (adapted from National Public Health Performance Standards Program (NPHPSP), 2007). *Health Promotion Leadership* is the ability to contribute to the development of a shared vision and strategic direction for health promotion action (adapted from Dempsey, Battel-Kirk, & Barry, 2011).
<table>
<thead>
<tr>
<th>Q11</th>
<th>In your country the health promotion leaders:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• are visible</td>
</tr>
<tr>
<td></td>
<td>• provide a credible voice for the promotion of health</td>
</tr>
<tr>
<td></td>
<td>• promote health on the political agenda</td>
</tr>
<tr>
<td></td>
<td>• take a leading role in advancing health equity</td>
</tr>
<tr>
<td></td>
<td>• address the social determinants of health</td>
</tr>
<tr>
<td></td>
<td>• follow up planned activities</td>
</tr>
<tr>
<td></td>
<td>Do you agree that Q11 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q12</th>
<th>National leadership for health promotion development is shared among the following in your country:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ministry of health</td>
</tr>
<tr>
<td></td>
<td>• Various government sectors</td>
</tr>
<tr>
<td></td>
<td>• Universities</td>
</tr>
<tr>
<td></td>
<td>• Health professions</td>
</tr>
<tr>
<td></td>
<td>• Not for profit organisations</td>
</tr>
<tr>
<td></td>
<td>• Non-governmental organisations</td>
</tr>
<tr>
<td></td>
<td>• Civil society</td>
</tr>
<tr>
<td></td>
<td>• Intergovernmental organisations (e.g. UN agencies)</td>
</tr>
<tr>
<td></td>
<td>• Donor countries</td>
</tr>
<tr>
<td></td>
<td>• Any other (please specify)</td>
</tr>
<tr>
<td></td>
<td>Do you agree that Q12 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q13</th>
<th>Effective leadership in national health promotion development in your country means:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Establishing a unit/section/centre/ department responsible for health promotion</td>
</tr>
<tr>
<td></td>
<td>• Developing health promotion capacity at all governance levels for the country</td>
</tr>
<tr>
<td></td>
<td>• Developing strategies and medium to long term national plans for health promotion (5-10 years)</td>
</tr>
<tr>
<td></td>
<td>• Monitoring and evaluating the health promotion policies and interventions on a regular basis</td>
</tr>
<tr>
<td></td>
<td>• Supporting strategic planning for health promotion through improving synergies across sectors, policies and programme</td>
</tr>
<tr>
<td></td>
<td>Do you agree that Q13 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
</tr>
</tbody>
</table>
### Appendices

#### B4. Transparency

Transparency is a set of rules to guide action in health organisations and allows those affected by administrative decisions, business transactions or charitable work to know not only the basic facts and figures but also the mechanisms and processes (Transparecy International, 2012).

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Agreement Options</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q14</strong></td>
<td>In your country there is legislation providing a clear outline of responsibilities and accountability at governmental level to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- assess and promote population health at national level</td>
<td>Strongly Disagree/Disagree/Uncertain/ Agree/Strongly Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- assess and promote population health at regional level</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Q15</strong></td>
<td>Knowing basic facts, figures, mechanisms and processes promote accountability and increase stakeholder engagement. Please rate the following statements in accordance with the situation in your country:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- State ensures political participation throughout the decision-making process in the health sector</td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Responsibilities and accountability of organisations for the implementation of health promotion interventions are clearly specified within the regulatory and institutional framework</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Q16
Both the government and health development assistance partners (international development agencies / donors) work together to foster and maintain their legitimacy for health promotion development through:
- fair and explicit priority setting processes
- wide representation of all relevant stakeholders
- balance of decision making powers
- commitment to accountability and transparency

Do you agree that Q16 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree
Comments:

### Q17
Does your country have the capacity to create a health promotion working environment free from corruption?

Do you agree that Q17 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree
Comments:

### General questions about Health Promotion Governance

#### Q18
Please give examples of institutes/agencies/organisations/units with a clear mandate for health promotion in your country:
(Table format)
<table>
<thead>
<tr>
<th>Name of institutes/agencies/organisations/units</th>
<th>Status (national / regional / local (community); governmental / independent)</th>
<th>Focus of HP interventions</th>
</tr>
</thead>
</table>

Do you agree that Q18 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree
Comments:

#### Q19
Please identify the main barriers for health promotion governance in your country.

Do you agree that Q19 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree
Comments:
Policy Environment

*Health Promotion Policy Environment refers to national structures and mechanisms which enable formulation and implementation of healthy public policies to achieve health promotion objectives (adapted from Aluttis, et al. 2012).*

The Health Promotion Policy Environment has two components:

**C1. National policies and plans**
**C2. Policy coherence**

C1. National Policies and Plans

*National Policies and Plans for health promotion consist of national health promotion policy, national health policy, and healthy public policies and plans that set health promotion goals, provide guidelines for health promotion practice, and frameworks for health promotion action across all sectors.*
### Q21
Is health promotion reflected in national government policies including health policy in your country? Please choose one response.

- Yes, there is stand-alone health promotion policy
- Yes, health promotion is part of an overall health policy
- Yes, there are health promotion elements in policies other than health policy
- No, there is no reference to health promotion in health policies
- No information available
- Don’t know
- Other (if other, please specify)

Do you agree that Q21 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Unceratin/Agree/Strongly Agree

Comments:

### Q22
Please rate the following statements about health promotion policy making in accordance with the situation in your country:

- Health promotion policy making is informed by and aligned with regional / local health needs of the population (provided through information systems)
- Health promotion policies are subject to a system of evaluation and monitoring, which feeds into future policy developments
- Health promotion policy environment enables key stakeholders to participate in policy making processes
- Health promotion policies ensure that an appropriate proportion of funds are allocated to support health promotion interventions
- Policy statements in other sectors, relevant to health promotion, contribute to the national health promotion goals and objectives
- Country legislation, policies, strategic plans or other regulations endorse equity in health as a government priority
- Donors influence the prioritisation of health issues in policy making in the country

Do you agree that Q22 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Unceratin/Agree/Strongly Agree

Comments:

### Q23
Please indicate whether each of the following is a policy/legislation/ regulation/ national plan of action/strategy/ guideline or a programme in your country. Also indicate the level of development from the drop down menus.

- Healthy lifestyles (reduced consumption of tobacco products, alcohol, fatty, sugary or salty food and increased physical activities)
- Socioeconomic determinants such as poverty, universal health services,

Do you agree that Q23 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Unceratin/Agree/Strongly Agree
Appendices

universal education and employment opportunities
- Consumption of illicit drugs and alcohol
- Road traffic injury prevention
- Environmental risks
- Occupational health and safety
- Tobacco control
- Mental health promotion
- Infectious diseases
- Non communicable diseases
- Settings-based health promotion (such as schools and workplaces)
- Health crisis management
- Health education, information and communication
- Any other

Comments:

Q24 In your country does the government, in collaboration with other stakeholders, strive to achieve health promotion development goals through a rights based approach to improve population health?

Do you agree that Q24 should be included in the Health Promotion Capacity Mapping Tool for developing countries?
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree
Comments:

C2. Policy Coherence

Policy coherence for health promotion is defined as the systematic promotion of mutually reinforcing policy actions across government departments and all other stakeholders creating synergies towards achieving the defined health promotion objectives (adapted from Development Assistance Committee, 2001).

Q25 In your country are health promoting policies mutually reinforced across government departments and agencies through:

Do you agree that Q25 should be included in the Health Promotion Capacity Mapping Tool for developing countries?

364
### Setting health promotion policy objectives and determining which objective takes priority

- Negotiating agreements with international donors and agencies to ensure that donors’ priorities are consistent with national priorities
- Co-ordination of health promotion policy with other sectors’ policies
- Developing effective systems for monitoring, analysis and reporting health promotion developments
- Any other (please specify)

### General questions about Policy Environment

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Do you agree that Q26 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q26</td>
<td>Please identify the main barriers in health promotion policy making in your country.</td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td>Q27</td>
<td>Please give example(s) of a health promotion policy and its functioning in practice in your country.</td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td>Q28</td>
<td>Please identify three indicators for the capacity domain “Health Promotion Policy Environment” which are most important for the strengthening or further development of the Health promotion in your country.</td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
</tbody>
</table>
Health Promotion Infrastructure

Health Promotion Infrastructure consists of human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide health promotion response to health issues and challenges (adapted from WHO, 1998).

Health promotion infrastructure has following components:

D1. Health Promotion Delivery
D2. Workforce
D3. Partnerships
D4. Financing
D5. Knowledge Management

D1. Health Promotion Delivery

Health Promotion Delivery consist of the delivery structures and mechanisms for health promotion priorities including support for inter-sectoral partnerships located at national and/or subnational levels according to country needs. (adapted from Catford, 2005)

<table>
<thead>
<tr>
<th>Q29</th>
<th>Are there national guidelines available in relation to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health promotion needs assessment</td>
</tr>
<tr>
<td></td>
<td>Health promotion programme implementation</td>
</tr>
<tr>
<td></td>
<td>Health promotion evaluation</td>
</tr>
<tr>
<td></td>
<td>Do you agree that Q29 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
<tr>
<td></td>
<td>Comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q30</th>
<th>In your country planning health promotion interventions consist of the following components:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Engaging stakeholders</td>
</tr>
<tr>
<td></td>
<td>Assessing a situation and defining vision and mandate</td>
</tr>
<tr>
<td></td>
<td>Formulating policies and strategies</td>
</tr>
<tr>
<td></td>
<td>Providing infrastructure (workforce, budget, administration,</td>
</tr>
<tr>
<td></td>
<td>Do you agree that Q30 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
</tbody>
</table>
- Developing monitoring and evaluation plan
- Setting an action plan
- Implementing the plan, including evaluation

At which of these stage(s) do you see the biggest issues? And what are those?

**Q31** In relation to strategies that are employed to promote health in your country, please indicate what is the main focus of health promotion activity by clicking on the relevant option where 1 = not employed, 2 = infrequently employed 3 = frequently employed, 4 = very frequently employed

- Developing personal skills
- Reorienting the health service
- Creating supportive environments
- Strengthening community action
- Building healthy public policy

Please add any comments:

Do you agree that Q31 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:

**Q32** Please rate the following statements in accordance with the situation in your country:

- The existing organisational structures are comprehensive and effective for the implementation of health promotion policies and programmes
- There is use of evidence-based health promotion planning, implementation and evaluation
- Health promotion interventions are multistrategy (i.e. they are a combination of policy development, legislation and regulation, organisational change, community development, advocacy, communication and education)
- The main focus of health promotion activity is appropriate for best practice in your country

Do you agree that Q32 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

Comments:
• Health promotion interventions in your country are accountable for the sensitivity of their activities with regards to gender and other cultural, social or linguistic dynamics
• Health promotion interventions in your country are sustainable (any change can be continued once initial funding has ended)

D2. Workforce

Health Promotion Workforce refers to the availability and development of qualified human resources with sufficient skills and knowledge to deliver essential health promotion action (adapted from Aluttis, C. et al., 2012).

<p>| Q33 | Are there dedicated posts or job descriptions, which contain the title ‘health promotion’ in your country? Yes / No If yes, please give details of range of posts: Number of dedicated health promotion posts, statutory/ NGO/ Other | Do you agree that Q33 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree Comments: |
| Q34 | Is there a specialist workforce for health promotion in your country? If yes, please give details. | Do you agree that Q34 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree Comments: |
| Q35 | Are there any national-level education and training programmes in health promotion available in your country? You may choose more than one response. Please click the appropriate boxes • Yes, there are specific courses (postgraduate Diploma and Master’s courses or undergraduate Bachelor training) dedicated to health promotion | Do you agree that Q35 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree Comments: |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Text</th>
<th>Comments:</th>
</tr>
</thead>
</table>
| Q36 | **Does the government support health promotion education and training:**  
- at the undergraduate level  
- at university and postgraduate levels | Do you agree that Q36 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree  
Comments: |
| Q37 | **Do you consider that the education and training available in your country is adequate to build and maintain workforce capacity for health promotion?** | Do you agree that Q37 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree  
Comments: |
| Q38 | **Do you consider that the education and training in health promotion available in your country is:**  
- relevant  
- culturally appropriate  
- needs based | Do you agree that Q38 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree  
Comments: |
| Q39 | **Who, in your opinion, is the priority target audience** | Do you agree that Q39 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree  
Comments: |
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q40  Is there a set of core competencies based on international standards specified for professionals working in the field of health promotion in your country?</td>
<td>Do you agree that Q40 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Yes / No Comments:</td>
</tr>
<tr>
<td>Q41  Are you aware of any networks which support education and training in health promotion in your country and/or region? Yes / No If yes, please give details</td>
<td>Do you agree that Q41 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Yes / No Comments:</td>
</tr>
<tr>
<td>Q42  Is there a national professional association for</td>
<td>Do you agree that Q42 should be included in the Health Promotion Capacity Mapping Tool for developing countries? Yes / No Comments:</td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Q43</td>
<td>Please rate the following statements about the health promotion workforce in accordance with the situation in your country:</td>
</tr>
<tr>
<td></td>
<td>- The health promotion workforce is sufficient in numbers to address the population needs</td>
</tr>
<tr>
<td></td>
<td>- The health promotion workforce is adequately distributed according to population needs</td>
</tr>
<tr>
<td></td>
<td>- The available workforce for health promotion represents an adequate distribution of functions (e.g., academia, practitioners, researchers, specialists)</td>
</tr>
<tr>
<td></td>
<td>- The available workforce for health promotion represents an adequate distribution of backgrounds (e.g., medical, public health, psychology, political sciences, etc.)</td>
</tr>
<tr>
<td></td>
<td>- There is professional expertise and capacity within universities and research institutes to carry out evidence based research oriented towards establishing effectiveness of health promotion policies and practice</td>
</tr>
<tr>
<td>Q44</td>
<td>Provide at least one example of the existing capacity for training and development in the health promotion in your country.</td>
</tr>
<tr>
<td>Q45</td>
<td>What do you see as the main barriers for education and training in health promotion in your country?</td>
</tr>
</tbody>
</table>
### D3. Partnerships

*Health Promotion Partnerships* refer to relationships between various partners in the health and non-health sectors (donors, development agencies, NGOs, civil society, private and government sectors) to work towards a set of shared outcomes thereby strengthening the health promotion system in a country (adapted from WHO, 1998).

