The following organisations have played key roles in the development and implementation of ProLead since its inception. Their contribution is gratefully acknowledged.

- Health Promotion Switzerland
- International Network of Health Promotion Foundations
- Southeast Asian Ministers of Education Organization, Regional Tropical Medicine and Public Health Network
- Thai Health Promotion Foundation (ThaiHealth)
- The Victorian Health Promotion Foundation (VicHealth)
- United Nations Environment Programme Environmentally Sound Technologies Information System
- World Health Organization Centre for Health Development (Kobe)
- WHO Eastern Mediterranean Regional Office
- La Trobe University School of Public Health
- University of the Philippines Open University
- Pacific Open Learning Health Network.

This paper was prepared as a working document for discussion at the 7th Global Conference on Health Promotion, "Promoting Health and Development: Closing the Implementation Gap", Nairobi, Kenya, 26-30 October 2009.

It may not be reviewed, abstracted, quoted, reproduced, transmitted, distributed, translated or adapted, in part or in whole, in any form or by any means. The views presented in this discussion paper do not necessarily represent the decisions, policies or views of WHO or the organizations for which the contributors and reviewers work.
# CONTENTS

List of Abbreviations ................................................................................................................................. 3  
Introduction .................................................................................................................................................. 5  
Background .................................................................................................................................................. 5  
   Concepts of health promotion capacity .................................................................................................... 5  
   Methods of capacity building .................................................................................................................... 6  
Model of Reflective Learning and Action (RELEASE) .................................................................................. 7  
   Applications of RELEASE ........................................................................................................................ 9  
   ProLead achievements .............................................................................................................................. 16  
Incorporating health promotion practice in all programmes: Assuring intervention effectiveness ........................................... 18  
Conclusion: Towards a global action agenda for releasing capacity for promoting health .......... 24  
References ................................................................................................................................................... 26  
Annex 1. ProLead country team projects .................................................................................................. 27
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>NCD</td>
<td>Noncommunicable disease/s</td>
</tr>
<tr>
<td>PDSA</td>
<td>Plan/Do/Study/Act</td>
</tr>
<tr>
<td>RELEASE</td>
<td>Reflective learning and action systems</td>
</tr>
<tr>
<td>SEAR/SEARO</td>
<td>South East Asian Region/ South East Asian Regional Office</td>
</tr>
<tr>
<td>WPR/ WPRO</td>
<td>Western Pacific Region/ Western Pacific Regional Office</td>
</tr>
</tbody>
</table>
**KEY MESSAGES**

- A systems perspective for health promotion is needed to effectively bridge gaps in capacity for promoting health and addressing underlying determinants of health.

- Capacity and the potential to change and influence determinants of health may be stifled by systems and contexts that are disempowering.

- Capacity can be "released" through dialogue-based and participatory methods of reflection, learning and action in "learning environments" that enable individual, programme, communities and social institutions to address underlying barriers, threats and risks that impact on health and quality of life.

- Learning environments that promote systems thinking and continuous quality improvement principles support the release of potential and capacity for promoting health:
  - at the individual and team level. Leadership development based on these principles has strengthened health promotion infrastructure and capacity in several countries already
  - in health promotion programmes. Integrating these principles into health promotion practices has strengthened the effectiveness of programmes across a diverse range of programmes.

- Reflective learning and action systems approach (RELEASE) is defined as capacity building through dialogue-based and participatory learning environments of teams who can influence the way resources and knowledge for promoting health are organized and utilized using principles of continuous quality improvement in order to achieve higher performing health promotion systems.

**IMPLIED ACTIONS FOR ACTION**

- Develop leadership capacity (for example, through ProLead) to strengthen health promotion infrastructure.

- Map national health promotion capacity as a routine process for quality improvement.

- Apply tools for programme, team, organisational and system development to support development of high performing health promotion systems.
INTRODUCTION

Although the Ottawa Charter was adopted over 20 years ago, health promotion is still a relatively new practice in developing countries and has limited infrastructure and capacity support. As a result, the integration of health promotion practice into health programmes is limited. Over the past seven years, capacity building for health promotion effectiveness has been the major agenda in the Western Pacific Regional Office of WHO\(^1\). The emerging perspective for releasing capacity and potential for high performing health promotion systems as experienced in the Western Pacific Region is used as a take-off point for discussions on capacity building at the global level. The work is evolving. This paper aims to highlight different aspects of capacity building experience to date in the hope that they can be further distilled and applied to practice in a wide range of settings, programmes and initiatives. The complex nature of health problems facing countries now, and likely to emerge in the near future, requires scaled up and more rigorous health promotion practice. As a basis for strengthening practice, sustainable, adequate health promotion infrastructure and capacity is required.

This paper will introduce the evolving reflective learning and action systems approach ("RELEASE") to achieving high performing health promotion systems. It will firstly define the key concept of health promotion capacity and different methods of capacity building. It will then describe RELEASE and review how it has been applied. The paper will conclude with a brief discussion of the agenda for future developments in the region.

