CAPACITY BUILDING

Mapping national capacity to engage in health promotion: Overview of issues and approaches

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SUMMARY

This paper reviews approaches to the mapping of resources needed to engage in health promotion at the country level. There is not a single way, or a best way to make a capacity map, since it should speak to the needs of its users as they define their needs. Health promotion capacity mapping is therefore approached in various ways. At the 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. In Europe, capacity mapping has been undertaken at the national level by the WHO for a decade. A complementary capacity mapping approach, HP-Source.net, has been undertaken since 2000 by a consortium of European organizations including the EC, WHO, International Union for Health Promotion and Education, Health Development Agency (of England) and various European university research centres. The European approach emphasizes the need for multi-methods and the principle of triangulation. In North America, Canadian approaches have included large- and small-scale international collaborations to map capacity for sustainable development. US efforts include state-level mapping of capacity to prevent chronic diseases and reduce risk factor levels. In Australia, two decades of mapping national health promotion capacity began with systems needed by the health sector to design and deliver effective, efficient health promotion, and has now expanded to include community-level capacity and policy review. In Korea and Japan, capacity mapping is newly developing in collaboration with European efforts, illustrating the usefulness of international health promotion networks. Mapping capacity for health promotion is a practical and vital aspect of developing capacity for health promotion. The new context for health promotion contains both old and new challenges, but also new opportunities. A large scale, highly collaborative approach to capacity mapping is possible today due to developments in communication technology and the spread of international networks of health promoters. However, in capacity mapping, local variation will always be important, to fit variation in local contexts.

Key words: capacity mapping; strategic development; workforce planning; health promotion infrastructure
INTRODUCTION

This paper reviews approaches to the mapping of resources needed to engage in health promotion at the country level. Capacity mapping approaches are illustrated with examples from across the globe. Also discussed are various uses of capacity maps. The terms ‘capacity mapping’ and ‘health promotion’ do not have self-evident meanings. Capacity mapping is perhaps easier to grasp because of the cartography metaphor. Cartography is in its narrowest sense the drawing of images meant to represent the world around us. More broadly, cartography refers to all the activities that lead to finished maps: understanding the customer’s requirements, planning the work, collecting information and agreeing on unsure or disputed borders, terms, topography, features and forms. The finished map itself is out of date even before it goes to print, and many map features are disputed by people living in the places that are mapped. A map is a social construction modelling aspects of environment that are important. Maps are not produced for the cartographers, but for others whose interests influence greatly what is mapped, and how. Two useful maps of the same coastline may differ greatly, the one intended for navigation having the detail below the waterline and the other intended for landsmen having the detail above the waterline.

So there is no single way or a best way to make a capacity map, since it should speak to the needs of its users as they define their needs. Therefore, the definition of health promotion is of more than academic interest, since the definition will drive much of the decision-making about what a health promotion capacity map should include.

There remains the question of what is meant by national capacity. All ideas are disputable, even the meaning of a nation. Here, the term national refers to sovereign states, but also includes regions other than sovereign states that have been delegated the main responsibility for health promotion. Capacity refers to the ability to carry out stated objectives (Goodman et al., 1998). Having the capacity to perform a task is an essential but not sufficient condition for good performance:

The matching of capacity to a desired level of action is the art upon which many enterprises succeed or fail. It is a serious mismatch if one wishes to produce Fords and has the capacity to produce Porsches, and vice-versa. The wide spread interest in measuring capacity arises from the wish to “tune” capacity to achieve the level of action aspired to. In the development arena, including health promotion, one hardly ever hears about over-capacity. In public services delivery—education for example—there is constant tension between demands for more capacity to achieve better action, and ‘good enough’ capacity for affordable action. (Mittelmark et al., 2005)

Health promotion capacity mapping is approached in various ways, for reasons made obvious above (see also Êbbesen et al., 2004). At the 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 (National Health and Medical Research Council, 1997; Wise and Signal, 2000; WHO, 2001).