<table>
<thead>
<tr>
<th>Q46</th>
<th>In your country are legal mechanisms and policies in place to support formal partnerships between government, NGOs, civil society, private sector and international donors for addressing health promotion priorities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you agree that Q46 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q47</th>
<th>In your country effective collaboration within government to address health promotion priorities exist between:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• authorities for health and other sectors</td>
<td></td>
</tr>
<tr>
<td>• health care services and the health promotion unit/department</td>
<td></td>
</tr>
<tr>
<td>• academic institutions and the health promotion unit/department</td>
<td></td>
</tr>
<tr>
<td>• between levels of decision-making (national, regional, local level)</td>
<td></td>
</tr>
<tr>
<td>• Any other (please specify)</td>
<td></td>
</tr>
<tr>
<td>Do you agree that Q47 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>
### Q48
In your country effective partnerships with government to address health promotion priorities exist between:
- organisations within the field of health promotion and public health
- organisations in the public and private sector
- health promotion and public health bodies and international organisations
- health promotion unit/department and the private sector
- health promotion unit/department and NGOs,
- health promotion unit/department and civil society
- Any other (please specify)

**Do you agree that Q48 should be included in the Health Promotion Capacity Mapping Tool for developing countries?**
- Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

**Comments:**

### Q49
Please rate the following statements with respect to your country’s experience of partnering with an international development agency or donor:
- your country’s health promotion / public health priorities are at the centre
- donor funded activities fall within the framework of the national health promotion strategies and approach
- planning and implementation processes include both state and non-state actors to ensure a high level of national health promotion ownership
- strengthening national health promotion capacity to undertake national health development initiatives is considered essential

**Do you agree that Q49 should be included in the Health Promotion Capacity Mapping Tool for developing countries?**
- Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree

**Comments:**

### D4. Financing

*Financing for health promotion refers to the allocation of sufficient resources and incentives to create and sustain effective national health promotion structures and strategies (adapted from Catford, 2005).*
<table>
<thead>
<tr>
<th>Q50</th>
<th>Are there dedicated sources of funding available for health promotion activities in your country?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Government</td>
</tr>
<tr>
<td></td>
<td>• International development agencies</td>
</tr>
<tr>
<td></td>
<td>• International donors (countries)</td>
</tr>
<tr>
<td></td>
<td>• Non-governmental organisations</td>
</tr>
<tr>
<td></td>
<td>• Other (please specify)</td>
</tr>
<tr>
<td></td>
<td>• None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q50</th>
<th>Do you agree that Q50 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Q51</th>
<th>Please rate the following statements regarding sustainable financing for health promotion in your country:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• There are 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</td>
</tr>
<tr>
<td></td>
<td>• There is a stable flow of financial resources for health promotion development (i.e. annual allocation of funds)</td>
</tr>
<tr>
<td></td>
<td>• Health promotion authorities are able to make autonomous decisions about funding priorities unconstrained by funding sources</td>
</tr>
<tr>
<td></td>
<td>• Governmental funds are generated from different sectors to enable intersectoral interventions to promote health equity and reduce poverty</td>
</tr>
<tr>
<td></td>
<td>• The percentage of the national health budget spent on health promotion is adequate compared to health care</td>
</tr>
<tr>
<td></td>
<td>• The national expenditure for health promotion is adequate in comparison with other sectors addressing the wider determinants of health</td>
</tr>
<tr>
<td></td>
<td>• Mechanisms and regulations are in place to control and ensure transparency of health promotion expenditure</td>
</tr>
<tr>
<td></td>
<td>• There is a separate budget line designated for health promotion at sub-national (provincial, district) levels</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q51</th>
<th>Do you agree that Q51 should be included in the Health Promotion Capacity Mapping Tool for developing countries?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
</table>
D5. Knowledge Development and Management

*Health Promotion Knowledge Development* refers to developing a body of knowledge and an evidence base to support policymaking at all levels (adapted from Aluttis, et al., 2012). *Knowledge Management* consists of using this knowledge to develop capacity for health promotion research, information systems, performance improvement, evaluation and monitoring to strengthen national health systems.

<table>
<thead>
<tr>
<th>Q52</th>
<th>Please rate the following statements in accordance with the situation in your country:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• A national health information system is in place which collects, processes and analyses population health related data</td>
</tr>
<tr>
<td></td>
<td>• There is adequate access to information on health promotion (i.e. theory, models, research, examples of best practice, etc).</td>
</tr>
<tr>
<td></td>
<td>• There is access to the data from other sectors addressing the socioeconomic determinants of health (e.g., poverty, employment, education, environment, transport, etc.)</td>
</tr>
<tr>
<td></td>
<td>• The health information system periodically tracks and reports on lifestyle health determinants (e.g. nutrition, tobacco, alcohol, physical activity)</td>
</tr>
<tr>
<td></td>
<td>• The health information system communicates relevant information to decision makers at national, regional and local level for health promotion development</td>
</tr>
<tr>
<td></td>
<td>• There are periodical (i.e. yearly) governmental reports that define common health promotion objectives, priorities and strategies</td>
</tr>
<tr>
<td></td>
<td>• Universities and research institutes are initiating or participating in health promotion research</td>
</tr>
<tr>
<td></td>
<td>• There is professional expertise within the universities and research institutes to carry out health promotion monitoring activities and interpret outcomes and trends</td>
</tr>
<tr>
<td></td>
<td>• Health promotion research findings and results are regularly or periodically communicated to policy and decision makers</td>
</tr>
<tr>
<td></td>
<td>• Local health promotion intervention studies are published in professional journals at the national, regional or international levels</td>
</tr>
</tbody>
</table>

| |
| Do you agree that Q52 should be included in the Health Promotion Capacity Mapping Tool for developing countries? |
| Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree |
| Comments: |
**General Questions about Health Promotion Infrastructure**

| Q53 | Provide example(s) of health promotion implementation at national, regional and local level. | Do you agree that Q53 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree  
Comments: |
|-----|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| Q54 | Please identify the main barriers to health promotion implementation at national level in your country. | Do you agree that Q54 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree  
Comments: |
| Q55 | Please identify three indicators for the capacity domain “Health Promotion Infrastructure” which are most important for the further development of the health promotion capacity in your country. | Do you agree that Q55 should be included in the Health Promotion Capacity Mapping Tool for developing countries?  
Strongly Disagree/Disagree/Uncertain/Agree/Strongly Agree  
Comments: |
Part 3

About this tool

<table>
<thead>
<tr>
<th>Q56.</th>
<th>Please rate the following statements about the proposed Health Promotion Capacity Mapping Tool.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The Health Promotion Capacity Mapping Tool adequately reflects health promotion capacity mapping in developing countries</td>
</tr>
<tr>
<td></td>
<td>• The Health Promotion Capacity Mapping Tool will be useful in planning and implementing health promotion interventions in developing countries</td>
</tr>
<tr>
<td></td>
<td>• The Health Promotion Capacity Mapping Tool will be useful in developing health promotion capacity in developing countries</td>
</tr>
<tr>
<td></td>
<td>• The Health Promotion Capacity Mapping Tool adequately reflects the evidence base for good practice in health promotion</td>
</tr>
</tbody>
</table>

| Q57. | If you have any suggestions on how to improve the Health Promotion Capacity Mapping Tool for developing countries as a whole or specific capacity domains/items please give detailed feedback here. |
APPENDIX N: Health Promotion Capacity Mapping Tool for Thailand

We recommend that you read this document, and have ready the required information, before starting responding to the online version of the questionnaire. Please note that the responses to the questions can only be submitted via accessing the online version at http://www.surveymonkey.com/s/P8BRD5W

A glossary of the various terms used in the questionnaire is attached for your information.

1. Please enter some basic details about yourself. Please note that this question is mandatory in order to proceed.

- Name
- Organisation or Employer
- Area of particular expertise
- Email address

Health Promotion Governance

Health Promotion Governance is defined as a system of values, policies and institutions which manages the development of a country’s Health Promotion within and among the state, civil society and private sector through ‘whole of government’ and ‘whole of society’ approaches.

Health Promotion Governance has following sub-domains:

1.1 Institutional Capacity
1.2 Vision and Leadership
1.3 Transparency and Accountability

Institutional Capacity

Institutional Capacity refers to a government’s ability to define the scope and purpose of the Health Promotion system in the country, outline the values to guide health promoting policies, set aims for promoting health, and establish structures to develop and implement policy.

2. Which of the following best describes the current situation in your country? Please choose from one of the options below:

a. The country has a designated “Health Promotion” unit or section within the national Ministry of Health
b. The country has a unit or section described differently but which performs functions relating to Health Promotion
c. The country has no designated Health Promotion unit or section
d. The country has other ways to strengthen the institution of Health Promotion. Please give details (box)

Comment box
(Please note, the words ‘comment box’ and ‘text box’ have been used interchangeably in this document)

3. Please give at least 3 examples of agencies or organisations with a clear mandate for Health Promotion in your country:
   For each organisation you will be asked to provide:
   Name
   Please state at what level: National, provincial (regional), local (community) or International
   Is it: Governmental, semi-government or non-governmental or Private
   What is the organisation’s focus of Health Promotion intervention / activities? Web-link
   Comment box

4. Please rate the following statements about institutional capacity for Health Promotion in your country:
   (Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree)
   a. There is a national plan which oversees and guides the Health Promotion policymaking and implementation
   b. There is a political commitment to deliver Health Promotion
   c. Essential health promoting functions in the national health system are clearly defined

Comment box

5. Does your country receive international assistance in relation to health and development?
   Yes/No

6. If yes, please click on the relevant option below:
   a. The government have complete control of health policies and strategies
   b. The government and international agencies collaborate on a 50-50 basis on leading policy and strategies
   c. Policies and strategies are mainly led by international agencies

Please give details in support of your response (comment box)
Vision and Leadership
Health Promotion Vision expresses goals that are worth striving for and incorporates shared Health Promotion ideals and values.
Health Promotion Leadership is the ability to contribute to the development of a shared vision and strategic direction for Health Promotion action.

7. **There is a clear understanding of the concept of Health Promotion among stakeholders in your country. Please rate your agreement to this statement.**
*(Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree)*

8. **Effective leadership in national Health Promotion development in your country means that:**
*(Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree)*

Part 1

a. leadership is visible
b. leadership is shared
c. it provides a credible voice for the promotion of health
d. promoting health is on the political agenda
e. it oversees Health Promotion development at policy formulation and policy implementation levels
f. it improves linkages across sectors, policies and programme areas (e.g. Health in All Policies, Intersectoral Action for Health, Whole of Government Approach)
g. it develops policies and interventions that address health inequalities (e.g. Health Equity in All Policies)
h. it develops international and national partnerships and collaborations to achieve national, regional (provincial) and local Health Promotion goals
i. it recruits national Health Promotion experts to provide technical support
j. it monitors and evaluates the Health Promotion policies and interventions on a regular basis

Part 2

k. Please name up to five key leaders (or leading organisations) involved in Health Promotion development in your country (text box)

Comment box

9. **Following agencies / sectors work in partnerships to achieve common goals for Health Promotion development in the country:**
(Drop down menus ‘Partner most frequently with’ and ‘Partner least frequently with’ contain all the names from a - j)

<table>
<thead>
<tr>
<th></th>
<th>Partner most frequently with</th>
<th>Partner least frequently with</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ministry of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Various government sectors / departments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Universities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Health Professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Not for profit organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Non-governmental organisations (NGOs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Civil society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Intergovernmental organisations (e.g. UN agencies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Donor countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Any other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comment box

10. Please identify five significant players (organisations) in Health Promotion development in your country, covering the areas of policy, practice and research?

5 text boxes

Comment box

1.1 Transparency and Accountability

Transparency is built on the free flow of information for all health matters. Processes, institutions and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters.

Accountability refers to the obligation on the part of public officials to report on the use of public resources and answerability for failing to meet stated performance objectives

11. Please rate the following statement about transparency in relation to the situation in your country:

Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree

Knowing basic facts, figures, mechanisms and processes promote transparency. Information about how the Health Promotion activities are funded and regulated is accessible.
12. Please rate the following statements about accountability in relation to the situation in your country.

Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree

a. The accountability of organisations for the implementation of Health Promotion interventions is clearly specified within the regulatory / governance framework

b. Government ensures that the organisations and institutions performing health promoting activities report their actions to the relevant higher authorities regularly

13. The government and its partners (national and international bodies or agencies) work together for Health Promotion development through:

Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree

a. Fair and explicit priority setting processes

b. Wide representation of all relevant stakeholders

c. Balancing of decision making powers

d. Adherence to accountability and transparency

e. Lobbying with public authorities

Policy Environment

The Health Promotion Policy Environment refers to national structures and mechanisms which enable formulation and implementation of healthy public policies to achieve Health Promotion objectives.