BACKGROUND

CONCEPTS OF HEALTH PROMOTION CAPACITY

Hawe et al (1997) argue that a range of capacities are required to achieve sustainable health outcomes. In particular, three key factors must be present: (1) infrastructure – that is, the capacity to develop and deliver services and activities in response to health needs; (2) ownership and partnership – that is, the capacity and commitment to maintain health programmes by mobilizing a range of resources; and (3) adaptation to and management of change – that is, a problem-solving capacity (or organizational and system-learning capacity) that enables continuous learning from experience and then the application of that learning to new health challenges.

Effectiveness of health promotion practice ultimately translates into individuals and communities being able to exercise control over their health decision-making and acting on the determinants of health. This means they are able to identify and prioritise their health concerns, act proactively on the determinants of health, maintain their initiatives, and apply increased skills and learning to other areas of community concern. To achieve effective practice requires high-performing health promotion systems, that is, organisational systems embedded in the community that work to empower individuals and communities.

A health promotion system relies on stable basic infrastructure – or system building blocks – such as finance, workforce, resources, information systems and organisational and intersectoral teams and partnerships. These building blocks are harnessed to work together

---

\(^1\) WHO WPRO Regional Health Promotion Strategic Plan 2003-2005
as a system through governance arrangements, and consequent policy and planning frameworks. How well the building blocks can support effective health promotion is a function of how good the capacity is in the system. In other words, capacity = the performance capabilities to deliver health promotion outcomes.

Health promotion theory points to the importance of coordinated action at multiple levels, and therefore suggests that health promotion capacity is needed at national, local, organisational and programme levels. Capacity-building efforts need to address (1) the health programme or service organization – for there to be commitment (resources, policies), skills (competence), structures (networks, planning, decision-making, communication) in place for health gain, and (2) the health system level – to enable delivery of particular services or response to a wide range of problems (competencies, performance standards, quality improvement), solve new problems and act in the face of uncertainty (workforce development, organizational development, leadership development).

The multi-level and multi-dimensional nature of health promotion practice also point to the importance of systems thinking and the ability to adapt and act according to context. Capacity building for health promotion, therefore, needs to address not only individual building blocks in the health promotion system but ultimately how well the system can function as a whole.

Attention is therefore needed on: 1) how to strengthen links between infrastructure, capacity and performance, and 2) how to incorporate health promotion understanding and skills across diverse programmes and stakeholders.

**METHODS OF CAPACITY BUILDING**

Capacity building is often thought about as the training of individuals, where capacity is conceived of as a means to achieve a stated end, and a lack of individual skills or knowledge is seen as the problem. Traditional efforts at institutional capacity development have also focused more narrowly on creating or reorganizing government units and building individual skills (Nevers, Leautier and Oto, 2005). The supply-side of capacity captures much of the traditional view of capacity as comprising material resources, technical skills and organizational capability to make appropriate policy decisions and also implement them. This often translates into training programmes for health workers, or the provision of technical assistance in designing and implementing programmes.

The human capability approach of Nussbaum (2000) and Sen (1998) sees capacity more as a means. This approach is also concerned with understanding why some blatant inequalities in society occur and how to address them (Alexander 2005). While human beings differ from one another in personal characteristics such as health, age, sex and genetic endowments, these differences relate to differences in the types of external environment and social conditions they live in. These different elements of human diversity crucially affect the ways in which resources such as income and wealth are transformed into relevant capabilities.

Applied to health promotion concerns of acting on social determinants and health inequalities, this means capacity building efforts need to be concerned with both the means (that is, exercising choice and taking control over factors influencing health) and ends (that is, participation in social, economic and political life, and achievement of good health and quality of life outcomes).

In this sense, capacity building methods need to recognise that expert knowledge and skills together with the conceptual and sensory information that helps individuals make sense of
things are applied in context, and on a continuous basis, where each application also modifies the context for action (Pawson, 2006).

Capacity building efforts, therefore, should comprise both specific interventions at individual/team/organisational/network levels, as well as embedding learning into organisational processes. As such, health promotion capacity building is related to such concepts as reflective practice (Schon, 1983), learning organisations (Senge, 1990) and continuous quality improvement.

MODEL OF REFLECTIVE LEARNING AND ACTION (RELEASE)

We have previously recognised that effectiveness relies not only on evidence but also on infrastructure and implementation efforts (Lin & Fawkes, 2005). The ‘Effectiveness Equation’ is presented in Box 1.

**BOX 1: THE EFFECTIVENESS EQUATION**

Effectiveness = Evidence + Infrastructure + Implementation

Implementation of programmes relies on there being capacity to achieve intended outcomes, and in turn, capacity building efforts need to focus on both infrastructure for health promotion and on capacity to apply health promotion understanding and skills in all programmes. Once capacity has been sufficiently developed, the potential to improve health is in place. The experience of health promotion capacity building in WPRO (WPRO Regional Health Promotion Strategy, 2003-2006) points to a model of a reflective learning and action system which can enhance system infrastructure and implementation capacity, as seen in Figure 1. The model sets out the logical links between infrastructure, potential and performance, through processes of reflection based on the continuous quality improvement cycles (the Plan, Do, Act, Study cycle – PDSA). This system, and the experiences that have informed its development, are described in turn in the following sections.
FIGURE 1: REFLECTIVE LEARNING AND ACTION SYSTEMS (RELEASE)

HEALTH PROMOTION INFRASTRUCTURE

- Capacity released to think and act for the promotion of health in the context of systems

HEALTH PROMOTION CAPACITY IMPROVED AND APPLIED

- Capacity released to address underlying determinants of health in all programmes

EFFECTIVE PERFORMANCE

- System
- Programme
APPLICATIONS OF RELEASE

Mapping health promotion infrastructure and capacity

Health promotion capacity mapping is a first step in ascertaining whether all the key building blocks for the health promotion system are in place. It assesses how comprehensive and robust the health promotion infrastructure is, and whether its capacities are sufficiently developed and being strengthened.