For at least the past decade, national capacity for health promotion has been the subject of conferences, scholarly dialogue and political debate (French Committee for Health Education, 1995; Wise, 1998; Wise and Signal, 2000). At the Fifth Global Conference on Health Promotion in Mexico City (June 2000), national investment for health and the need to build infrastructure for health promotion were dominant themes (Moodie et al., 2000; Ziglio et al., 2000).

ILLUSTRATIONS OF CAPACITY MAPPING AROUND THE GLOBE

Europe

A capacity mapping model developed by the WHO Regional Office for Europe, and used as part of its Investment for Health initiative (Ziglio et al., 2000a; 2000b), has at its heart National Health Promotion Infrastructure Appraisals. The first such appraisal—in the Republic of Slovenia—originated from a request for assistance from the President of the Parliament of Slovenia. Six experts prepared for a site visit by studying a wide range of documents about Slovenian geography, political system and laws, economic situation, demographic, social, health and sickness profiles, and structures and institutions. During a site visit in 1996, they conducted interviews, participated in semi-structured discussions and a workshop.
Based on the information garnered from documents and meetings, the team composed a report with two elements: (i) an assessment of Slovenia's strengths, weaknesses and opportunities for investment in health and (ii) an Investment for Health Strategy for Slovenia, based on the conclusions of the assessment. In the course of the work, the team developed a simple capacity mapping instrument to assess 10 elements of health promotion infrastructure, and subsequently applied the instrument during similar processes that were mounted in other European countries.

In Europe, a triangulation approach to capacity mapping has been adopted, using four orchestrated activities, that was reported at the WHO's Sixth Global Conference on Health Promotion in Bangkok, Thailand:

(i) Summarization of existing data on capacity for health promotion, for example, from WHO-EURO’s Venice Office’s ‘National Appraisals of Health Promotion Policy, Infrastructures and Capacity’ carried out in collaboration with a number of European member states between 1996 and 2004;

(ii) Analysis of social and economic trends affecting population health at various levels from country level to Europe as a whole (WHO, 2002);

(iii) A WHO Capacity Mapping Initiative, begun in 2005: to synthesize key social and economic trends in 20 countries across four subregions of Europe; map the current capacity of health promotion systems, with particular emphasis on responsiveness to the broader determinants of health; highlight the implications for health promotion policy and infrastructure development (WHO, 2005);

(iv) Summarization of present country-level health promotion policy, infrastructure and programmes, a project undertaken by HP-Source.net that developed a uniform system for collecting information on health promotion policies, infrastructures and practices; created 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 organizations and researchers; analysed the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice; actively imparted this information and knowledge, and actively advocated the adoption of models of proven effectiveness and efficiency, by means of publications, seminars, conferences and briefings, among other means (Mittelmark, et al., 2005).

North America

In the USA, mapping community capacity to inform community development has for the past 25 years been stimulated by the pioneering work of McKnight and Kretzmann (1990). At a time when American public health was developing advanced methods to assess health needs and develop policy and programmes to meet public health deficits, McKnight and Kretzmann (1990) called for a new perspective—one in which policy and programmes would flow also from an assessment of communities’ capacities, skills and assets. This perspective has had great influence in American public health, where the focus of health promotion has been at the individual, small group and community levels.

However, there have also been capacity mapping exercises at the state level, including all 50 states plus 8 special districts and territories such as the District of Columbia (ASTDHPPHE, 2001). Using a standard assessment form, each state/territory reported on state-level disease prevention in five arenas:

(i) policy and environmental content areas addressed in the prior 3 years;
(ii) examples of successful intervention in each content area;
(iii) critical success factors and barriers regarding policy and environmental change interventions;
(iv) roles played by local health departments;
(v) key contacts. Based on data generated in the period 1996–1999, the mapping results showed clear differences between the content areas addressed by policies compared to those addressed by environmental interventions. Tobacco control was by far the most popular content area for policy development, whereas nutrition and physical activity were the most popular content areas for environmental change interventions.