Policy environment has following sub-domains:

2.1 National policies and plans
2.2 Policy coherence

1.1 National Policies and Plans

National Policies and Plans for Health Promotion consist of all policies and plans that set Health Promotion goals, provide guidelines for Health Promotion practice, and frameworks for Health Promotion action across all sectors.
14. Is Health Promotion included in national government policies including the health policy in your country? You can choose more than one response from the options below:  
   a. There is stand-alone Health Promotion policy  
   b. Health Promotion is part of an overall health policy  
   c. There are Health Promotion elements in policies other than health policy  
   d. There is no reference to Health Promotion in health policies  
   e. No information available  
   f. Don’t know  
   g. Any other (box)  
   Comment box.

15. Please rate the following statements about policy making in your country:  
   Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree  
   a. General policymaking is conducive to advancing a ‘health in all policies’ approach.  
   b. Health Promotion policy making is aligned with the health needs of the population.  
   c. Evaluation and monitoring of Health Promotion policies feed into future policy developments.  
   d. Health Promotion policy making is a participative process i.e. based on consultation with key stakeholders.

16. Is there a policy or programme in your country in relation to each of the following? Please choose one of the options from the drop down menus for each of the policy and programme areas listed below.  
   Drop down menus for each option: Menu 1 (Policy), Menu 2 (Programme)  
   Drop down menu items: Fully implemented, Partially implemented, Actioned, Under development, Being considered, Not currently actioned  
   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.  
   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.
**Actioned:** This means that work has started but that it is too early to assess impact or outputs.

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

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

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

a. Healthy lifestyles i.e. reduced consumption of tobacco products, alcohol, fatty, sugary or salty food and increased physical activities
b. Socioeconomic determinants such as poverty, universal health services, universal education and employment opportunities
c. Consumption of illicit drugs
d. Consumption of alcohol
e. Road traffic injury prevention
f. Environmental risks to health
g. Occupational health and safety
h. Tobacco control
i. Mental Health Promotion
j. Suicide prevention
k. Promotion of physical activity
l. Promotion of healthy diet
m. Prevention of infectious diseases
n. Prevention of non-communicable diseases
o. Settings-based Health Promotion (such as schools and workplaces)
p. Health crisis management
q. Health education, information and communication
r. Any other

17. **Is there a human rights-based approach in promoting health in your country?**

Yes/No

If yes, please give details
18. Please provide example(s) of a current Health Promotion policy and a report on its implementation at national, regional or local level. If possible, provide a web link or any reference to access publication, etc.

Text box

Policy Coherence

Policy coherence refers to the extent to which different policies complement or support each other, including public, international and global health policies.

19. Please rate the following statements according to the situation in your country.

*Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree*

a. Mechanisms exist in the government to ensure that public policies support the attainment of national health promotion objectives.

b. Global health policies across a range of issues, in relation to Thailand, do not undermine the attainment of national health promotion objectives.

c. Global health policies across a range of issues, in relation to Thailand, support the attainment of national health promotion objectives.

Comment box

Health Promotion Infrastructure

Health Promotion Infrastructure consists of human and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide Health Promotion response to health issues and challenges.

Health Promotion infrastructure has following sub-domains:

3.1 Health Promotion Delivery
3.2 Workforce
3.3 Partnerships
3.4 Financing
3.5 Knowledge Management

Health Promotion Delivery
Health Promotion Delivery consist of the delivery structures and mechanisms for Health Promotion priorities including support for inter-sectoral partnerships located at national and/or subnational levels according to country needs.

20. Are there national bodies / agencies responsible for:

Answer choices: No, Yes, Uncertain

a. Health Promotion needs assessment  
b. Health Promotion programme planning  
c. Health Promotion programme implementation  
d. Health Promotion monitoring  
e. Health Promotion evaluation  
f. Health impact assessment

Comment box

21. Please identify the organisations or institutions in your country that carry out the following tasks.

(Text box provided against each option)

a. Health Promotion needs assessment  
b. Health Promotion programme planning  
c. Health Promotion programme implementation  
d. Health Promotion monitoring  
e. Health Promotion evaluation  
f. Health impact assessment

22. The Ottawa Charter for Health Promotion outlines five action areas to promote health. These are listed below. Please indicate the level of awareness and/or use of each action area in your work?

Answer options for each action area below: Uncertain, Not aware, Aware, Aware and use action areas in developing strategies

a. Building healthy public policy (e.g. bicycle helmet legislation)  
b. Creating supportive environments (e.g. banning junk food in elementary schools)
c. Strengthening community action (e.g. supporting community coalitions taking action on homelessness)
d. Developing personal skills (e.g. health parenting programmes)
e. Reorienting the health service (e.g. baby friendly hospitals)

Comment box

Workforce

Health Promotion Workforce refers to the availability and development of qualified human resources with sufficient skills and knowledge to deliver essential Health Promotion action.

23. Is there a specialist workforce for Health Promotion in your country? i.e. practitioners with dedicated posts or job descriptions, which contain the title 'Health Promotion'?

If yes, please give details of range of posts: Number of dedicated Health Promotion posts, statutory/ NGO/ Other.

If no, do other similar roles exist?

Comment box

24. Are there any education and training programmes at national level in Health Promotion available in your country? Please click the appropriate boxes. You may choose more than one response.

a. Yes, there are specific courses (postgraduate Diploma and Master’s courses or undergraduate Bachelor training) dedicated to Health Promotion
b. Yes, there are courses in which Health Promotion is a module, a subject or a part
c. Yes, there are short courses in Health Promotion for health and community workers (e.g. nurses, community workers, teachers, health professionals etc.)
d. Yes, there are courses which include health equity and the socio-economic determinants of health
e. No, there is no specific training in Health Promotion
f. No information available
g. Other (please specify) or comment
25. In your opinion is the education and training in Health Promotion available in your country sufficient to address the health needs of the population?

*Answer choices: Yes, No*

(Comment box)

26. Who, in your opinion, is the priority target audience for training and education in Health Promotion in your country? Please indicate your opinion on the order of importance.

*Options provided: Not important, Low importance, Moderate importance, High importance, Very high importance*

a. Community workers
b. Primary health care professionals
c. Health Promotion practitioners
d. Public health practitioners
e. Health education practitioners
f. Other health service professionals (doctors, nurses, etc.)
g. Health service managers
h. Local government managers
i. Policy makers (e.g. Ministry of Health)
j. Educators (teachers in schools, colleges etc.)

Any other (please specify) or Comment?

27. Is there a set of core competencies specified for professionals working in the field of Health Promotion in your country?

*Answer choices: Yes, No, Uncertain*

If yes, please give details

28. Is there a national professional association for health promoters or an association that caters for the interests of health promoters? *Answer choices: Yes, No, Uncertain*

If yes, please specify or give a comment

29. In your opinion is there professional expertise and capacity within universities and research institutes to carry out Health Promotion research? *Answer choices: Yes, No, Uncertain*
Any comments?

30. Please provide at least one example of the existing programmes for training and development in the Health Promotion in your country.

Name:
Funded by (Government, Private, Donor):
Web link, or a reference:
Any other comments

Partnerships

Health Promotion Partnerships refer to relationships between various partners in the health and non-health sectors (donor countries, development agencies, NGOs, civil society, private and government sectors) to work towards a set of shared outcomes thereby strengthening the Health Promotion system in a country.

31. To address Health Promotion priorities, partnerships exist within government between:

Answer choices: Very weak, Weak, Strong, Very strong, Uncertain
a. authorities for health and other sectors
b. health care services and the Health Promotion unit/section
c. academic institutions and the Health Promotion unit/section
d. between levels of decision-making (national, regional, local level)

Any other (please specify) or any other comments

32. To address Health Promotion priorities, the government works in partnerships with:

Answer choices: Very weak, Weak, Strong, Very strong, Uncertain
a. Private organisations promoting health
b. International Health Promotion bodies and organisations
c. Non governmental organisations
d. Community groups

Any other (please specify) or any other comments

Financing

Financing for Health Promotion refers to the allocation of sufficient resources and incentives to create and sustain effective national Health Promotion structures and strategies.
33. Are there dedicated sources of funding available for Health Promotion activities in your country from the following sources?

*Answer options: Yes, No, Uncertain*

a. Government
b. Intergovernmental organisation (e.g. United Nations and its agencies like the World Health Organisation (WHO), etc.)
c. International development agencies (Department for International Development (DFID), Canadian International Development Agency (CIDA), United States Agency for International Development (USAID), etc.)
d. Donor countries
e. International non-governmental organisations (Oxfam International, CARE International, International Committee of the Red Cross (ICRC), etc.)
f. Private sector (commercial)
g. Private sector (philanthropes) (e.g. Bill & Melinda Gates Foundation (Gates Foundation), etc.)

Any other (please specify) or any other comments

34. Please rate the following statements regarding sustainable financing for Health Promotion in your country:

*Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree*

a. There is a stable flow of financial resources for Health Promotion development (i.e. annual allocation of funds)
b. Financial resources for Health Promotion are also channelled through other government sectors (education, transport, environment, etc.)
c. There are arrangements for the 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
d. The funding for Health Promotion development is adequate (fulfills national Health Promotion objectives)

Any comments?

Knowledge Development and Management

Health Promotion Knowledge Development refers to developing a body of knowledge and an evidence base to support policymaking at all levels. Knowledge Management consists of using this knowledge to develop capacity for Health Promotion research, information systems, performance improvement, evaluation and monitoring to promote health and strengthen national health system.
35. Please rate the following statements in accordance with the situation in your country:

*Rating scale: Strongly disagree, Disagree, Uncertain, Agree, Strongly Agree*

- a. There is adequate access to information on Health Promotion (i.e. theory, models, research, examples of best practice, etc).
- b. A national health information system is in place which collects, processes and analyses population health related data
- c. There are periodical (i.e. yearly) governmental reports that define common Health Promotion objectives, priorities and strategies
- d. Universities and research institutes are initiating or participating in Health Promotion research
- e. There is professional expertise within the universities and research institutes to carry out Health Promotion monitoring activities and interpret outcomes and trends
- f. A system exists where health information is channelled to decision makers at national, regional and local level for Health Promotion development
- g. Stakeholders have access to relevant knowledge and use it in their Health Promotion actions and interventions

Any comments?

Country Specific Context for Health Promotion

The Country Specific Context describes the environmental, historical, political, economic, social and cultural factors which influence the development of Health Promotion capacity in a country.

36. Which of the following developments in your country have contributed to improve Health Promotion infrastructure (i.e. knowledge, skills, commitment, system and leadership):*

- a. Government papers and policies on achieving Health for All/ Primary Health Care
- b. Adoption of the Ottawa Charter (WHO, 1986)
- c. Steps taken towards development of healthy public policies
- d. Inclusion of concrete Health Promotion objectives into the health reform strategies
- e. Health Promotion education and training
- f. Health Promotion Conferences

Any other (please specify) or any other comments?

37. What do you consider to be the most important assets of your country in relation to building capacity for Health Promotion? You can click on more than one option.

- a. Community knowledge, tradition and culture
Appendices

b. Eagerness to learn and to build capacity
c. Low cost infrastructure leading to more sustainable Health Promotion capacity development
d. Political commitment
e. Commitment of the existing workforce
f. Strong leadership provided by key individuals and organisations
g. Links to regional and global networks
h. Civil society partnerships (e.g., multiple levels of government, NGOs and community organisations)
i. Health Promotion financing
j. Health Promotion trained workforce
Any other (please specify)

38. In your country what are the main barriers which affect its capacity to deliver Health Promotion interventions that improve population health. Please state these barriers for each of the following options.

A box provided against each option.

a. Political environment
b. Economic issues
c. Socio-cultural environment
d. Expertise (technical capacity)

Other (please specify):

General questions

39. Please identify three main barriers to implementing each of the following aspects of Health Promotion development in your country.

Text box provided for each option

1. Ensuring good governance for Health Promotion
2. Policy environment that is conducive to Health Promotion
3. A good infrastructure for the planning and delivering of Health Promotion actions

40. Are there any other aspects of Health Promotion capacity mapping that should be included in this tool?

Text boxes provided for each option

1. Health Promotion Governance
2. Health Promotion Policy Environment
3. Health Promotion Infrastructure
41. Do you envision that the information provided by this research tool could be used for planning, implementing, developing Health Promotion capacity in your country? Please comment.

(Comment box)

42. Would you like to be part of a discussion group on Health Promotion Capacity Mapping in Low and Middle-income Countries at the forthcoming World Conference on Health Promotion, 25 – 29 August 2013 at Pattaya, Thailand? The discussion will be held at noon on 27 August, 2013.

If you answer yes, an email invitation will be sent to you to be a member of the discussion group and will inform you of the confirmed time and venue at the The Pattaya Exhibition and Convention Hall (PEACH).

Yes/No

Any comments?

If you like to nominate someone else, please give name and email address of the nominee.
APPENDIX O: Phase II Findings Online Questionnaire

Question 1

In a mandatory question, the participants were asked to state their names, the organisation they worked in (or the employer) and area of expertise. In light of the responses the participants were classified based on their level of work (national, regional or global), job sector (public, private, semi-state or NGO), and HP area (research, policy or practice). Eighty one percent of participants (n=17) were experts working at a national level in Thailand. Forty three percent of participants (n=9) worked in the public sector and 38% (n=8) were focused on HP research.