National health promotion capacity mapping in 2005 across 17 WPR countries\(^2\) pointed to gaps in health promotion financing and workforce in most countries in the region. The experience also pointed to the value and importance of engaging key stakeholders in the process of capacity assessments to reflect on the current status of national health promotion infrastructure and capacity. A dialogue-based tool was therefore developed to offer a framework and a process for thinking about shortfalls in system capacity, namely, for stakeholders to jointly undertake a rapid assessment of the system, and to arrive at some consensus about shortfalls and, therefore, investment priorities.

The multi-domain tool for mapping national health promotion capacity was piloted in Brunei Darussalam, Papua New Guinea and Philippines in 2006. Countries recognised a) the need to build capacity that supports programme and service effectiveness and is sustainable and b) the benefit of using a combination of a social or dialogue-based process and a technical tool to reflect on existing capacity as a basis for gaining a strategic approach to capacity building.

With participation from key stakeholders across sectors, and drawn from government, non-government, academic and civil society sectors, a range of insights and perspectives were brought to bear in discussing the strengths and weaknesses in health promotion capacity in each country. Despite differences in public administration systems, resources, and cultural backgrounds, common priorities were identified across the countries:

- Strengthen governance and leadership for health promotion at the national level supported by authority, leadership and expertise for health promotion in the Ministry of Health to deliver on health promotion objectives depicted in the Ottawa Charter for Health Promotion, in particular, advocacy for the development of healthy public policies;
- Sustain national health promotion capacity within and outside of the Ministry of Health;
- Intensify efforts to build the workforce through: achieving multi-level coverage of health promotion expertise; build a critical mass of technical specialists in health promotion; expose more personnel to professional development programmes and international links; equipping all practitioners with adequate basic skills in monitoring and evaluating health promotion policies and programmes; and employ a critical mass of individuals with advanced levels of expertise to call on as required for complex initiatives;

---

\(^2\) Participating countries were: Australia, Brunei Darussalam, China, Cook Islands, Fiji, Japan, Republic of Korea, Laos PDR, Malaysia, Mongolia, Papua New Guinea, New Zealand, Philippines, Samoa, Singapore, Tonga, Vietnam
• Leverage gains for health promotion capacity (such as workforce skilling and intersectoral partnerships for health) from programmes such as those conducted with funding from the Global Fund;

• Gain a cross-national perspective on information systems that support health promotion planning, implementation and monitoring and use this to inform the further development of health information systems;

• Undertake evaluation of health promotion on a systematic basis and analyse implementation failures to gain insight into short and longer term priorities and mechanisms for building capacity.

The process for capacity mapping – one of information collection, reflection and prioritisation - was identified as invaluable. It essentially involved the implementation of a one-day workshop for key stakeholders, for which some preparatory research had been undertaken.

Countries wanted a good mix of participants so that there could be authoritative, insightful input from a range of perspectives - not only from those planning, but also from those implementing health promotion. A similar range of participants took part in the pilot processes in all countries. Ministry of Health staff were from different levels and areas and included policy and planning, finance, information and knowledge management systems, director and senior staff of the divisions of health promotion and community health/community development. Individuals from other ministries took part (e.g. education, sport and recreation, local government) as did local level health agencies, national level non-government and community organisations, academic institutions and people from non-health sectors. Officers of the Prime Minister and Treasury as well as senior policy officers from other sectors provided input on some key infrastructure issues. Some individuals from the private sector and donor bodies took part in some pilots.

The workshops were found to stimulate robust discussion about, and intentions to take action on, important aspects of capacity in the countries. Valuable ideas for enhancing the tool and process were made. The process itself was recognised as a step toward building capacity, through the introduction of key stakeholders to each other and provision of a meaningful process for discussion and debate about the status of different aspects of capacity and prospects for their further development.

Piloting the tool therefore affirmed the value of a dialogue-based process of reflection, drawing together stakeholders from across and outside the health sector and government. A key outcome of the dialogue process was to strengthen understanding of the role and contribution of health promotion, and the importance of health promotion infrastructure among all players. It was generally agreed that mapping should not be a one-off exercise, but repeated to maintain momentum for capacity building, thus the idea of continuous quality improvement was readily adopted by participants in the process.

---

3 Where there was ambivalent participation by some individuals, this provided useful insights for government into likely engagement of particular organisations at a later time in health promotion.
A regular Plan/Do/Study/Act/Continuous Quality Improvement (PDSA/CQI) process can allow for periodic monitoring of capacity and re-adjustment of investments to ensure appropriately balanced development of health promotion infrastructure and capacity.

**Strengthening infrastructure and capacity through leadership development**

Whether the intention is to marshal investment in infrastructure or harness all elements of the system to work effectively, there must be vision, mobilisation of stakeholders, and effective governance. Leadership capabilities are thus critical to system change.