In Canada, capacity mapping technology has developed, among other ways, through Canada’s strong emphasis on international cooperation for development. Exemplifying this is Canadian collaboration with Nepal and Fiji to
examine various approaches to mapping community capacity for health promotion (Gibbon et al., 2002). In this work, community capacity is viewed as both a means and an end, emphasizing the importance of stakeholder participation and the ability to ‘ask why’ and increase control over programme management, among other capacity domains such as leadership development and improvement in resource mobilization (Gibbon et al., 2002). Another example of international cooperation for development is Canada’s participation in a 19-country analysis of national strategies for sustainable development (Swanson et al., 2004). Using a country case study methodology, the project mapped three aspects of national capacity: strategy, participation and implementation. For example, each national case strove to answer these and similar questions: Is there a national sustainable development strategy? If so, what are its goals and thematic areas? Is it linked to the national budgeting and planning processes? What roles are played by NGOs? Is there financing for implementation? Is there accountability for performance? Based on analysis of the case studies, the project extracted key learning related to leadership, planning, implementation, monitoring, coordination and participation.

**Australia and Asia**

Australia’s experience in mapping national capacity to engage in health promotion has spanned more than two decades (Better Health Commission, 1986; National Health Strategy, 1993; National Health and Medical Research Council, 1997a; National Health and Medical Research Council, 1997b; New South Wales Health Department, 1999). Beginning with an assessment of the capacity (systems for information\(^1\), policy and prioritization, financial, human and physical resources, management and design/delivery systems, partnerships) needed by the health sector to design and deliver effective, efficient health promotion, capacity mapping has more recently evolved in three directions (New South Wales Department of Health, 1999):

(i) First has been the continuation of mapping capacity needed to conduct project-based work, but also mapping capacity of the health sector to deliver comprehensive, integrated interventions that influence society as a whole.
(ii) Second has been mapping the capacity of the health sector and/or agencies in other sectors to sustain either interventions or positive outcomes, or both.
(iii) Third has been mapping the generic capacity of communities to identify problems and to design solutions based on the existing strengths of the community (Bush et al., 2002).

There have also been reviews of Australian legislative frameworks for health promotion (Bidmeade, 1991) and of public health law (Bidmeade and Reynolds, 1997).

The capacity mapping carried out to date has resulted in clearer definitions of the health promotion capacity required by governments and, to a lesser extent, other organizations. The New South Wales Health project (1999) developed valid, reliable indicators to help with capacity building: the reviews of legislation included recommendations for the future, and the National Health and Medical Research Council (1997) review was associated with the establishment of a new national, coordinating structure for public health and health promotion, the National Public Health Partnership.

Capacity mapping in Australia has been an effective means of identifying the capacity needed by governments, other agencies and communities to promote health. It has resulted in more effective national planning and priority setting, and in commitment to the implementation of large-scale, intensive, comprehensive, integrated health promotion interventions.

Australia’s experience has demonstrated the importance of mapping capacity to engage in health promotion, and has contributed to the conceptualization of ‘capacity’ and to the development of tools to assist in mapping. Australian experience has also highlighted the need to continue to expand the work, but more, to establish minimum benchmarks for governments and civil society to use to assess the extent to which the health of populations and people is protected, promoted and sustained.

**Korea**

Korean national capacity mapping for health promotion is an emerging activity, stimulated by

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\(^1\) Including monitoring and surveillance, research and evaluation.
the growth of the Korea Health Promotion Fund, a key source of funding for national health promotion programmes (Oh, 2001; Nam, 2003). The Ministry of Health and Welfare is responsible for implementation and evaluation of Health Plan 2010, the adoption of which is the foundation for building national capacity in the coming period. The Korea Institute for Health and Social Affairs is in charge of and actively developing programmes on health promotion. However, a critical lack until quite recently has been the absence of capacity to train qualified health educators. In a positive development, the Korean Association of Public Health Administration and the Korean Association of Health Education introduced standards for health education professional training in 1998 (Nam, 2003). In 1999, professional training of health educators emerged at the non-governmental level (Nam, 2002), and capacity is fast accelerating; at the time of this writing, it is estimated that around 1000 health educators work in health centres, health promotion centres and other facilities related to public health.

