Chapter 7
Capacity Building as a Key Mechanism of Organizational Health Development

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Abstract As a targeted change process within organizations, organizational health development (OHD) builds on and develops individual and organizational health capacities. This chapter shows how the generic capacity building (CB) approach gainfully can be adapted as a key mechanism of OHD. CB for OHD covers both the development process and its outcomes, comprising health-oriented interventions on multiple levels. CB refers to systemic thinking, as it views organizations as complex social systems and enables the organization and its members to deal with health-relevant issues and gain autonomy on this issue. Further guidance for CB is provided by the underlying OHD model, which describes six capacities as relevant targets and outcomes of CB for OHD: individual competencies, motivation, and identity, as well as organizational structure, strategy, and culture. Overall, CB contributes to OHD, as it offers an appropriate, generic guidance for company-driven health intervention planning, program design, and communication as well as for theory-driven evaluation of the targeted OHD process.

Keywords Organizational health development • Organizational development • Capacity building • Workplace health promotion • Occupational health • Intervention planning

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7.1 Introduction

Organizational health (OH) is an evolving construct in the occupational health sciences (Bennett, Cook, & Pelletier, 2010; Shoaf, Genaidy, Karwowski, & Huang, 2004; Tetrick & Quick, 2010). Cox (1988) defines organizational health as seeing the "health and viability of the organization as more than the sum total of health of its employees" (p. 1). Shoaf et al. (2004) emphasize that OH connects both individual well-being and organizational performance. It "blends the pursuit of individual wellness with organizational effectiveness to yield a strategy for economic resilience" (Shoaf et al., 2004, p. 81). OH can be considered a reciprocal concept, because an organization always affects the health of its members (Noblet & Rodwell, 2010; Tetrick & Quick, 2010) and at the same time employees' health contributes to the performance of an organization (Lindstrom, Schrey, Ahonen, & Kaleva, 2000; Sauter, Lim, & Murphy, 1996).

To more clearly distinguish the determinants and outcomes of OH on both the individual and organizational level, Bauer and Jenny (2012) define the development of organizational health to be "both the ongoing re-production and targeted improvement of health in organizations as social systems, based on the interaction of individual and organizational capacities" (Bauer & Jenny, 2012, p. 8).

With their definition, Bauer and Jenny (2012) point to individual and organizational health capacities as key interacting determinants of both individual and organizational level OH outcomes. Further, it suggests *capacity building* (CB) as a starting point of targeted organizational health development. This conceptualization supports the argument by Hodgins, Battel-Kirk, and Asgeirsdottir (2010), who note: "The need to build capacity in workplace health promotion cannot be overstated" (p. 66).

In this chapter, we develop the idea of capacity building as a basic approach of targeted organizational health-development interventions. In its origins, the concept of capacity building represents a multi-level development approach. We will show that CB adapts and contributes to organizational health development (OHD) and offers guiding principles at the heart of OHD interventions.

The following section consists of three parts. (1) We recapitulate the understanding of CB in its two main applications: CB in foreign aid and CB in health promotion. (2) We identify key issues and characteristics of CB. (3) We show how CB contributes to OHD and guides OHD interventions. In conclusion, we propose that CB can be applied as a key mechanism at the heart of organizational health development (OHD).

7.2 Origins of the Capacity Building Approach

The following section clarifies CB in its two main applications: CB as a general development approach in foreign aid and CB in health promotion (HP). Several capacity building concepts and definitions coexist in both applications.