Since 2004, a transformational leadership development programme (ProLead) has been implemented with three cohorts in the WPR (and one in EMR in 2007) with a focus on addressing the national infrastructure shortfalls, particularly in health promotion financing (Lin & Fawkes, 2005). To change a system requires a comprehensive understanding of what the system is, what the dynamics are in the system, and how to use possible levers for change.

ProLead recognises that there are general leadership skills and attributes across sectors, as seen in Table 1 below. These categories are regarded as essential for achieving strategic and sustainable changes to advance health promotion in countries.

**TABLE 1: TYPICAL LEADERSHIP SKILLS AND ATTRIBUTES**

<table>
<thead>
<tr>
<th>Category</th>
<th>Generic Leadership Qualities and Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intra-personal qualities</td>
<td>Self-awareness; self-regulation; self-motivation; “appropriate” set of beliefs, values and ethics; moral character and integrity; loyalty</td>
</tr>
<tr>
<td>Inter-personal qualities</td>
<td>Build and maintain teams; establish trust; demonstrate respect (re gender, culture, nationality, religion etc); listen empathetically and show sensitivity to others; provide helpful feedback; take initiative; motivate others; empower others; manage conflict</td>
</tr>
<tr>
<td>Cognitive skills</td>
<td>Detect, analyse and solve problems; see and generate alternative problem solutions; explore and resolve ambiguity; question assumptions</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Articulate and express a vision; communicate with influence</td>
</tr>
<tr>
<td>Task-specific skills</td>
<td>Expertise to carry out certain tasks; knowledge of particular specialised content areas that enables structuring of tasks and clarification of objectives, resolution of ambiguities about how to proceed, provide direction</td>
</tr>
</tbody>
</table>

**ProLead curriculum**

ProLead aims to enhance practical skills of health promotion leaders across five categories of skills. In particular, the ProLead curriculum gives emphasis to individuals developing self-

---


awareness coupled with specific leadership skills (such as systems thinking, advocacy, communication, negotiations), and country teams applying learnings by undertaking a strategic analysis of current system shortfalls and developing a project to address the barriers to change. The specific curriculum of ProLead for each cohort of fellows is adapted in accordance with the learning needs. Mentors for country team projects have been provided through the International Network of Health Promotion Foundations.

The ProLead programme is based on the participation of country-based teams comprising two to three senior level professionals with leadership experience of promoting health and well-being in their countries. Fellows are selected through the country offices of WHO, in collaboration with national governments.

Prior to the first module, fellows are given the task of gathering data about the status of health promotion in their countries using tools for capacity mapping and Figure 2 illustrates the domains of health promotion capacity which are mapped. Their findings are represented in a spidergram to show existing strengths and reveal areas for further development.
FIGURE 2. MODEL OF HEALTH PROMOTION CAPACITY MAPPING DOMAINS

SYSTEM GOVERNANCE
B.1 Governance
Mandate for health promotion
Strategic vision and Leadership
Institutional links and relationships

B.2 Policy environment
Healthy public policy and plans
Health sector policies and plans

SYSTEM INPUTS
B.3 System infrastructure and resources
Workforce
Financing and funding
Program delivery system
Health information system

SYSTEM OUTPUTS
B.4 Programs and services
Programs designed to improve the health of populations
Health promotion in clinical settings

IMPACTS
Changes to determinants of health

OUTCOMES
Improved Quality of life, Health and Wellbeing
The initial meeting consists of seminars, small group discussions and self- and team-reflection at the end of which, the groups agree on their project idea. Deciding on a project is a reflective process that involves a sequence of connected activities\(^6\), and each is illustrated below:

1) Stakeholder analysis,
2) Nodal governance mapping,
3) Problem identification and root cause analysis,
4) Constructing countermeasures, and
5) Developing action plan.

1. Stakeholder analysis

FIGURE 3.

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Level of Influence in the Society</th>
<th>Level of Interest in Health Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td><strong>Internal stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^6\) Sources:


2. Nodal governance mapping

FIGURE 4.

3. Problem identification and root cause analysis (using Ishikawa Diagram)

FIGURE 5.
4. Construction of countermeasures

FIGURE 6.

For the subsequent six months, fellows go through learning materials that are designed for self-study. Learning activities, for both individuals and groups, offer opportunities for enhancing knowledge and skills related to health promotion, leadership and management. Discussion questions help participants understand concepts and apply these to their own context and situation. These discussions are done online, with facilitators. Worksheets are provided to help structure outputs, later for compilation into a portfolio. During these six months, fellows continue to work on their project with their mentors. Twinning arrangements are negotiated with well-respected health promotion institutions from throughout the Region, depending on the needs of project teams.

Team progress is reviewed at the second meeting, six months later, when further seminars are offered. At a third and final meeting, fellows present their country team projects and discuss what they have achieved, learned and been challenged by the programme.

The nature of ProLead is that it provides experiences and frameworks for gaining and testing knowledge, skills and attributes. ProLead operates within an open system. This means that learning occurs in an environment where situational factors influence the attitudes, knowledge and skills acquired by the fellows. Also, behavioural, performance, leadership and management changes across a range of domains (such as partners and networks, public policy, health systems) may result from numerous influences, not just the enhancement of leadership (through ProLead) in the system.