Table O1: Profile of participants who responded to the online questionnaire

<table>
<thead>
<tr>
<th>Organisation or Employer</th>
<th>Area of particular expertise</th>
<th>Level</th>
<th>Job</th>
<th>HP Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Instructor</td>
<td>Health promotion</td>
<td>Regional</td>
<td>Public</td>
<td>Practice</td>
</tr>
<tr>
<td>International health policy program</td>
<td>Health systems research</td>
<td>Global</td>
<td>*Semi-state</td>
<td>Policy</td>
</tr>
<tr>
<td>Freelance consultant</td>
<td>Social development, planning and evaluation</td>
<td>Global</td>
<td>Private</td>
<td>Research</td>
</tr>
<tr>
<td>Faculty of Medicine Chiang Mai university</td>
<td>Endocrinology</td>
<td>National</td>
<td>Public</td>
<td>Research</td>
</tr>
<tr>
<td>Khon Kaen University</td>
<td>Community empowerment</td>
<td>National</td>
<td>Public</td>
<td>Research</td>
</tr>
<tr>
<td>The Foundation for Child Development</td>
<td>Child and Youth Development</td>
<td>National</td>
<td>Private</td>
<td>Practice</td>
</tr>
<tr>
<td>Ministry of Public Health</td>
<td>Medicine Policy &amp; Public Health</td>
<td>National</td>
<td>Public</td>
<td>Policy</td>
</tr>
<tr>
<td>Stopdrink Network</td>
<td>Civil Movement</td>
<td>National</td>
<td>Semi-state</td>
<td>Practice</td>
</tr>
<tr>
<td>ThaiRoads Foundation</td>
<td>Road Safety</td>
<td>National</td>
<td>NGO</td>
<td>Practice</td>
</tr>
<tr>
<td>Faculty of Dentistry, Khon Kaen University</td>
<td>Oral health promotion, Qualitative research</td>
<td>National</td>
<td>Public</td>
<td>Research</td>
</tr>
<tr>
<td>International Health Policy Program (IHP), Ministry of Public Health, Thailand</td>
<td>Financing healthcare, health policy research</td>
<td>National</td>
<td>Public</td>
<td>Policy</td>
</tr>
<tr>
<td>Thai Health Promotion Foundation</td>
<td>Epidemiology, Public Health</td>
<td>National</td>
<td>Semi-state</td>
<td>Policy</td>
</tr>
<tr>
<td>Chulalongkorn University</td>
<td>Health Consumer Protection</td>
<td>National</td>
<td>Public</td>
<td>Research</td>
</tr>
<tr>
<td>Health Intervention and Technology Assessment Program (HITAP)</td>
<td>Childhood obesity, alcohol consumption</td>
<td>National</td>
<td>NGO</td>
<td>Research</td>
</tr>
<tr>
<td>Health system research institute</td>
<td>Disability and Rehabilitation</td>
<td>National</td>
<td>Semi-state</td>
<td>Research</td>
</tr>
<tr>
<td>Thai Health Promotion Foundation</td>
<td>International Information for Health and Well being</td>
<td>National</td>
<td>Semi-state</td>
<td>Policy</td>
</tr>
<tr>
<td>Action on Smoking and Health Foundation (ASH) Thailand</td>
<td>Tobacco control/health promotion</td>
<td>National</td>
<td>NGO</td>
<td>Practice</td>
</tr>
<tr>
<td>Trauma care, Pre Hospital Care, Traffic injury prevention</td>
<td>National</td>
<td>Public</td>
<td>Practice</td>
<td></td>
</tr>
<tr>
<td>Knowledge Management Institute</td>
<td>Knowledge Management</td>
<td>National</td>
<td>Semi-state</td>
<td>Policy</td>
</tr>
<tr>
<td>Community Physical Therapy</td>
<td></td>
<td>Regional</td>
<td>Private</td>
<td>Practice</td>
</tr>
<tr>
<td>Institute of Nutrition, Mahidol University</td>
<td>Health promotion; Intervention Program</td>
<td>National</td>
<td>Public</td>
<td>Research</td>
</tr>
</tbody>
</table>

*Semi state = Autonomous
Governance

Institutional Capacity

Question 2

Participants were asked to choose the best description of Thailand’s HP institutional capacity. None of the Participants chose the option ‘no designated health promotion unit or section’. The highest percentage of Participants (43.8%) chose ‘other ways to strengthen the institution of HP’.

There were 10 comments provided in the comments section. All the comments identified Thai Health Foundation as an ‘independent’ unit for HP in Thailand. Out of these 7 related to option d (‘other ways’) and three were general. Two of the 3 general comments stated that there are HP units within and outside the MOPH. Seven other comments identified Thai Health Foundation as the ‘other ways’ to strengthen HP and 3 used the terms ‘independent’ and ‘autonomous’ to define the status of the HP unit (Thai Health).

Question 3

Participants were asked to give 3 examples of agencies or organisations with a clear mandate for health promotion in Thailand. The participants were asked to provide level at which the each organisation functioned (national, provincial, community or international), type of organisation (governmental, semi-government or non-governmental or private) and focus of organisation (HP area) (Tables N2 a, b and c). Sixteen participants responded to the question. In total participants provided 40 names, 5 of which were repeated by more than 1 participant: Thai Health Foundation 100% (n=16), Department of Health 44% (n=7), Bureau of health promotion 31% (n=5), Department of Disease Control 12% (n=2), National Health Security Office 12% (n=2), and other 50% (n=8).
The ‘level’ and ‘type’ of the organisations identified were grouped and n value expressed. To present the focus of the organisations, participants identified various foci for the same organisation. These foci were grouped together and expressed in how many times they were mentioned for a particular organisation.

The various foci for each organisation were classified under HP Management (administrative and organisational management), Research & Academia and Interventions (delivery of specific interventions). The identified foci under these classes were expressed as percentages to show how many foci were related to HP Management, Research & Academia and Interventions.

Table O2a: Agencies or organisations with a clear mandate for HP in Thailand (n=16)

<table>
<thead>
<tr>
<th>Name</th>
<th>%</th>
<th>n</th>
<th>Level</th>
<th>Type</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thai Health Foundation</td>
<td>100</td>
<td>1</td>
<td>National, National &amp; Interna</td>
<td>Public / State</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>tional</td>
<td>Semi Govt.</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Autonomous</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Independent</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Non-Govt.</td>
<td>4</td>
</tr>
<tr>
<td>Department of Health</td>
<td>44</td>
<td>7</td>
<td>National, National</td>
<td>Government</td>
<td>7</td>
</tr>
<tr>
<td>Bureau of Health Promotion</td>
<td>31</td>
<td>5</td>
<td>National, National</td>
<td>Government</td>
<td>5</td>
</tr>
<tr>
<td>Department of Disease Control</td>
<td>12</td>
<td>2</td>
<td>National, Semi-government</td>
<td>Government</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>50</td>
<td>8</td>
<td>National, Community</td>
<td>Autonomous</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Non Govt.</td>
<td>3</td>
</tr>
</tbody>
</table>
### Table O2b: Agencies or organisations with a clear mandate for health promotion in Thailand (n=16)

<table>
<thead>
<tr>
<th>Name</th>
<th>Foci identified</th>
<th>No. of times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thai Health Foundation</td>
<td>Funding / financing</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Networking / Multi-sectoral interventions</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Health risk factors control</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Misc</td>
<td>4</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Physical activity</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Maternal and Child Health</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health promotion</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health behaviour</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Policy development</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Implementation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dental health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Health of the elderly</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Risk factors</td>
<td>1</td>
</tr>
<tr>
<td>Bureau of Health Promotion</td>
<td>Policy and Regulation Advocacy</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Innovation and Technical Development</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>System Capacity Building</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Vertical health promotion program development and implementation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Creating health policies</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Controlling health risk factors</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Designing health promotion activities</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Service base health education/promotion</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Technical support for MOPH health promotion service unit</td>
<td>1</td>
</tr>
<tr>
<td>Department of Disease Control</td>
<td>Alcohol consumption control</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Accidents</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Health promotion</td>
<td>1</td>
</tr>
<tr>
<td>National Health Security Office</td>
<td>Health promotion</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Disease prevention</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>Research</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Knowledge management</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Improve health system</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Intervention under policies of Ministry of Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Health promotion activities</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Population and social research</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Literacy</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Reduce the domestic violence by reduce alcohol</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Protect young people from the alcohol industry's advertisement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Reduce the alcohol consumption</td>
<td>1</td>
</tr>
</tbody>
</table>

### Table O2c: Agencies or organisations with a clear mandate for health promotion in Thailand (n=16)

<table>
<thead>
<tr>
<th>Name</th>
<th>HP Management n (%)</th>
<th>Research &amp; Academia n (%)</th>
<th>Intervention n (%)</th>
<th>No of intervention areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thai Health Foundation</td>
<td>11 (73)</td>
<td>2 (13)</td>
<td>3 (20)</td>
<td>8</td>
</tr>
<tr>
<td>Department of Health</td>
<td>1 (14)</td>
<td>0 (0)</td>
<td>5 (71)</td>
<td>9</td>
</tr>
<tr>
<td>Bureau of Health Promotion</td>
<td>4 (100)</td>
<td>0 (0)</td>
<td>3 (75)</td>
<td>0</td>
</tr>
<tr>
<td>Department of Disease Control</td>
<td>1 (50)</td>
<td>1 (50)</td>
<td>2 (100)</td>
<td>2</td>
</tr>
<tr>
<td>National Health Security Office</td>
<td>2 (100)</td>
<td>1 (50)</td>
<td>1 (50)</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1 (13)</td>
<td>2 (25)</td>
<td>6 (75)</td>
<td>5</td>
</tr>
</tbody>
</table>
Question 4

Participants were asked to rate 3 statements on various aspects of governing HP in Thailand on 5 point Likert scales. Eighty percent of participants agreed that there is a national plan which guides HP policymaking and implementation and existence of clearly defined HP functions in the national health system. While 73% participants agreed that there is a political commitment to deliver HP, 20% disagreed with the statement. The items in the question had good internal consistency, Cronbach’s $\alpha$.88.

Two participants commented on different aspects of the question statements. One said that Thai Health Foundation needs to share its resources and outcome. The second commented that government body seems to be weaker than the semi-government bodies. The second participant further said that this might be caused by the medicalisation of health system which focuses mostly on disease diagnosis and treatment and uses a personal care approach rather than empowering communities and collective approach.

Question 5 & 6

Participants were asked whether Thailand receives international assistance for health and development activities. Sixty seven percent (n=10) of participants reported that Thailand receives international assistance.

If a participant replied yes s/he was asked to choose the option which best describes how much the government has control over leading policymaking and strategy (ownership of policies). Participants were also asked to provide supporting details.

Eighty Percent (n=8) of the 10 participants who answered in affirmative reported that the Thai government had complete control of health policies and strategies, while the remaining 20% said that the government and international agencies collaborated on a 50-50 basis on leading policy and
strategies. None of the participants thought that international agencies led policymaking and strategies in Thailand.

Four participants commented regarding ownership of health promotion policies and strategies. Two participants highlighted Thai Health Foundation’s central role in developing the national strategic plan, and working with multi-sectoral and international agencies like the WHO and VicHealth. One participant expressed that the international assistance is focused on scholarly and research collaboration. One participant commented that alcohol was one area where the government collaborated 60-40 with the international agencies.

Vision and Leadership

Question 7

The participants were asked about their opinion on understanding of HP among stakeholders in Thailand. Out of 15 participants 47% (n=7) agreed that the stakeholders have a clear understanding of HP, while 40% (n=6) were uncertain.

Six participants also expressed their views via comments. One participant said that:

‘There is a clear understanding of the rationale for health promotion (e.g. NCDs) and a clear understanding that health promotion is about prevention and goes beyond health issues, but there is little understanding of health promotion approaches.’

A second participant identified the barrier to understanding HP as the absence of ‘health in all policies’ strategy in ‘research and operations’. A third participant commented that some key stakeholders understand HP in ‘health promotion care service’ context rather than in the social movement context which includes health in all policies. A fourth participant commented that ‘scholars, health personnel, and some health activists’ are among the stakeholders who have clear understanding of HP. A fifth
participant highlighted that the HP slogan ‘build before repair’ is an easy to understand perspective. A sixth participant commented that HP is more understood by theory rather than perception and practice. Overall the participants had mixed views of how HP is understood by the stakeholders.

Question 8

Participants were asked to rate 10 statements about HP leadership effectiveness existing at the national level in Thailand on 5-point Likert Scales. At least 71% of participants agreed or strongly agreed with all 10 statements with 94% agreeing that the leadership is visible. Only 3 participants disagreed with any of the statements (a(6.7%) and j(14.3%)), with all remaining participants ‘uncertain’. The internal consistency between the 10 statements was good (α= .70).

The participants were also asked to name five key leaders (or leading organisations) involved in health promotion development in Thailand. Thirteen participants identified key organisations as: Thai Health Foundation, National Health Security Office, National Health Commission Office (NHCO) and National Health System Research Institute (NHSI) in addition to 3 universities leading HP research: Khon Kaen, Mahidol and Chulalongkorn. The participants also provided the names of 20 HP leaders.

Question 9

The participants were asked about which agencies and sectors, with common goals for HP in the country, partnered most frequently and least frequently with each other (n=11to14). The three most highly endorsed ‘most frequent’ partnerships were: Intergovernmental organisations partnered most frequently with the MOPH (73%); Civil society partnered most frequently with the NGOs (62%); MOPH partnered most frequently with various government sectors / departments (57%). MOPH was endorsed at least once as most frequent partner with all the agencies and sectors except Non-profit Organisations.
The partnerships regarded as being ‘least frequent’ were Donor countries with civil society (46%). ‘Donor countries’ were also endorsed at being the least frequent partner with all the 9 agencies and sectors.

Table N3 shows the most highly endorsed ‘most frequent’ and ‘least frequent’ partnerships for each agency / sector.