7.2.1 Capacity Building Defined as a Development Approach

CB has been used since the 1970s as a general development approach in the fields of community development and foreign aid (Hristova, 2009; Kühl, 2004; Lusthaus, Adrien, & Perstinger, 1999; Nickel & Trojan, 2011). In this context, CB is defined as a "process through which individuals, organizations and societies obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time" (United Nations Development Group, 2008; United Nations Development Programme & Capacity Development Group, 2008). The concept of CB is closely linked to the term capacity development. Both terms are often used interchangeably. Today, the United Nations pursues capacity development as a core approach to assure national development strategies: "Capacity development is critical for ensuring national ownership of development plans and effective resource management" (United Nations Development Group, 2008, p. 3, further definitions and terminology in Hristova, 2009, p. 12 ff. and Lusthaus, Adrien & Perstinger, 1999). In this context, CB covers universal processes of (social) change. As a general development approach, CB is not restricted with regard to its content, e.g., health issues, or to its intervention levels (Crisp, Swerissen, & Duckett, 2000; Eriksson, Falch, Lisznyai, & Ritoók, 2003; Gugglberger & Krajic, 2009; Guijt, 2008; Leeder, 2000).

7.2.2 Capacity Building Defined in the Context of Health Promotion

The need for CB in Health Promotion emerged from several evidence-based preventive programs that could not be implemented as intended. The concept of Capacity Building was identified as a way of increasing and sustaining the effectiveness of health promotion programs (Hawe, 2000; Hawe, King, Noort, Jordens, & Lloyd, 2000). Thus, in the field of health promotion, capacity building is defined "as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion" (Smith, Tang, & Nutbeam, 2006, p. 341). According to Kickbusch (2008), CB "refers to the process of enhancing the ability of an individual, organization or a community to address their health issues and concerns. The process of capacity building relies heavily on collaborations and partnerships" (p. 59). While emphasizing the important role of partnerships and collaborations, CB transgresses traditional health sector boundaries and encourages inter- and cross-sectoral partnerships. Thus, the World Health Organization integrated CB into the Jakarta Declaration on Leading Health Promotion into the Twenty-first Century as a strategy for community strengthening and individual empowerment (World Health Organisation, 1997). Today, CB is a well-known and largely accepted concept within the field of health promotion.

7.2.3 *Interim Conclusion*

In its origins, capacity building is an expression of a political strategy: CB has now been integrated into the political agendas of the United Nations and the World Health Organization. Both of these assume the existence of capacities as a precondition for planned development, change and action. CB is consequently conceptualized as a multi-level intervention and development concept (Hailey, James, & Wrigley, 2005). Further, the UN definition of CB draws our attention to the issue of ownership in and of development processes. In the context of health promotion, CB emphasizes the issue of collaborations and partnerships.

7.3 Key Principles of Capacity Building

Since CB is rooted in the political agenda, there have been initiatives to implement the concept into practice. Thus, a growing body of CB concepts, frameworks, guidelines and approaches has appeared from research and practice (Crisp et al., 2000; Lusthaus, Adrien, & Perstinger, 1999; Potter & Brough, 2004; United Nations Development Group, 2008; Watson, 2006).

The strengths and weaknesses of CB stem from the elasticity of the concept. The literature provides sufficient and extensive material to understand its complexity. In recent years, various concepts of CB have emerged, but there is no consensus on any one CB method or approach (Guijt, 2008). Due to the scope and overlapping contents of CB integrating and subsuming several similar concepts, it is also considered as an umbrella concept (Kühl, 2004; Morgan, 1997), or as Lusthaus, Adrien, and Perstinger (1999) conclude: "The lack of clarity about capacity development encourages people to use the term as a slogan rather than as a meaningful concept to improve an understanding of the process" (p. 9).

Therefore, in the next section we will explore and identify recurring and overlapping principles between coexisting CB concepts and describe CB in terms of key principles and main characteristics.

7.3.1 *Capacity Building as a Multi-Level Intervention Approach*

In all its applications, CB is defined as a multi-level approach comprising micro-, meso-, and macro-levels. Only the level designations and placements differ. The following three examples show these contrasts: (a) Some authors address CB only at individual, organizational, or community level (Chinman et al., 2005), (b) Soko

(2006), who describes a capacity building approach to transport and infrastructure development in rural South Africa, distinguishes individual, institutional, and system levels, (c) for the health sector, Brown, LaFond, and Macintyre (2001) distinguish health-system, organizational, and human resource levels. They additionally introduce an individual or community level.