PROLEAD ACHIEVEMENTS

To date, the achievements from ProLead have been significant, with essential foundations for sustainable health promotion established in countries through the work of ProLead country teams (See Annex 1 for list of ProLead team projects). Health promotion foundations and centres have been established in Mongolia (See Box 2), Tonga, Brunei, Philippines, Malaysia, Oman, and Bahrain. The programme has been adapted to address social determinants of health in urban settings in Santiago, Bangalore, and Suzhou. In addition, the highlights of the ProLead curriculum has been adapted for a short course on leadership for health promotion, offered initially in August 2009 in Lugano, Switzerland, and geared more for countries with a reasonable level of health promotion and infrastructure (See Annex 2 for program).
BOX 2. SUCCESSFUL ADVOCACY FOR HEALTH PROMOTION CAPACITY BUILDING IN MONGOLIA

ProLead 1 (August 2004 – March 2005)

Mentor: ThaiHealth

Major achievement: Established Mongolian Health Promotion Foundation (HPF)

Background:
Mongolia identified the barriers to improving health promotion in the country as:

- Lack of funds available for sustainable health promotion including advocacy & social mobilization;
- Health sector budget makes no specific allocation to health promotion.
- International donors were supporting health promotion activities through one-way interventions and mostly on ad hoc basis.
- Lack of advocacy skills among main players for improving health promotion infrastructure and financing through good governance in Mongolia.

Actions:
Based on a thorough needs assessment, the team coordinated a range of advocacy actions. These included:

- Conducting round table discussions about current status of health promotion and shared presentations of ProLead training;
- Completing an advocacy tool on promoting health and shared it with key people;
- Developing an information, education and communication strategy for Healthy Lifestyle Team;
- Producing 40 CDs on ProLead in Mongolia, and submitted them to WHO and related providers;
- Making presentations: (1) at a Ministerial breakfast meeting, which was broadcast on radio and TV (2) to a meeting of Mongolian Public Health Professional Association and public health stakeholders (3) to a national committee for anti-alcohol and an anti-tobacco foundation

Results and impact:
As a result of their actions:

- An information, education and communication strategy for healthy lifestyle was approved by Health Minister’s order # 18, Jan 05, 2005;
- 70 million togrogs (approximately USD 60,000) was supplied to invest in health promotion in 2005;
- There has been greater awareness of health promotion;
- A new Cabinet and Ministry of Health expressed commitment to support and further develop health promotion;
- Legal enforcement of ban on alcohol and tobacco advertisements started on 1 March 2005.

Follow up:
Since the ProLead program finished, a number of major achievements have been made:
• Design of Mongolian HPF with ThaiHealth support;
• Mongolia's first attempt to pass a tobacco control law failed. The working group intensified education and gained support among government officials for the tobacco control law and dedicated funding;
• Mongolia passed legislation for tobacco control including a tobacco-tax funded health promotion foundation at the end of 2005. Mongolia's HPF is funded from 2% of the tax on tobacco.

An evaluation of ProLead in 2006 pointed to a range of short- and medium-term changes at the level of individual and networks/partners (Lin & Fawkes, 2006), based on the proposition that three types of change may occur as a result of fellows' participation in ProLead. Grove, Kibel and Haas (2005) termed these changes 'episodic', 'developmental' and 'transformative'. Essentially, these changes occur in the short term (such as knowledge gained by fellows), medium term (such as a sustained change in work-related behaviour of fellows and their teams such as patterns of decision-making) and longer term (such as shifts in worldview of government teams in which fellows are members or social attitudes to health promotion). Individual and team reflection and quality improvement tools have been essential elements that have supported the learning.

Key findings from the evaluation were that ProLeads I and II:

• Trained 37 health promotion leaders across three Regions, enabling them to acquire skills, cultivate attitudes, personal attributes, networks and gain insights required to initiate and drive systemic change in their respective countries, with the goal of securing health promotion as a priority strategy to improve population health.
• Stimulated capacity-building for health promotion in countries.
• Assisted Fellows in a number of countries to create or fast-track legislation to earmark taxes on tobacco or alcohol products (or both) for health promotion and introduce health promotion foundations as a strategy to create continuous financing of health promotion.
• Produced tangible benefits for Fellows’ countries such as setting national agendas for pro-health governance in order to tackle the social determinants of health through health promotion, and mobilising action to create new and autonomous structures and sustainable financing for health promotion.
• Created bridges between international organisations (such as health promotion foundations, universities, SEAMEO-TROPMED Network) around the task of health promotion leadership development.
• Established the basis for a ProLead alumni network that has an ongoing role to play in training leaders as well as engaging in international efforts associated with the ProLead agenda for change.

INCORPORATING HEALTH PROMOTION PRACTICE IN ALL PROGRAMMES: ASSURING INTERVENTION EFFECTIVENESS

Having adequate health promotion infrastructure capacity across the system is a starting point, but sound health promotion practice needs to be incorporated into all health
programmes if positive health outcomes are to be achieved. WPRO has been developing rapid assessment tools that can be adapted to different programmes to ensure that specific programmatic interventions are balanced, coordinated, and appropriately targeted. The design and application of the tools draw from the same principles of system thinking, strategic engagement of relevant partners, and quality improvement principles. As with capacity mapping, the intervention effectiveness mapping tool can bring partners together to identify gaps in current strategies and agree on new priorities. Furthermore, the tool can be used as part of a CQI process to support periodic monitoring and adjustment of programme strategies, alongside reviews of key performance indicators for the programme.