Capacity mapping in Korea with an emphasis on health promotion policies is now coming to have a higher priority, undoubtedly a product of political commitment. The example of national tobacco control policies illustrates success in government stimulation of health promotion. Today, many public health leaders are interested in strategies for implementing health promotion, and realization is growing that capacity mapping could certainly help to improve Korean health status and quality of life. Thus, Korea is an example of recently but quickly emerging interest in capacity mapping, providing the opportunity for fast developments based on lessons learned in places where capacity mapping has a longer history.

Japan

Japanese experience in mapping national capacity to engage in public health and health promotion paralleled a remarkable rise of life expectancy after the end of World War II, the increasing prevalence of lifestyle-related disease and the emerging need for nursing care. Responding to these trends, the national government advocated the development of infrastructure for health promotion through two initiatives in 1978 and 1988 and soon thereafter by Healthy Japan 21 (Kawahara, 2001). The central government continued to stimulate national capacity for health promotion by passing the Health Promotion Act in 2002. The Ministry of Health, Labour and Welfare is responsible for implementation and evaluation of Healthy Japan 21 (Hasegawa, 2004). Three organizations were established for effective implementation of the initiative at the national level, i.e. Headquarters for Promotion of Healthy Japan 21, the National Council for Promotion of Healthy Japan 21 and the National Liaison Council for Promotion of Healthy Japan 21. Surveys and research on health promotion and the development of relevant databases are conducted by the Japan Health Promotion and Fitness Foundation, the National Institute of Health and Nutrition and the National Institute of Public Health. National data on public health such as the National Nutrition Survey are regularly collected for the monitoring of public health.

There is no academic institution in Japan that offers a degree in health promotion; however, many degree programs in relevant fields such as health sciences and nutrition have lectures on health promotion as a part of their courses. Training courses for instructors of health fitness are also available at universities, colleges and at the Japan Health Promotion and Fitness Foundation. Also, the Japanese Society of Health Education and Promotion introduced professional health education in 1994.

Thus, the cases of Korea and Japan illustrate recent and rapid expansion of interest and activity in the health promotion arena. The kind of international collaboration in health promotion that has arisen in Europe during the past two decades is not yet evident in Asia, but seems on the cusp of emerging. As or more interesting, perhaps, is the very recent development of inter-continental collaboration for health promotion capacity mapping, involving European countries and Korea and Japan. In collaboration with HP-Source.net, described in an earlier section, capacity mapping has been undertaken in Korea and Japan, using the same general approach that HP-Source.net uses in Europe (Nam et al., 2004). The experience in Europe, confirmed in Korea and Japan, is that control over and responsibility for health promotion is in many countries situated at a level other than the national. Accordingly, HP-Source.net was adjusted so that mapping
may take place at any administrative level, for example, at the local prefecture level in Japan. The experience in Korea and Japan also indicates a need to map developments in health promotion policy, infrastructure and key programmes, not merely whether these resources exist or not (Nam et al., 2004).

IN SUM: FURTHER OPPORTUNITIES FOR CAPACITY MAPPING

A key outcome of the Fifth Global Conference on Health Promotion, held in Mexico City in June 2000, was the call for the development of countrywide plans of action for health promotion. To develop such plans and monitor progress, countries require information on what already exists, is being developed or does not yet exist in the way of policy, infrastructure and programmes. Having such information for one’s own country, and from other countries, helps in priority setting and can speed the development of national plans and action. For example, existing national health promotion policies in other countries can be useful sources of ideas for a country intent on developing such policy.

Thus, mapping capacity for health promotion is a practical and vital aspect of developing capacity for health promotion. The Mexico City conference summarized the context for health promotion capacity building: because joint and individual responsibility and action are required to improve the public’s health, public policies that establish the conditions for health improvement are essential. The links between social and economic determinants of health, socioeconomic structural changes, physical environment and individual and collective lifestyles, call for an integrated view of health development. Best practices in health promotion need wide dissemination, both with regard to policy-making and programme implementation. Ministries of Health cannot manage the task of health promotion alone; they need to engage other public and private sectors to generate the required policies, infrastructure and key programmes.