Table O3: Agencies / Sectors partnering most and least frequently with others (highest percentage only)

<table>
<thead>
<tr>
<th>Agency / Sector</th>
<th>Partner most with – % (n)</th>
<th>Partner least with – % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>Various government sectors / departments 57 (8)</td>
<td>NPOs, NGOs, Civil Society, Donor Countries 23 (3)*</td>
</tr>
<tr>
<td>Various government sectors / departments</td>
<td>Ministry of Health 50 (7)</td>
<td>NGOs and Donor Countries 31(4)*</td>
</tr>
<tr>
<td>Universities</td>
<td>Various government sectors / departments, Universities, Health Professionals 21(3)*</td>
<td>NPOs and Civil Society 25(3)*</td>
</tr>
<tr>
<td>Health Professionals</td>
<td>Ministry of Health 43(6)</td>
<td>NPOs and NGOs 25(3)*</td>
</tr>
<tr>
<td>Not for profit organisations (NPOs)</td>
<td>NPOs 30 (4)</td>
<td>Ministry of Health 36(4)</td>
</tr>
<tr>
<td>Non-governmental organisations (NGOs)</td>
<td>Civil society 35(4)</td>
<td>Donor Countries 36(4)</td>
</tr>
<tr>
<td>Civil society</td>
<td>NGOs 62(8)</td>
<td>Ministry of Health and Donor Countries 36(4)</td>
</tr>
<tr>
<td>Intergovernmental organisations (e.g. UN agencies)</td>
<td>Ministry of Health 73(8)</td>
<td>Civil society 36(4)</td>
</tr>
<tr>
<td>Donor countries</td>
<td>Ministry of Health 36(4)</td>
<td>Civil society 46(5)</td>
</tr>
</tbody>
</table>

*for each Question 10

Fifteen participants identified 17 significant organisations in health promotion development in Thailand covering the areas of policy, practice and research organisations in total (see Table O4).
Table O4: List of organisations identified as being involved in HP development in Thailand (n=15)

<table>
<thead>
<tr>
<th>No.</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Thai Health Promotion Foundation</td>
</tr>
<tr>
<td>2.</td>
<td>Centre for Alcohol Studies</td>
</tr>
<tr>
<td>3.</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>4.</td>
<td>Action on Smoking and Health Foundation, Thailand</td>
</tr>
<tr>
<td>5.</td>
<td>Mahidol University</td>
</tr>
<tr>
<td>6.</td>
<td>National Health Security Office</td>
</tr>
<tr>
<td>7.</td>
<td>Health Systems Research Institute</td>
</tr>
<tr>
<td>8.</td>
<td>International Health Policy Program, MOH</td>
</tr>
<tr>
<td>9.</td>
<td>Department of Health Service Support, Ministry of Public Health</td>
</tr>
<tr>
<td>10.</td>
<td>The office of alcohol control, Ministry public health</td>
</tr>
<tr>
<td>11.</td>
<td>NCD Network Thailand</td>
</tr>
<tr>
<td>12.</td>
<td>International Health Policy Program, Thailand (IHPP)</td>
</tr>
<tr>
<td>13.</td>
<td>Alcohol Policy Research Centre</td>
</tr>
<tr>
<td>14.</td>
<td>Woman and Men move forward foundation</td>
</tr>
<tr>
<td>15.</td>
<td>Customer Protection Organization</td>
</tr>
<tr>
<td>16.</td>
<td>Tobacco Control Research and Knowledge Management Centre (TRC)</td>
</tr>
<tr>
<td>17.</td>
<td>National Institute for Hospital Accreditation</td>
</tr>
</tbody>
</table>

Transparency and Accountability

Question 11

The participants were asked to rate a statement about transparency in HP development in relation to Thailand. The statement included a brief definition of transparency followed by a statement that information regarding funding and regulation of HP activities is accessible. Sixty percent (n=10) of participants agreed/strongly agree with the statement while 27% (n=4) said that they were uncertain. One participant commented that information about funding and regulation is not made available to the public:

‘Most information about HP funding and regulation available to health personnel, is not generated to public.’

Question 12

The participants were asked to rate two statements about accountability in relation to the situation in Thailand on 5 point Likert scales. At least 93% of

402
participants agreed with statements ‘a’ and ‘b’. The items in the question had acceptable internal consistency, Cronbach’s $\alpha=.68$.

Two participants commented on different aspects of the accountability. One said that Thai Health Foundation is required by law to report annually to the Cabinet/House of Representative/the Senate, subject to be audited by the Auditor General. The second commented that it would depend on the organisation.

Question 13

The participants were asked to rate 5 statements about transparency and accountability amongst national and international bodies/agencies in relation to the situation in Thailand on 5 point Likert scales. There was a lot of variation in responses to these statements, ranging from 35% agreeing/strongly agreeing with statement ‘e’ to 93% agreeing/strongly agreeing with statement ‘b’. The items in the question had good internal consistency, Cronbach’s $\alpha=.84$.

Two participants commented on different aspects of the accountability. One said that Thai Health Foundation is required by law to report annually to the Cabinet/House of Representative/the Senate, subject to be audited by the Auditor General. The second commented that it would depend on the organisation.

Policy Environment

National Policies and Plans

Question 14

Participants were asked to choose the options which best described whether and how HP is included in Thailand’s health and non-health policies. Four fifths of the participants (n=11) selected option ‘b’ (health promotion is part of an overall health policy). None of the participants selected ‘d’ (There is no reference to health promotion in health policies).
Question 15

Participants were asked to rate 4 statements on various aspects of HP policymaking in Thailand on 5-point Likert scales. Eighty-six percent of participants agreed that health promotion policy making is aligned with the health needs of the population. Forty-three percent of participants were uncertain that evaluation and monitoring of health promotion policies feed into future policy developments. The items in the question had good internal consistency, Cronbach’s $\alpha=.77$. One participant clarified in the comment box that her/his choice of answer options applied to Thai Health Foundation and not Division of health promotion in MOPH.

Question 16

The participants were asked to rate the level of implementation of 17 HP policies and programmes in Thailand according to a 6-point rating scale (fully implemented, partially implemented, actioned, under development, being considered, not currently actioned). The 3 policies and programmes which were rated fully/partially implemented were: Healthy lifestyles i.e. reduced consumption of tobacco products, alcohol, fatty, sugary or salty food and increased physical activities, Tobacco control and Prevention of infectious diseases. The 2 programmes which were rated the least fully/partially implemented were Suicide prevention (42%) and Environmental risks to health (8%).

Question 17

Participants were asked whether human rights-based approach is applied in promoting health in Thailand. Sixty-nine percent of participants (n=9) said ‘Yes’. The participants were also asked to provide details if they answered ‘Yes’. Two participants commented on accessibility of HP programmes which anyone can join voluntarily and are available for ‘all people, age, gender, religion, etc’. One participant commented that HP policies include strategies for reduction of health inequity, violence and focus on child health. One participant mentioned policy on restriction on smoking in public.
places as an example of human rights-based approach. One comment was found to be uninterpretable.

Question 18

Participants were asked to provide example/s of existing HP policy or policies implemented at national, regional or local level, along with a web link or publication reference. Ten participants commented and their response is summarised in Table O5 below.

Table O5: Examples of HP policies implemented at national, regional or local levels in Thailand

<table>
<thead>
<tr>
<th>Number</th>
<th>Example Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>National Quit Drink Day</td>
</tr>
<tr>
<td>3.</td>
<td>Campaign for quitting drinking during the Buddhist lent</td>
</tr>
<tr>
<td>4.</td>
<td>Prohibition to sell alcohol during Arsahabuja Day and Kuampansa Day. web link <a href="http://www.stopdrink.com">www.stopdrink.com</a> and <a href="http://www.thaiantialcohol.com">www.thaiantialcohol.com</a></td>
</tr>
<tr>
<td>5.</td>
<td>National Tobacco Control Plan (Bureau of Tobacco Control, Department of Disease Control, MOPH)</td>
</tr>
<tr>
<td>6.</td>
<td>Policy on reduced sugar in follow-on formula milk</td>
</tr>
<tr>
<td>7.</td>
<td>Policy on reducing sugar, salt and fat consumption</td>
</tr>
<tr>
<td>8.</td>
<td>Policy on promotion of physical activities</td>
</tr>
<tr>
<td>9.</td>
<td>Seat belt and helmet policy for road traffic accident prevention</td>
</tr>
<tr>
<td>10.</td>
<td>Policy on no advertisement of tobacco and alcohol policy</td>
</tr>
</tbody>
</table>

Policy Coherence

Question 19

The participants were asked to rate 3 statements regarding various national and international policies complementing and supporting each other within the national policy environment on a 5-point Likert scales. While 69% (n=9) agreed that mechanisms existed in the government to ensure that public policies support the attainment of national health promotion objectives, 23% (n=3) were uncertain. Participants were divided in expressing whether global health policies do not undermine the attainment of national health promotion objectives. While most agreed, 46% (n=6), 23% (n=3) and 31% (n=4) disagreed or were uncertain respectively. The items in the question had good internal consistency, Cronbach’s $\alpha=.80$. 

405
With regards to answer statement ‘a’, one participant commented that the existing mechanisms are found in ‘top-down commanding structure’ from national and regional levels to community level.

Health Promotion Infrastructure

Health Promotion Delivery

Question 20

The participants were asked whether assessment, planning, implementation, monitoring, evaluation and health impact assessment were carried out by national bodies/agencies in Thailand. With the exception of HP needs assessment (50% ‘Yes’), more than 70% of participants agreed that each of the other mechanisms were carried out. It is also notable that a substantial percentage of participants were ‘Uncertain’ whether some mechanisms were carried out e.g. 36% in case of HP needs assessment. There was one comment, however this was uninterpretable.

Question 21

Participants were asked to identify organisations involved in HP delivery performing needs assessment, programme planning, implementation, HP monitoring, evaluation and health impact assessment. The responses of the participants (n=13) were summarised in a tabulated form in Table O6.
Table O6: Organisations involved in HP delivery in Thailand

<table>
<thead>
<tr>
<th>Health promotion needs assessment</th>
<th>Health promotion programme planning</th>
<th>Health promotion programme implementation</th>
<th>Health promotion monitoring</th>
<th>Health promotion evaluation</th>
<th>Health impact assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of health</td>
<td>Thai Health Foundation</td>
<td>Thai Health Foundation</td>
<td>Thai Health Foundation</td>
<td>Thai Health Foundation</td>
<td>National Health Commission Office (NHCO)</td>
</tr>
<tr>
<td>Ministry of Public Health</td>
<td>Ministry of Public Health</td>
<td>Ministry of Public Health</td>
<td>Universities: Mahidol, Khon Kaen, Chaing Mai,</td>
<td>Health Intervention and Technology Assessment Program (HITAP)</td>
<td>Thai Health Foundation</td>
</tr>
<tr>
<td>Thai Health Foundation</td>
<td>Department of Health</td>
<td>Department of Health</td>
<td>National Statistical Office</td>
<td>Thai Health Foundation</td>
<td>Kasetsart University</td>
</tr>
<tr>
<td>National Health Security Office (NHSO)</td>
<td>Department of Health Service Support</td>
<td>Ministry of Public Health</td>
<td>Universities: Mahidol, Khon Kaen, Chaing Mai,</td>
<td>Health System Research Institute (HSRI)</td>
<td></td>
</tr>
<tr>
<td>Heath System Research Institute (HSRI)</td>
<td>Department of Mental Health</td>
<td>Ministry of Public Health</td>
<td>Health Intervention and Technology Assessment Program (HITAP)</td>
<td>Heath System Research Institute (HSRI)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>International Health Policy Program (IHP),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The Royal Thai government</td>
</tr>
</tbody>
</table>

Question 22

The participants were asked to rate their familiarity with the 5 action areas of Ottawa Charter on a 4-point rating scales (Uncertain, Not aware, Aware, Aware and use action areas in developing strategies). There is a high level of awareness about all 5 action areas (the lowest percentage of participants who are aware and/or use the action areas in their work is 86%). The
category ‘Awareness and/or use of action areas in developing strategies’ had the highest percentage of participants for 3 out of 5 action areas.

Workforce

Question 23

In an open-ended question participants were asked whether there is a specialist workforce for health promotion in Thailand. The participants saying ‘Yes’ were asked to provide details like number of dedicated health promotion posts, statutory/ NGO/ Other. The participants saying ‘No’ were asked whether other similar roles existed. The responses of the participants (n=10) are summarised in Table O7.

Table O7: Specialist workforce for HP in Thailand

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Technical Officers and Director of Tambon Health Promoting Hospital</td>
<td>No. It's integrated within health professionals, health workers and health volunteers.</td>
</tr>
<tr>
<td>Yes. Specific health promotion workers in Government agencies could be some hundreds in number, and around one or a few hundreds in NGOs in similar roles.</td>
<td>I am not sure. In terms of alcohol control, we learn by doing and sharing experiences with tobacco control. We do not have a specific course on alcohol in health promotion.</td>
</tr>
<tr>
<td>Many health professionals who work in health promotion such as dentist, family doctor, community nurse.</td>
<td>No. It is found only in community health personnel who are dedicated to HP jobs, and volunteers in related issues such as Stop Drinking Alcohol volunteers.</td>
</tr>
<tr>
<td>There are about 150-200 personnel in Thai Health Promotion Foundation. They work to support 'health promotion' in various activities.</td>
<td>There are no specialised personnel in health promotion. Personnel are fully integrated into routine systems. All health workers are trained on health promotion actions.</td>
</tr>
<tr>
<td>Yes. Thai Health Foundation has 70 number of staff dedicated to health promotion. MOPH has several thousand staff dedicated to health education/promotion.</td>
<td></td>
</tr>
<tr>
<td>There is a department of health promotion in every public hospital at every level.</td>
<td></td>
</tr>
</tbody>
</table>

Question 24

Participants were asked to choose the options about availability of education and training programmes at national level in health promotion in Thailand. All participants reported ‘No’ to option ‘e’ (No, there is no specific training
in health promotion) (n=15). Sixty seven percent of participants (n=9) affirmed that there were courses in which health promotion is a module, a subject or a part. One participant, in response to option ‘g’ (‘other (please specify) or comment’) commented that there were workshops related to development of HP capacity for scholars, health professionals and community workers provided by Thai Health Promotion Foundation.