The intervention effectiveness mapping tool is composed of several components which can be adapted for application to the programmatic areas of tobacco, HIV/AIDS and NCDs. Similar to the process followed in ProLead, the steps are as follows:

1) SWOT analysis (Strengths, Weaknesses, Opportunities and Threats)
2) Intervention mapping spidergram
3) Priority selection matrix
4) Traffic lights for stakeholder engagement assessment
5) Stakeholder mapping
6) Multi-voting on priority areas
7) Fishbone analysis
8) Countermeasures and practical methods development
9) Innovation window
10) Action Plan

An example of the intervention mapping tool used during the Workshop on Using Data on Second-hand Smoke (SHS) Exposure for Policy and Action can be found in Figure 7. The spider legs can be adapted according to the topic area chosen, to engage in the reflection, learning and action processes. Priorities are then selected based on the barriers which emerged from the group’s discussions. Figure 8 shows the priority selection matrix that can be used.
FIGURE 7. COMPONENT OF THE INTERVENTION EFFECTIVENESS MAPPING TOOL
Using data on tobacco control for policy and action

Quality improvement tools have recently been introduced to the Global Tobacco Surveillance System through collaboration between WHO and the US Centers for Disease Control and Prevention. The Global Tobacco Surveillance System that includes the Global Youth Tobacco Survey is the largest and most reliable data base on a behavioural risk factor for noncommunicable diseases. The system has been in place for ten years and an identified gap has always been the need to more effectively use data for policy and action.

The use of quality improvement tools were piloted in the Western Pacific Region through training of teams of surveillance officers and programme managers. In many countries, this was the first time that tobacco surveillance officers and programme managers had a chance to dialogue, discuss and prioritize how data collected through various tobacco control surveys could be used to improve policies and programmes. The process of using quality improvement tools in a team has been liberating for many tobacco surveillance officers who have never seen it within their "role" to define how and when data can be used to achieve programme goals. Currently, the package of tools is being rolled out in Africa and will be extended for use in South East Asia.

A similar set of quality improvement tools have been adapted for use for enabling teams to use data on monitoring second-hand smoke (air nicotine and particulate matter) for advocacy and to strengthen regulations and enforcement of 100% indoor smoke-free settings in countries. This is a collaborative project of the Johns Hopkins School of Public Health, Flight Attendants Medical Research Institute, WHO SEARO and WPRO.

---

### FIGURE 8. PRIORITY SELECTION MATRIX

#### Setting Selection Matrix

<table>
<thead>
<tr>
<th>3 PRIORITY AREAS FOR ACTION</th>
<th>Reason for improvement</th>
<th>Internal stakeholders</th>
<th>External stakeholders</th>
<th>High impact on stakeholders 1-5</th>
<th>Favorable conditions 1-5</th>
<th>Total X/25</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**High impact** – significant and positive outcomes are expected for internal and external stakeholders (1-low; 5-high)

**Favorable conditions** – opportunity, political timing and environmental factors favor success (1-low; 5-high)
Improving health promotion effectiveness for projects on HIV-AIDS, malaria and tuberculosis

Health promotion and health systems development units in WPRO have collaborated to use quality improvement tools to improve health promotion effectiveness in countries that are implementing projects under the Global Fund for Tuberculosis, HIV-AIDS and malaria. The tools enable capacity to be assessed and mapped in four domains for action:

- social determinants of health
- healthy settings
- health systems
- behaviour change for individual risk factors

The assessments can be represented as ‘spidergrams’. Pilots of the tool will be implemented in the Philippines and Lao PDR. **Figure 9** illustrates a working version of a spidergram below.

**FIGURE 9. SPIDERGRAM OF HEALTH PROMOTION CAPACITY IN FOUR DOMAINS OF ACTION**
Working with teams to address inequity in urban areas

The WHO Centre for Health Development (WHO Kobe Centre), as a follow-up to the work of the WHO Commission on Social Determinants of Health and as the hub of the Knowledge Network on Urban Settings, developed a tool called the *Urban Health Equity Assessment and Response Tool* (Urban HEART) to encourage national and sub-national teams to map health inequities across cities and identify interventions and responses in a participatory approach to reduce health inequities across the gradient. The *Urban HEART* has been piloted in 3 countries within the WHO Western Pacific Region, namely the Philippines, Mongolia and Vietnam. The tool has been demonstrated to be an effective way to focus attention on underlying determinants of health, to organize multi-sectoral initiatives and to engage the community in addressing issues related to reproductive health, water and sanitation, tobacco control, nutrition, housing and communicable diseases.

**Environmentally Sustainable and Healthy Urban Transport (ESHUT)**

In collaboration with the UN Centre for Regional Development, WHO has started work on an initiative to encourage cities to work on environmentally sustainable and healthy urban transport systems. Four cities, participated in the first workshop organized jointly by WHO and UNCRD at which the ESHUT initiative was introduced. The initiative seeks to create dialogue and bridge understanding between the health, environment and transport sectors in cities to develop interventions that can contribute to the reduction of greenhouse gas emissions, improve physical activity and reduce health inequities. Environmentally sustainable and healthy urban transport projects also focus on barrier-free access for individuals with disabilities and for older persons, as well as smoke-free public transport. Quality improvement tools have also been used to encourage group discussions, prioritization and identification of barriers to improve transport systems and render them more conducive to the environment and the health of urban populations.