These contextual issues have been more or less steady factors for many years, yet in important ways, the global, national and local contexts for health promotion have changed remarkably in the last two decades. Globalization, a process set in motion many centuries ago, has been accelerated dramatically in the past decade by communication technology that is fast spreading to every corner of the globe. Among the benefits of globalization has been the linking up of health promoters everywhere, sharing ideas and experience about practical and effective ways to build capacity for health promotion. This has happened, too, in the capacity mapping arena, but there is room for improvement.

The new context for health promotion, which was a major theme of the Sixth Global Conference on Health Promotion, Bangkok, Thailand, August 2005, contains both old and new challenges, but also new opportunities. A large scale, highly collaborative approach to capacity mapping is possible today due to developments in communication technology and the spread of international networks of health promoters. In capacity mapping, local variation will always be important, to fit variation in local contexts. However, many elements of health promotion capacity can be implemented in many contexts, with suitable adjustments. An excellent approach to professional education, for example, can be implemented wherever trained people and data collection resources can be mustered. Capacity mapping provides information about what exists, and where, in the way of health promotion policy, infrastructure and key programmes. The sharing of this information can and should stimulate the dissemination of practices that are suited to the continually evolving context of health promotion.

Some key lessons have emerged from the past decade of experience with national-level capacity mapping. It is impossible to use one single mapping protocol for all health promotion capacity mapping exercises, as capacity has different meanings in different contexts, and is often politically defined. Moreover, the capacity that is required for effective health promotion in a given country may be different from that in other countries because of differing cultural, social, economic and political conditions. For example, regarding information dissemination, a developed media network may be an important aspect of capacity in high income countries but for low income countries, a developed social network is essential and more appropriate. Although there must be a reasonable degree of commonality in what constitutes capacity among countries, there will also be differences arising from addressing different health issues. For
example, the facilities, equipment and expertise required for tackling motor vehicle injury vary from those required to eradicate polio. Thus, the mapping of capacity must also take into consideration the priority health concerns of the countries.

Although it is not appropriate to pursue one single mapping protocol for the reasons given here, effort should be made to develop models of best practice and construct typologies of capacity that are suited to various purposes. This can best be done by examining the concept of capacity across different countries through a combination of qualitative and quantitative methods. The triangulation approach being used in Europe seems promising in that regard.

The mapping of capacity as a tool for policy management is an innovative area that is growing rapidly, but with a number of problems that need addressing:

- **First**—what to map? Systems? Money? Manpower? Activities? Plans? Intentions? Hopes and aspirations? This calls to attention the need to define the construct ‘health promotion infrastructure’ with care, a task for the immediate future, and not addressed at all in this paper.
- **Second**—what to include . . . and exclude? The formal public or private investments in health promotion are often not separated from other health budgets. Much of health promotion policy, infrastructure and programmes may be hard to identify as such. This problem is of precisely the same calibre as that facing health promotion in general: broad as well as narrow definitions raise objections and generate controversy.
- **Third**—who to count? A health promotion workforce is obviously critical, but 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.
- **Fourth**—how to map the extent of health promoting work of the hidden workforce: Of individuals themselves, of parents, of teachers, of politicians.
- **Fifth**—how to compare apples and oranges? 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. League tables will be difficult or impossible to construct.
- **Six**—what data to use? Not all data are accessible or dependable. Private institutes consider data as business information and are often reluctant to share it. Public data may be tainted by political considerations.

These and many other problems stand in the way of further development of capacity mapping as a tool for policy-making. Nevertheless, dialogue and consensus building are feasible, as is collaborative work to create a base of experience with various approaches to capacity mapping. Capacity mappers and map users will not go far wrong if they respect the value, but also the limits of capacity mapping. Map making took a large step forward when Mercator invented his type of projection, yet today many geographic mapping systems are in use, each suited to different purposes. In the arena of health promotion capacity mapping, there seems little point in attempting to develop the ‘right’ map, but developing the right type of map for the right purpose is a worthy pursuit. A journey without a map—that is wandering.

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