Question 25

Participants were asked whether the HP education and training available in Thailand was sufficient for the country’s population health needs. Ninety three percent participants (n=14) reported that the available HP education and training was not sufficient. One participant commented that there is a lack of understanding on translating ‘health in all policies’ into action, along with lack of intersectoral action and policy coherence across sectors, in particular, trade and transport. A second participant commented that Thailand needs more international comparison to understand different contexts of health promotion.

Question 26

Participants were asked to rate the level of importance that 10 target audiences should receive training and education in HP on a 5-point rating scales (1=not important, 2=low importance, 3=moderate importance, 4=high importance, 5=very high importance). The 2 target audiences with the highest mean scores on importance were: health promotion practitioners (mean=4.6), and Public health practitioners (mean=4.4).

Question 27

Participants were asked whether a set of core competencies was specified for professionals working in the field of health promotion. Fifty four percent of participants (n=7) were ‘uncertain’ out of 13 participants. One participant
commented that s/he had limited knowledge on the subject. A second participant’s comment was uninterpretable.

Question 28

Participants were asked whether a national professional association for health promoters or an association that caters for the interests of health promoters exists in Thailand. Forty six percent of participants (n=6) were uncertain, out of total of 13 participants. Only 15% (n=2) said ‘Yes’ while 39% (n=5) said ‘No’. In response to ‘If yes, please specify or give a comment’ one participant mentioned ‘Thai Health Foundation’.

Question 29

Participants were asked whether there was professional expertise and capacity within universities and research institutes to carry out health promotion research. While 71% (n=10) participants said ‘Yes’, 21% (n=3) participants were uncertain out of a total of 14 participants. One participant commented that though there is professional expertise in universities to carry out HP research, the recommendations of the researchers were likely to be neglected in the national HP policies and during implementation. One participant commented this professional expertise only exists in ‘specific issues’.

Question 30

Participants were asked to provide at least one example of an existing programme for training and development in the health promotion in Thailand. Seven participants responded to the question. The responses are summarised in Table O8.
Table O8: Existing programmes for training and development in health promotion in Thailand

<table>
<thead>
<tr>
<th>Name</th>
<th>Funded by (Government, Private, Donor)</th>
<th>Web link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty of Public Health, Mahidol University</td>
<td>Government</td>
<td><a href="http://www.ph.mahidol.ac.th/edu/dgreeprogram_eng.html">http://www.ph.mahidol.ac.th/edu/dgreeprogram_eng.html</a></td>
</tr>
<tr>
<td>Health Promotion Capacity Development</td>
<td>Thai Health Promotion Foundation</td>
<td></td>
</tr>
<tr>
<td>Master of Public Health (Health Promotion), Walailak University</td>
<td>Government</td>
<td></td>
</tr>
<tr>
<td>Faculty of Public Health, Khon Kaen University</td>
<td>Government</td>
<td></td>
</tr>
<tr>
<td>Health promotion program for persons with disabilities</td>
<td>Semi-government</td>
<td><a href="http://www.healthyability.com">www.healthyability.com</a></td>
</tr>
<tr>
<td>ASEAN Institute for Health Development (AIHD)</td>
<td>various parties</td>
<td><a href="http://www.aihd.mahidol.ac.th/eng/">http://www.aihd.mahidol.ac.th/eng/</a></td>
</tr>
<tr>
<td>TEACH VIP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Partnerships

Question 31

The participants were asked to rate the strength of partnerships existing within four groupings of government sectors/departments on 4-point scales, each with an ‘Uncertain’ option. The participants who were uncertain were excluded from analysis. Sixty nine percent of participants reported ‘very strong/ strong’ partnership between health authorities and other sectors, while only 31% reported ‘very strong/ strong’ partnership between national, regional and local levels of decision-making (Figure O1).

![Figure O1: Strength of partnerships for HP within the Thai government](chart.png)
Question 32

The participants were asked to rate the strength of Thai government partnerships existing outside the government for four groups of non-government sectors/organisations on 4-point scales, each with an ‘Uncertain’ option. The participants who were uncertain were excluded from analysis. Seventy one percent of participants reported Very strong/Strong partnership between Thai government and Non-governmental organisations, while only 36% reported Very strong/Strong partnership between Private organisations promoting health (Figure O2).

Figure O2: Strength of Thai government partnerships for HP outside government

Financing

Question 33

Participants were asked whether dedicated funding was available for HP activities in Thailand from a list of seven sources (Table O9). The
participants were asked to choose Yes, No or Uncertain for each source. The option ‘Government’ was the most reported dedicated funding source for HP activities in Thailand (93% (n=13)), while only 14% (n=2) participants reported ‘Donor countries’ as the source of funding. Half or more participants were uncertain about international sector as the funding source: international development agencies (57% (n=8)), international NGOs (50% (n=7)), donor countries (50% (n=7)) and intergovernmental organisations (43% (n=6)). Thai Health Foundation was mentioned by one participant in the comment box as a semi-independent state agency source of funding from earmarked levy.

Table O9: Dedicated sources of funding for HP activities in Thailand (n=14)

<table>
<thead>
<tr>
<th>Question Items</th>
<th>Yes % (n)</th>
<th>No % (n)</th>
<th>Uncertain % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Government</td>
<td>93(13)</td>
<td>0</td>
<td>7(1)</td>
</tr>
<tr>
<td>b. Intergovernmental organisation (e.g. United Nations and its agencies like the World Health Organisation (WHO), etc.)</td>
<td>43(6)</td>
<td>14(2)</td>
<td>43(6)</td>
</tr>
<tr>
<td>c. International development agencies (e.g. Department for International Development (DFID), Canadian International Development Agency (CIDA), United States Agency for International Development (USAID), etc.)</td>
<td>21(3)</td>
<td>21(3)</td>
<td>57(8)</td>
</tr>
<tr>
<td>d. Donor countries</td>
<td>14(2)</td>
<td>36(5)</td>
<td>50(7)</td>
</tr>
<tr>
<td>e. International Non-governmental organisations (e.g. Oxfam International, CARE International, International Committee of the Red Cross (ICRC), etc.)</td>
<td>36(5)</td>
<td>14(2)</td>
<td>50(7)</td>
</tr>
<tr>
<td>f. Private sector (commercial)</td>
<td>50(7)</td>
<td>29(4)</td>
<td>21(3)</td>
</tr>
<tr>
<td>g. Private sector (philanthropes) (e.g. Bill &amp; Melinda Gates Foundation (Gates Foundation), etc.)</td>
<td>50(7)</td>
<td>14(2)</td>
<td>36(5)</td>
</tr>
</tbody>
</table>

Question 34

The participants were asked to rate four statements regarding sustainable financing for HP in Thailand on a 5-point Likert scales. The participants highly ‘Strongly agreed/ Agreed’ to the statements ‘a’ and ‘c’ regarding ‘stable flow of financial resources for health promotion development’ (93%) and ‘funding of HP from dedicated taxes or levies on tobacco, alcohol, gasoline, or other products and services’ (100%).

There was wide variation in the participants’ agreement for statements ‘b’ and ‘d’: ‘Financial resources for health promotion are also channelled
through other government sectors’ (36% Disagree/Strongly disagree, 50% Agree/Strongly Agree), and ‘funding for health promotion development is adequate’ (43% Disagree/Strongly disagree, 50% Agree/Strongly Agree). The items in the question had poor internal consistency, Cronbach’s $\alpha=.45$.

Knowledge Development and Management

Question 35

The participants were asked to rate seven statements regarding sustainable financing for HP in Thailand on a 5-point Likert scales. There was wide variation in the participants’ agreement for the seven statements. The participants ‘strongly agreed/agreed’ to the statements ‘d’ and ‘e’ regarding ‘Universities and research institutes are initiating or participating in health promotion research’ (71%) and ‘professional expertise within the universities and research institutes to carry out health promotion monitoring activities and interpret outcomes and trends’ (71%). Thirty nine and 50% Participants reported ‘uncertain’ for statements ‘f’ (a system exists where health information is channelled to decision makers at national, regional and local level for health promotion development) and ‘g’ (stakeholders have access to relevant knowledge and use it in their health promotion actions and interventions) respectively. The items in the question had poor internal consistency, Cronbach’s $\alpha=.48$.

Country Specific Context for health promotion

Question 36

Participants were asked to choose the options which best described developments contributing towards improvement of HP infrastructure. The developments selected by most of the participants were adoption of the Ottawa Charter (77%), development of healthy public policies (69%) and inclusion of HP objectives into the health reform strategy (77%). The least selected option was HP conferences (54%). Two participants identified
‘Thai health promotion Act 2001’ or ‘surcharge tax from tobacco and alcohol for health promotion fund’ as developments in Thai context.

Question 37

Participants were asked to choose the most important assets of Thailand in relation to building capacity for HP. Ninety three percent (n=14) of participants selected ‘strong leadership provided by key individuals and organisations’ as the most important asset in relation to capacity building. Political commitment, civil society partnerships (e.g., multiple levels of government, NGOs and community organisations) and HP financing were equally considered to be the second most important assets (67%, n=10). The answer options linked to workforce, commitment of the existing workforce and HP trained workforce, were considered the least ‘most important’ assets by 33% and 27% of participants respectively.

Question 38

Participants were asked about barriers affecting the capacity to deliver HP interventions that improve population health. Table O10 gives a summary of the barriers, grouped under themes, identified by eleven participants.
### Table O10: Barriers in the economic environment affecting HP capacity

<table>
<thead>
<tr>
<th>Political environment</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Economics dominates health</td>
<td>Economics dominate policies</td>
</tr>
<tr>
<td>2. Dominated by the economical concern.</td>
<td></td>
</tr>
<tr>
<td>3. Political environment is more focused on economic issues.</td>
<td></td>
</tr>
<tr>
<td>1. Frequent changes in the MOPH or the government</td>
<td>Changes in the government</td>
</tr>
<tr>
<td>2. Lack of continuity across government / high turnover of government</td>
<td></td>
</tr>
<tr>
<td>Uncertain political conflicts</td>
<td>Political conflicts</td>
</tr>
<tr>
<td>Lack of transparency.</td>
<td>Transparency</td>
</tr>
<tr>
<td>Popular policies have no capacity building strategies to develop self-reliance.</td>
<td>Self-reliance</td>
</tr>
<tr>
<td>Inadequate understanding of health promotion among policy maker/politicians</td>
<td>Understanding of HP</td>
</tr>
<tr>
<td>Lack of strong commitment e.g. in road safety issues</td>
<td>Commitment</td>
</tr>
<tr>
<td>Economic issues</td>
<td>Theme</td>
</tr>
<tr>
<td>1. Poverty and unemployment are major barriers</td>
<td>Poverty, Unemployment, Inequality</td>
</tr>
<tr>
<td>2. Poverty and unfair income distribution.</td>
<td></td>
</tr>
<tr>
<td>3. Majority of population still poor</td>
<td></td>
</tr>
<tr>
<td>GDP-focused economic structure</td>
<td>GDP</td>
</tr>
<tr>
<td>Heavy consumerism and materialism</td>
<td>Consumerism &amp; Materialism</td>
</tr>
<tr>
<td>Economic development through changing agriculture to industry and tourism</td>
<td>Effect on agriculture</td>
</tr>
<tr>
<td>Strong opposition in some issues such as alcohol, tobacco, etc.</td>
<td>Opposition/ Disagreement</td>
</tr>
<tr>
<td>Socio-cultural environment</td>
<td>Theme</td>
</tr>
<tr>
<td>People believe in the doctor more than themselves</td>
<td>Self-reliance</td>
</tr>
<tr>
<td>1. Social inequality</td>
<td>Inequality</td>
</tr>
<tr>
<td>2. Wide income gap between the rich and the poor</td>
<td></td>
</tr>
<tr>
<td>Urbanization and poor infrastructure</td>
<td>Urbanisation</td>
</tr>
<tr>
<td>Alcohol consumption and road risk behaviour</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Expertise (technical capacity)</td>
<td>Theme</td>
</tr>
<tr>
<td>1. Limited number of experts</td>
<td>Workforce</td>
</tr>
<tr>
<td>2. Inadequate health promotion man power</td>
<td></td>
</tr>
<tr>
<td>3. Responsible personnel do not have real expertise</td>
<td></td>
</tr>
<tr>
<td>1. Lack of health promotion Training</td>
<td>Training &amp; Professionalism</td>
</tr>
<tr>
<td>2. Lack of professionalism in health promoters / social workers</td>
<td></td>
</tr>
<tr>
<td>Lack of technical capacity to evaluate health promotion practices</td>
<td>Evaluation capacity</td>
</tr>
<tr>
<td>Lack of capacity in road safety</td>
<td>Road Safety</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>Theme</td>
</tr>
<tr>
<td>Business advertisement</td>
<td>Advertising in business</td>
</tr>
<tr>
<td>Inadequate understanding of health promotion vs health education</td>
<td>HP vs H Ed</td>
</tr>
</tbody>
</table>
General questions

Question 39

The participants were asked to identify three main barriers to implementing: ensuring good governance for health promotion, policy environment that is conducive to health promotion, and good infrastructure for the planning and delivering of health promotion actions. The barriers identified by the participants were re-arranged in order of importance in light of emerging themes elsewhere in the participants’ responses in the questionnaire:

1. **Barriers in ensuring good governance for health promotion**
Two comments were found to be interpretable and omitted.

The barriers mentioned were: corruption, more focus on financial/economic issues, abuse of power by the politicians, conflict of interest, and lack of capacity for leadership and commitment.