A spidergram tool was used during the first workshop with representatives from the city's health, environment and transportation departments to identify environmentally sustainable and healthy interventions. *Figure 10* below is an example of how the spidergram can be used to identify: the need and relevance of an ESHUT intervention (by placing a black star in the spidergram); the current capacity to implement/improve an ESHUT intervention (by placing a white star); and the feasibility of implementing/improving an ESHUT initiative (by placing a grey star).

The number 1 on the leg of the spidergram denotes that the intervention is not relevant and not needed, that the city lacks capacity to implement the intervention, and that it is not politically and socially feasible to implement the intervention. Whereas the number 4 denotes: high relevance, strong capacity in place and high feasibility to implement the intervention. Thus, in the example provided below: "increased connectivity" was selected a possible intervention area. Cities are able to change the interventions, suggested in the spidergram, according to the needs of the city.
The development of sustainable infrastructure continues to be a basic requirement for health promotion systems, and priorities for infrastructure development should be directed to financing and workforce (including the workforce in all health programmes). Leadership development remains a pivotal investment for fostering a critical mass of people who can work together to instigate and pursue system change strategies. Leadership development goes hand in hand with organisational and systems development. A further challenge lies in fostering continuous learning, particularly by ensuring organisational learning systems are in place so that health promotion practice can be institutionalised into health systems. The agenda for health promotion capacity building is therefore one of building productive, goal-directed learning systems.

The WPRO Regional Health Promotion Plan of Work placed capacity building for health promotion firmly as the central agenda. Using infrastructure and capacity for health promotion as a platform, a reflective learning and action system has been trialled successfully. Capacity mapping and reflective learning points to how a systems-based approach can be used to identify, prioritise, and act on key areas for investment.

The strategic learning and reflective action system has also been shown in WPRO to be adaptable to multiple health issues and health system contexts. The model demonstrates the clear, logical links between infrastructure, capacity and performance, provided that a quality improvement cycle is in place to support reflective learning and action.
Strengthening investments in health promotion infrastructure and capacity is a critical first step in closing the implementation gap, between the ideals of promoting health and the delivery of high performing health promoting systems.

A global agenda for health promotion capacity building should include the following priorities:

1) Application and use of dialogue-based and participatory methods for creating learning environments for various groups:
   - teams of managers of specific programmes (tobacco control, reduction of harmful use of alcohol, diet and physical activity, noncommunicable disease prevention and control, safe pregnancy) as well as cross-cutting initiatives (health promotion, healthy cities, health promoting schools, healthy islands)
   - multisectoral teams that are tasked to address complex issues that require action of several sectors with uneven power and influence in policy-making e.g. tobacco taxation, environmentally sustainable and healthy urban transport
   - teams of surveillance managers working in non-communicable disease
   - multi-agency, local government teams working on urban health equity
   - teams across the various levels of the health systems (eg community representatives, health services managers, clinical professionals, policy makers) and different sub-sectors (ie public health, primary health care, hospitals, traditional medicines) working to build health promoting health systems (and people-centred healthcare).

2) Evaluation, documentation and sharing of good practices in the future. CQI principles emphasise the importance of continual reflection, learning, and then acting. Through the use of rapid assessment tools, coupled with key indicators, a monitoring and evaluation system can be built to suit developing country contexts.

In summary, the key elements of a reflective learning and action system include:

1) Fostering cross-sectoral leadership teams that can focus on strengthening infrastructure and capacity for health promotion at all levels and in diverse programs;

2) Strengthening the focus on linking capacity and performance by incorporating reflective practice and quality improvement (about health promotion activities in all health programmes); and

3) The further development of rapid assessment and evaluation tools that can serve the technical and social aspects of managing change (to support stakeholder dialogue and agreement on planning, prioritisation, and quality improvement).
REFERENCES


## ANNEX 1. PROLEAD COUNTRY TEAM PROJECTS

### PROLEAD 1 (2004-2005)

<table>
<thead>
<tr>
<th>Country</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>Shanghai health promotion project</td>
</tr>
<tr>
<td></td>
<td>Exploring the feasibility of setting up a foundation for health promotion in Shanghai, China</td>
</tr>
<tr>
<td>Malaysia</td>
<td>Establishing the Malaysian Health Promotion Foundation (MHPF)</td>
</tr>
<tr>
<td></td>
<td>Increasing participation of health-related NGOs, sport and arts organizations in health promotion through advocacy and partnership development for MHPF</td>
</tr>
<tr>
<td>Mongolia</td>
<td>Health promotion in Mongolia</td>
</tr>
<tr>
<td></td>
<td>Improving health promotion in Mongolia through good governance</td>
</tr>
<tr>
<td>Philippines</td>
<td>Lobbying for Health Promotion: An on-the-job training programme for the networking unit of the National Center for Health Promotion</td>
</tr>
<tr>
<td>Tonga</td>
<td>The need for health promotion in Tonga</td>
</tr>
<tr>
<td></td>
<td>Improving efficiency and effectiveness of health promotion in Tonga</td>
</tr>
</tbody>
</table>

### PROLEAD II (2005-2006)

<table>
<thead>
<tr>
<th>Country</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>Advocacy and development of partnerships for health promotion</td>
</tr>
<tr>
<td>Japan</td>
<td>Developing mental health care systems for staff in emergency hospitals</td>
</tr>
<tr>
<td></td>
<td>Focused health promotion in Hyogo Prefecture: Food safety in disasters</td>
</tr>
<tr>
<td>Lebanon</td>
<td>Improving and coordinating media coverage of health issues in Lebanon</td>
</tr>
<tr>
<td>Oman</td>
<td>Revitalization of the health promotion programme in Oman</td>
</tr>
<tr>
<td>Korea</td>
<td>Building consensus on the strategic vision for health promotion</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Addressing the limited involvement of key stakeholders in health promotion</td>
</tr>
<tr>
<td>SEAMEO</td>
<td>Promoting and enhancing human resource development in health promotion at the SEAMEO-TROPMED Regional Centers</td>
</tr>
</tbody>
</table>
**PROLEADPLUS (2007-2008)**

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei Darussalam</td>
<td><strong>Establishment</strong> of a structured and integrated health promotion organization actively involving other partners in running health promotion programmes</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Development of a comprehensive national health promotion policy</td>
</tr>
<tr>
<td>Cook Islands</td>
<td><strong>Development</strong> of a national health promotion policy</td>
</tr>
<tr>
<td>Fiji</td>
<td><strong>Finding</strong> appropriate funding allocation for health promotion</td>
</tr>
<tr>
<td>Kiribati</td>
<td><strong>Improving</strong> coordination of health promotion programmes</td>
</tr>
<tr>
<td>Lao PDR</td>
<td><strong>Development</strong> of policy to support all health sectors and external related organizations to mainstream health promotion</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td><strong>Develop</strong> clear action plan on promoting health promotion policy</td>
</tr>
<tr>
<td>Samoa</td>
<td>Developing health promotion leadership within the health sector</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>Development of national health promotion policy</td>
</tr>
<tr>
<td>Tonga</td>
<td><strong>Improving</strong> stakeholder engagement in the health promotion foundation “Tonga Health”</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Establishing strategic alliances/partnerships to set framework for health promotion</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Setting up mechanisms for the involvement and coordination of the health sector and other sectors to promote healthy lifestyles</td>
</tr>
</tbody>
</table>
GCC (GULF COOPERATION COUNCIL) PROLEAD (2007)

<table>
<thead>
<tr>
<th>Country</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahrain</td>
<td>Developing a whole-of-government approach to health promotion</td>
</tr>
<tr>
<td>Oman</td>
<td>Revitalization legislation to be more conducive to health promotion</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td></td>
</tr>
<tr>
<td>Tunisia</td>
<td></td>
</tr>
<tr>
<td>United Emirates Arab</td>
<td>Strengthening institutional arrangements for health promotion in the UAE Ministry of Health</td>
</tr>
<tr>
<td>Yemen</td>
<td>Building the infrastructure, culture, advocacy activities and initiatives for promoting health</td>
</tr>
</tbody>
</table>

Note: Gulf Cooperation Council comprises Bahrain, Oman, Qatar, Saudi Arabia, Tunisia, United Arab Emirates, Saudi Arabia and Kuwait.
### ANNEX 2. LEADERSHIP FOR HEALTH PROMOTION SHORT COURSE

**17 august – 21 august 2009, Lugano, Switzerland**

<table>
<thead>
<tr>
<th>Teaching Days</th>
<th>Morning Content</th>
<th>Method</th>
<th>Afternoon Content</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
<td>Complexity and leadership</td>
<td>Introduction in leadership. Different types of leaders and leadership teams</td>
<td>Presentation</td>
<td>Complexity and management of complex situations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-reflection</td>
<td>Discussion of experiences</td>
<td></td>
</tr>
<tr>
<td><strong>Tuesday</strong></td>
<td>Leadership and communication</td>
<td>Communication in implementation of health promotion</td>
<td>Theoretical background</td>
<td>Getting to 'yes': negotiation skills in health promotion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group exercises</td>
<td></td>
<td>Discussion in small groups</td>
</tr>
<tr>
<td><strong>Wednesday</strong></td>
<td>Innovation and Leadership</td>
<td>Innovation for decision making process</td>
<td>Theoretical background</td>
<td>Outcome driven or nudge: Choice architecture in decision-making</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group exercise: Six thinking hats</td>
<td></td>
<td>Group work</td>
</tr>
<tr>
<td><strong>Thursday</strong></td>
<td>Leadership: successes and failures</td>
<td>Learning from successes and failures: Learning-centred leadership</td>
<td>Theoretical background</td>
<td>Group discussion – problem-solving of individual case studies using learning set methodology</td>
</tr>
<tr>
<td><strong>Friday</strong></td>
<td>Leadership and work-life balance</td>
<td>Work-life balance</td>
<td>Theoretical update</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Creating a healthy environment</td>
<td>Discussion</td>
<td></td>
</tr>
</tbody>
</table>

Page 30