2. **Barriers in the policy environment that is conducive to health promotion**
In descending order of frequency: lack of ‘variety’ of stakeholders, lack of understanding of health in all policies and social determinants of health, lack of finances and domination of ‘opposition’ trade policy.

3. **Barriers in building a good infrastructure for the planning and delivering of health promotion actions**
In descending order of frequency: lack of (political) vision and participation of local leaders, lack of finances, too much focus on service-based health promotion and ‘over-loaded’ jobs of community health personnel.
Table O11: Barriers to implementing good governance, policy environment and infrastructure

<table>
<thead>
<tr>
<th>Ensuring good governance for health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government policies</td>
</tr>
<tr>
<td>Thought of &quot;corruption is commonly acceptable&quot;</td>
</tr>
<tr>
<td>Conflict of interest, corruption</td>
</tr>
<tr>
<td>Thai politicians tend to have more focus on financial and economic issues.</td>
</tr>
<tr>
<td>Political interference/Abuse by politicians</td>
</tr>
<tr>
<td>Capacity of the leader, commitment of the leader</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy environment that is conducive to health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Variety of stakeholders</td>
</tr>
<tr>
<td>2. Only few stakeholders participated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domination of opposition trade policy</td>
</tr>
<tr>
<td>Time constraints and routine work can have a major impact for those who are involved in policy making.</td>
</tr>
<tr>
<td>Develop the policy and wait for the opportunity to push</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A good infrastructure for the planning and delivering of health promotion actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of political vision</td>
</tr>
<tr>
<td>2. Commitment and support of the high level leader</td>
</tr>
<tr>
<td>3. Facilitator and the participants from people or local leaders are the main factor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lack of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Technology is an essential tool to help deliver this aspect; however it takes time and funding to reach different levels.</td>
</tr>
<tr>
<td>Mainly concentrated on service based health promotion.</td>
</tr>
<tr>
<td>Over-loaded jobs of community health personnel</td>
</tr>
</tbody>
</table>

Question 40

The participants were asked to identify any other aspects of health promotion capacity mapping that should be included in this tool. Two participants answered ‘Yes’ in the text box against each capacity domain. Their responses were omitted.

*Health Promotion Governance:* Other aspects identified by the participants to include in this capacity domain were engagement by the civil society, need for a flexible management system and strong commitment by the public (or public sector?).
Health Promotion Policy Environment: realisation of people at community level that policies are not formulated by elite class, lobbying of policymakers, and understanding of health in all policies.

Health Promotion Infrastructure: empowerment of the local volunteers, health literacy and autonomy of HP unit.

Table O12: Other aspects of health promotion capacity mapping that should be included in this tool

<table>
<thead>
<tr>
<th>Health Promotion Governance</th>
<th>Health Promotion Policy Environment</th>
<th>Health Promotion Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>building the public strong commitment</td>
<td>lobby the policy maker</td>
<td>empower the local volunteer</td>
</tr>
<tr>
<td>Engaged governance by civil society</td>
<td>Accessible environment, health literacy</td>
<td>-</td>
</tr>
<tr>
<td>the need to have a flexible management system</td>
<td>understanding of health in all policy</td>
<td>the autonomy status of the health promotion unit</td>
</tr>
</tbody>
</table>

Question 41

Five out of seven participants responded ‘Yes’ to the question that the information provided by this research tool could be used for planning, implementing, and developing health promotion capacity in Thailand. The participants were of the view that the information from this tool is very useful, the information can also be used in health policymaking and the tool can also be used as an advocacy tool for improving HP capacity in Thailand. One participant said ‘No’ giving the reason that Thai people like to ‘talk’ and do things together. One participant was uncertain.
Table O13: Comments on use of mapping tool

<table>
<thead>
<tr>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No, because Thai people like to talk and done together</td>
</tr>
<tr>
<td>Yes it could, and information from this tool is very useful.</td>
</tr>
<tr>
<td>Uncertain</td>
</tr>
<tr>
<td>Yes. The reflection from international expertise on health promotion can be professionally used in health policy making.</td>
</tr>
<tr>
<td>Yes. It can be used as an advocacy tool for improving health promotion capacity in Thailand</td>
</tr>
<tr>
<td>yes certainly</td>
</tr>
</tbody>
</table>
### APPENDIX P: Item-wise internal consistency between rating scale questions

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-Domain (Q No.)</th>
<th>Question Items</th>
<th>% Agree / Strongly Agree</th>
<th>Item Mean (SD)</th>
<th>Cronbach's Alpha</th>
<th>Scale* Mean (SD)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Institutional Capacity (Q 4)</td>
<td>a. There is a national plan which oversees and guides the health promotion policy making and implementation</td>
<td>80 (12)</td>
<td>4.1 (1.2)</td>
<td>0.88</td>
<td>11.5 (3.3)</td>
<td>n=15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. There is a political commitment to deliver health promotion</td>
<td>73 (11)</td>
<td>3.7 (1.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Essential health promoting functions in the national health system are clearly defined</td>
<td>80 (12)</td>
<td>3.8 (1.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>Vision and Leadership (Q8)</td>
<td>a. leadership is visible</td>
<td>94(14)a</td>
<td>4.1 (.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. leadership is shared</td>
<td>73(11)a</td>
<td>3.9 (.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. it provides a credible voice for the promotion of health</td>
<td>87(13)a</td>
<td>4.1 (.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. promoting health is on the political agenda</td>
<td>80(12)a</td>
<td>4.2 (.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. it oversees health promotion development at policy formulation and policy implementation levels</td>
<td>86(12)</td>
<td>4.1 (.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. it improves linkages across sectors, policies and programme areas (e.g. Health in All Policies, Intersectoral Action for Health, Whole of Government Approach)</td>
<td>71(10)</td>
<td>3.9 (.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>g. it develops policies and interventions that address health inequalities (e.g. Health Equity in All Policies)</td>
<td>86(12)</td>
<td>4.0 (.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>h. it develops international and national partnerships and collaborations to achieve national, regional (provincial) and local health promotion goals</td>
<td>86(12)</td>
<td>4.2 (.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. it recruits national health promotion experts to provide technical support</td>
<td>71(10)</td>
<td>3.8 (.6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>j. it monitors and evaluates the health promotion policies and interventions on a regular basis</td>
<td>86(12)</td>
<td>3.9 (.9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>Transparency &amp; Accountability</td>
<td>a. The accountability of organisations for the implementation of Health Promotion interventions is clearly specified within the regulatory / governance framework</td>
<td>93(13)a</td>
<td>4.1(.4)</td>
<td>0.68</td>
<td>8.3(.9)</td>
<td>n=14 otherwise 13</td>
</tr>
<tr>
<td>Governance</td>
<td>Transparency &amp; Accountability (Q 13)</td>
<td>b. Government ensures that the organisations and institutions performing health promoting activities report their actions to the relevant higher authorities regularly</td>
<td>86(12)$^a$</td>
<td>4.0 (.6)</td>
<td>0.84</td>
<td>18.2(2.8)</td>
<td>$^n$=15 otherwise 14</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------</td>
<td>------</td>
<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td>a. Fair and explicit priority setting processes</td>
<td>64(9)</td>
<td>3.6(7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Wide representation of all relevant stakeholders</td>
<td>93(14)$^a$</td>
<td>3.9(6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Balancing of decision making powers</td>
<td>47(7)$^a$</td>
<td>3.5(7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Adherence to accountability and transparency</td>
<td>50(10)$^a$</td>
<td>3.9(7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Lobbying with public authorities</td>
<td>35(7)$^a$</td>
<td>3.3(7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Environment</td>
<td>National Policies and Plans (Q 15)</td>
<td>a. General policymaking is conducive to advancing a ‘health in all policies’ approach.</td>
<td>50(7)</td>
<td>3.2 (.97)</td>
<td>0.77</td>
<td>14.5 (2.3)</td>
<td>n=14</td>
</tr>
<tr>
<td>b. Health promotion policy making is aligned with the health needs of the population.</td>
<td>86(12)</td>
<td>4.0 (.55)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Evaluation and monitoring of health promotion policies feed into future policy developments.</td>
<td>50(7)</td>
<td>3.6 (.85)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Health promotion policy making is a participative process i.e. based on consultation with key stakeholders.</td>
<td>79(11)</td>
<td>3.7 (.61)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Environment</td>
<td>Policy Coherence (Q 19)</td>
<td>a. Mechanisms exist in the government to ensure that public policies support the attainment of national health promotion objectives.</td>
<td>8(1)</td>
<td>23(3)</td>
<td>69(9)</td>
<td>3.6 (.65)</td>
<td>0.8</td>
</tr>
<tr>
<td>b. Global health policies across a range of issues, in relation to Thailand, do not undermine the attainment of national health promotion objectives.</td>
<td>23(3)</td>
<td>31(4)</td>
<td>46(6)</td>
<td>3.2 (.83)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Global health policies across a range of issues, in relation to Thailand, support the attainment of national health promotion objectives.</td>
<td>0</td>
<td>23(3)</td>
<td>77(10)</td>
<td>3.8 (.55)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Promotion Infrastructure</td>
<td>Financing (Q 34)</td>
<td>a. There is a stable flow of financial resources for health promotion development (i.e. annual allocation of funds)</td>
<td>7(1)</td>
<td>0</td>
<td>93(13)</td>
<td>4.2(8.0)</td>
<td>0.45</td>
</tr>
<tr>
<td>b. Financial resources for health promotion are also channelled through other government sectors (education, transport, environment, etc.)</td>
<td>36(5)</td>
<td>14(2)</td>
<td>50(6)</td>
<td>3.2(1.05)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Promotion Infrastructure</td>
<td>Knowledge Development &amp; Management (Q 35)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. There are arrangements for the 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</td>
<td>0</td>
<td>0</td>
<td>100(14)</td>
<td>4.6(.49)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. The funding for health promotion development is adequate (fulfils national health promotion objectives)</td>
<td>43(6)</td>
<td>7(1)</td>
<td>50(7)</td>
<td>3.1(1.29)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. There is adequate access to information on health promotion (i.e. theory, models, research, examples of best practice, etc.)</td>
<td>14(2)</td>
<td>21(3)</td>
<td>64(9)</td>
<td>3.46(.77)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. A national health information system is in place which collects, processes and analyses population health related data</td>
<td>21(3)</td>
<td>29(4)</td>
<td>50(7)</td>
<td>3.15(.98)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. There are periodical (i.e. yearly) governmental reports that define common health promotion objectives, priorities and strategies</td>
<td>14(2)</td>
<td>29(4)</td>
<td>57(8)</td>
<td>3.38(.76)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Universities and research institutes are initiating or participating in health promotion research</td>
<td>0</td>
<td>29(4)</td>
<td>71(10)</td>
<td>3.92(.64)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. There is professional expertise within the universities and research institutes to carry out health promotion monitoring activities and interpret outcomes and trends</td>
<td>7(1)</td>
<td>21(3)</td>
<td>71(10)</td>
<td>3.69(.75)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. A system exists where health information is channelled to decision makers at national, regional and local level for health promotion development</td>
<td>8(1)</td>
<td>39(5)</td>
<td>54(7)</td>
<td>3.46(.66)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Stakeholders have access to relevant knowledge and use it in their health promotion actions and interventions</td>
<td>14(2)</td>
<td>50(7)</td>
<td>36(5)</td>
<td>3.23(.72)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendices
APPENDIX Q: Glossary

Glossary

Health Promotion Capacity Mapping

Accountability: Accountability refers to the obligation on the part of public officials to report on the use of public resources and answerability for failing to meet stated performance objectives (United Nations Public Administration Network, n.d.).

Decision-makers in government, the private sector and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders (UNDP, n.d.).

Advocacy: A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme. Advocacy can take many forms including the use of the mass media and multi-media, direct political lobbying, and community mobilization through, for example, coalitions of interest around defined issues (WHO, 1998).

Assessment: The systematic collection and analysis of data in order to provide a basis for decision-making (Ontario Ministry for Health and Long-Term Care, n.d.).

Needs assessment: A systematic procedure for determining the nature and extent of health needs in a population, the causes and contributing factors to those needs and the resources (assets) which are available to respond to these (WHO, 1998).

Collaboration: A recognized relationship among different sectors or groups, which has been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by one sector or group acting alone (Last & Edwards, 2007).

Capacity Development: Development of knowledge, skills, commitment, structures, systems and leadership to enable effective Health Promotion for strengthening national health system (modified – Smith, Tang, & Nutbeam, 2006).

Capacity mapping: Capacity mapping is a strategy to assess a country’s existing knowledge, skills, commitment, structures, systems and leadership to develop Health Promotion capacity for strengthening national health system (modified – Smith, 2006).

Competencies: A combination of the essential knowledge, abilities, skills and values necessary for the practice of health
promotion (Shilton, 2001).

**Consensus:** Ideally, unanimous agreement with an outcome, or at least a unanimous agreement that the final proposal is acceptable to all stakeholders, after every effort has been made to meet any outstanding objections (Susskind, 1999).

**Conceptual framework:** A framework that links capacity-related inputs, processes, outputs, and outcomes to performance of a system, organization, health personnel, or community (LaFond & Brown, 2003).

**Country specific context:** The environmental, historical, political, economic, social and cultural factors which influence the development of health promotion capacity in a country (Brown, LaFond, & Macintyre, 2001).

**Culture:** A socially inherited body of learning including knowledge, values, beliefs, customs, language, religion, art, etc. (Centre for Addiction and Mental Health, n.d.).

**Delphi technique:** A process used to collect and distil the judgments of experts using a series of questionnaires interspersed with feedback (Skulmoski, Hartman, & Krahn, 2007).

**Determinants of health:** The range of political, economic, social, cultural, environmental, behavioural and biological factors which determine the health status of individuals or populations (WHO, 1998).

**Development:**

*International development:* Development is an ensemble of institutions, policies, disciplinary formations and, practices of intervention in the alleviation of poverty in the Third World, or low and middle-income or developing nations. It consists of interventions by governments, rich and poor, and by an array of international institutions and organizations in civil society.

(Gregory, Johnston, Pratt, Watts, & Whatmore, 2009)

*Human development:* Creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests (and) thus about expanding the choices people have to lead lives that they value (UNDP, 2000).

Human development is the process of enlarging people’s choices. Their three essential choices are to lead a long and healthy life, to acquire knowledge and to have access to the resources needed.
for a decent standard of living. Additional choices, highly valued by many people, range from political, economic and social freedom to opportunities for being creative and productive and enjoying personal self—respect and guaranteed human rights (OECD, 2007).

**Donor country:** A country giving aid directly to an aid recipient country (OECD, n.d.).

**Empowerment:** The process through which people gain greater control over decisions and actions which impact on their health. Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. Individual empowerment refers to the individual’s ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community (WHO, 1998).

**Enable:** Taking action in partnership with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their health. A key role for health promotion practitioners is acting as a catalyst for change by enabling individuals, groups, communities and Organizations to improve their health through actions such as providing access to information on health, facilitating skills development, and supporting access to the political processes which shape public policies affecting health (WHO, 1998).

**Equity/Inequity in health:** Equity means fairness and equity in health means that people’s needs should guide the distribution of opportunities for wellbeing. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity which result, for example, in unequal access to health services, to nutritious food, adequate housing, etc. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life (WHO, 1998).

For more details please refer to the final report of the WHO Commission on Social Determinants of Health (CSDH, 2008).
**Evaluation:** It is the systematic examination and assessment of features of a programme or other intervention in order to produce knowledge that different stakeholders can use for a variety of purposes (Rootman, 2001).

**Financing:** This refers to transparent and sustainable source of public financing for health promotion priorities at national or subnational levels including direct government allocations, hypothecated taxes, or through social/health insurance (Catford, 2005).

**Health:** A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity (WHO, 1946). Within the context of health promotion, health is considered as a resource which permits people to lead an individually, socially and economically productive life. The Ottawa Charter (WHO, 1986) emphasizes pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these pre-requisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health, all key to a holistic understanding of health which is central to the definition of health promotion (WHO, 1998).

**Health Promotion action:** Describes programmes, policies and other organized health promotion interventions that are empowering, participatory, holistic, intersectional, equitable, sustainable and multi-strategy in nature which aim to improve health and reduce health inequities (Speller, Parish, Davison, & Zilnyk, 2012).

**Health action:** Any set of activities whose primary intent is to improve or maintain health (Murray & Frenk, 2000).

**Health education:** Planned learning designed to improve knowledge, and develop life skills which are conducive to individual and community health. Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health (WHO, 1998).

**Health Promotion:** The process of enabling people to increase control over, and to improve their health. Health promotion represents a comprehensive social and political process, which not only includes actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to
alleviate their impact on public and individual health. The Ottawa Charter (WHO, 1986) identifies three basic strategies for health promotion:

- advocacy for health to create the essential conditions for health
- enabling all people to achieve their full health potential
- mediating between the different interests in society in the pursuit of health.

These strategies are supported by five priority action areas for health promotion:

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health
- Develop personal skills, and
- Re-orient health services

**Health promotion delivery:** National health promotion delivery includes the structures and mechanisms for health promotion priorities at national and/or subnational levels responsible and accountable for health promotion actions including support for inter-sectoral partnerships (Catford, 2009).

**Health promotion governance:** A system of values, policies and institutions to manage the country’s health promotion development within and among the state, civil society and private sector (adopted - Olowu, & Sako, 2002).

Governance principles adopted from health literature are:

- **Strategic vision:** broad and long-term perspective on health and human development, along with a sense of strategic directions for such development, along with an understanding of the historical, cultural and social complexities in which that perspective is grounded.
- **Participation and consensus orientation:** all men and women to have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests.
- **Rule of law:** legal frameworks pertaining to health to be fair and enforced impartially, particularly the laws on human rights related to health
- **Transparency:** built on the free flow of information for all health matters. Processes, institutions and information to be directly accessible to those concerned with them, and enough information provided to understand and monitor health matters.
Appendices

- **Responsiveness**: institutions and processes try to serve all stakeholders to ensure policies and programs are responsive to the health and non-health needs of its users.

- **Equity and inclusiveness**: all men and women to have opportunities to improve or maintain their health and well-being.

- **Effectiveness and efficiency**: processes and institutions to produce results that meet population needs and influence health outcomes while making the best use of resources.

- **Accountability**: decision-makers in government, the private sector and civil society organizations involved in health to be accountable to the public, as well as to institutional stakeholders.

- **Intelligence and information**: essential for a good understanding of health system, without which it is not possible to provide evidence for informed decisions that influence the behavior of different interest groups that support, or at least do not conflict with, the strategic vision for health.

- **Ethics**: commonly accepted principles of ethics include respect for autonomy, non-maleficence, beneficence and justice.

  (Siddiqi et al., 2009)

Health promoting approach to governance is based on human rights and equity, with ‘whole of government’ approach. The common strategies employed to achieve Health Promotion goals are Health in All Policies, Health Equity in All Policies, Intersectoral Action for Health, etc.

**Outcomes**: Health promotion outcomes are changes to personal characteristics and skills, and/or social norms and actions, and/or organizational practices and public policies which are attributable to a health promotion activity (WHO, 1998).

**Healthy public policy**: The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives by making healthy choices possible or easier and social and physical environments health enhancing (WHO, 1998).

**Health system**: Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health (WHO
Health system is also defined as all the organizations, institutions, and resources that are devoted to producing health actions (WHO, 2000).

**Human development:** See ‘Development’

**Human rights:** A concept that presumes that all people ‘are born free and equal in dignity and rights’ and provides a universal frame of reference for deciding questions of equity and social justice (Krieger, 2001).

**Human rights-based approach:** A rights-based approach means integrating human rights, norms and principles in the design, implementation, monitoring and evaluation of all health-related policies and programmes. This includes human dignity, attention to the needs and rights of vulnerable groups and an emphasis on ensuring that health systems are made accessible to all. The principles of equality and freedom from discrimination are central to this approach. Integrating human rights into health development also means empowering poor people, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access (WHO, 2012).

**Inequality vs. Inequity in health:**
*Health inequalities* are differences in health between groups of people. These differences might be due to non-modifiable factors such as age or sex, or modifiable factors such as socioeconomic status. *Health inequities* refer to the subset of health inequalities that are systematic, socially produced (and therefore modifiable) and unfair (WHO, 2010).

Human poverty is defined as impoverishment in multiple dimensions—deprivations in a long and healthy life, in knowledge, in a decent standard of living, in participation. Impoverishment is further defined as ‘to lack or be denied adequate resources to participate meaningfully in society’ (Krieger, 2001).

**Social inequalities in health:** Health disparities between population groups defined by social characteristics such as wealth, education, occupation, racial or ethnic group, sex, rural or urban residence, and social conditions of the places where people live and work (Braveman, Starfield, Geiger, & Murray, 2001).

**Infrastructure:** Health Promotion infrastructure consists of human
and material resources, organisational and administrative structures, knowledge management and information systems which facilitate country-wide health promotion response to health issues and challenges (WHO, 1998).

**Institutional capacity:** Refers to the governments’ ability to define the scope and purpose of health promotion system in the country, outline the values to guide health promoting policies, set aims for promoting health and establish structures to develop and implement policy.

**Intergovernmental Organization (IGO):** An agency set up by two or more state governments to carry out projects and plans in common interest e.g. United Nations, World Bank, European Union (Union of International Associations, n.d.).

**Intersectoral action:** Refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector (PAHO/WHO, 2000).

**Knowledge development and management:** Health promotion knowledge development refers to developing a body of knowledge and evidence base to support policymaking at all levels (Aluttis, 2012).

Knowledge management consists of using this knowledge to develop capacity for health promotion research, information systems, performance improvement, evaluation and monitoring to strengthen national health system.

**Leadership:** Ability of an individual to influence, motivate, and enable others to contribute to the effectiveness and success of their Organization and/or community the in which they work. Leaders inspire people to develop and achieve a vision and goals, and encourage empowerment (Last & Edwards, 2011).

**Low and Middle-Income Country (LMIC):** A country which is ranked as medium or low human development on the Human Development Index (HDI). The list of countries ranked according to HDI can be found at http://hdr.undp.org/en/statistics/

**National policies and plans:** National policies and plans for health promotion consist of national health promotion policy, national health policy, and healthy public policies and plans to set health promotion goals, provide guidelines for health promotion practice, and framework for health promotion action across all sectors.
Needs assessment: See ‘Assessment’

Partnerships: A partnership for health promotion is a voluntary agreement between individuals, groups, communities, organizations or sectors to work cooperatively towards a common goal through joint action.

Health promotion partnerships refer to relationship between various partners in the health and non-health sectors (donors, development agencies, NGOs, civil society, private and government sectors) to work towards strengthening health promotion system in a country


Performance: A performance measure informs us how well a health system is carrying out its different tasks. Health Promotion defines a broader conceptual approach to measuring performance by explicitly using non-health care determinants, health care, and contextual information to give a clearer picture of improvement of health in a country (adopted - Arah, Westert, Hurst, & Klazinga, 2006).

Policy: It is the expressed intent of an institution (government, corporation, volunteer group, etc.) to act strategically to attain specified goals (Rootman, 2001).

Policy coherence: Policy coherence refers to the extent to which different policies complement or support each other, including public, international and global health policies. Policy coherence creates synergies between different policies, leverages capacity to realise a common policy goal and ensures that different policies do not undermine one another or cancel each other out (Chatwin, 2013).

Policy environment: Health promotion policy environment refers to national structures and mechanisms which enable formulation and implementation of national health promotion policy, national health policy, and healthy public policies and plans in form of health promotion interventions and action across all sectors (Aluttis, 2012).

Poverty: A human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights (UN, 2001).

Human poverty is defined as impoverishment in multiple
dimensions—deprivations in a long and healthy life, in knowledge, in a decent standard of living, in participation. Impoverishment is further defined as ‘to lack or be denied adequate resources to participate meaningfully in society’ (Krieger, 2001).

Practitioner: A person who works to promote health and reduce health inequities using the actions described by the Ottawa Charter (WHO, 1998).

Programme: Intervention, initiative or action aimed at promoting health (Rootman, 2001).

Shared leadership: In recent years conceptualization of leadership has been challenged and now, some scholars say that leadership involves behaviours, roles, and activities that can be shared or distributed among members of a team. Some examples are Jackson, S. (2000) and Konu, A., & Viitanen, E. (2008). According to this alternative conceptualization of leadership, individuals who are not formally designated leaders can rise to the occasion to exhibit leadership and then step back at other times to allow others to lead (Northouse, 2012).

‘Shared leadership is a dynamic, unfolding, interactive influence process among individuals, where the objective is to lead one another toward the achievement of collective goals. This influence process often involves peer influence and at other times involves upward or downward hierarchical influence. The fundamental distinction between shared leadership and traditional notions of leadership is that the influence process is built upon more than just downward influence on subordinates or followers by an appointed or elected leader. Shared leadership entails broadly sharing power and influence among a set of individuals rather than centralizing it in the hands of a single individual who acts in the clear role of a dominant superior’

(Pearce, Manz, & Sims, 2009)

Skills: The ability to apply knowledge and use know-how to complete tasks and solve problems. In the context of European Qualifications Framework (EQF), skills are described as cognitive (involving the use of logical, intuitive and creative thinking), or practical (involving manual dexterity and the use of methods, materials, tools and instruments) (European Parliament and Council of the EU, 2008).

Social determinants of health: Refer to both specific features of
and pathways by which societal conditions affect health and that potentially can be altered by informed action (Krieger, 2001).

The social conditions in which people live and work (CSDH, 2008).

Social Justice: The concept of a society that gives individuals and groups fair treatment and an equitable share of the benefits of society. In this context, social justice is based on the concepts of human rights and equity. Under social justice, all groups and individuals are entitled equally to important rights such as health protection and minimal standards of income (Last & Edwards, 2011).

Stakeholders: An agency, organization, group or individual that has direct or indirect interest in a particular activity, or its evaluation (WHO, 2009).

Standard: An agreed, repeatable way of doing something which is published and contains a technical specification or other precise criteria designed to be used consistently as a rule, guideline, or definition (British Standards Institution, 2012).

Strategies: Broad statements that set a direction and are pursued through specific actions, such as those carried out in programmes and projects (National Public Health Performance Standards Program (NPHPSP), 2007).

Sustainability: It is the capacity of the system to continue its normal activities well into the future (USAID, 2007).

Transparency: Transparency is built on the free flow of information for all health matters. Processes, institutions and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters (UNDP, n.d.).

Values: The beliefs, traditions and social customs held dear and honoured by individuals and collective society. Moral values are deeply believed, change little over time and may be, but are not necessarily, grounded in religious faith. Social values are more flexible and may change as individuals gain life experience and include, for example, attitudes towards the use of alcohol, tobacco and other substances (Last & Edwards, 2011).

Vision: Health promotion vision expresses goals that are worth striving for and incorporates shared health promotion ideals and values (National Public Health Performance Standards Program (NPHPSP), 2007).

Whole of government approach: Building a whole of government
commitment, across all sectors, by ensuring that head of government, cabinet and/or parliament, administrative leadership, key actors and decision-makers are aware of their responsibility for health and well-being in all policies and strengthen health as a driver of change for sustainable development (WHO, 2010a, 2011a).

References


Appendices