Interestingly, the accentuation of particular levels shows up in the sequence of level listing: bottom-up or top-down. In practice, CB is often limited to the implementation of specific, delimited single-level CB measures. Thus Brown et al. (2001) remark that "most capacity building interventions focus on the organizational or human resources/personnel level and the literature and measurement experience is dominated by experience in these areas" (p. 7). Despite the multi-level-perspective, the focus is placed on the most tangible levels which conform more easily to research and measurement criteria. However, Potter and Brough (2004) state that the less tangible levels, such as structure, systems and roles, are the most important ones. Furthermore, CB raises expectations as to general, multi-level outcomes (Watson, 2006).

It is still unclear whether all levels should be considered equally or, as Potter and Brough (2004) suggest, a hierarchy of capacity building needs should be accepted.

7.3.2 Capacity Building as a Systemic Approach

Most authors treating CB concepts refer to systemic thinking, an approach which has also been widely proposed in health promotion and public health (Best et al., 2003; Leischow et al., 2008). Thinking systemically implies accepting different and sometimes contradictory perspectives (Kesting & Meifert, 2004). As already shown, CB is a multi-level approach whose levels can be observed independently or on the basis of uni-directional, causal assumptions. However, systemic thinking calls for reciprocal relationships between these levels and multi-level integration (Bauer & Jenny, 2012), the latter being justified by stakeholder involvement and participative decision-making (Hailey et al., 2005). Especially in development projects, CB promotes partnerships and interrelationships within organizations, for instance via active target-group involvement (Storey, 2004) or the consideration of informal social rules (Woodhill, 2010).

7.3.3 Capacity Building as an Enabling Approach

CB requires project ownership regarding the issues to be addressed and multi-level enhancement of problem-solving ability, aiming at freedom from external support over the long term. This can be achieved via participative decision-making,

stakeholder involvement, knowledge transfer, and mutual support. Through these strategies, CB builds on and rebuilds existing capacities as a key resource in an iterative procedure. Some authors refer to this procedure as an improved problem-solving capacity (Hawe et al., 2000; Leeder, 2000; Morgan, 1997). Overall, enabling aims to ensure maintenance, sustainability, and continuous improvement of the capacity building approach (Dooris, 2006; Hawe et al., 2000; Honadle, 1981; Leeder, 2000; Lusthaus, Adrien, & Perstinger, 1999; Morgan, 1997).

7.3.4 Capacity Building as a Process and an Outcome

CB is a developmental approach (Crisp et al., 2000; Gugglberger & Krajic, 2009; Leeder, 2000). Accordingly, some authors emphasize the ability to anticipate, influence, and manage change (Honadle, 1981). Change represents an endogenous and emerging process of transformation (Hristova, 2009; Kühl, 2004). Thus, CB can be described from either a dynamic or a static perspective. In conclusion, CB has a "dual nature": It covers either the process of CB or the resulting "built" capacities (Baser & Morgan, 2008; Van den Broucke, 2007). Consequently, CB appears as a process, an outcome, or both. Regarding capacities as the relevant outcome, these have to be specified depending on the context (e.g., organizations) and aim (e.g., health) to which CB is to be applied. Interestingly, in the context of organizations, change is strongly linked to collective learning processes. Thus, some authors refer to the concept of organizational learning as a key process of organizational CB (Hristova, 2009; Jones, 2001).

7.3.5 Capacity Building has to Be Adapted to the Context

CB is a generic concept that leaves the issues or aims to be addressed by the built capacities open. Even if the aims (e.g., health or economic development) are specified, CB still needs a precise description of the context: the targeted levels, applied processes, and intended outcomes (capacities). The literature provides several approaches for organizational capacity assessment as well as capacity indicator requirements (overview in Guijt, 2008; Hailey et al., 2005; Hawe et al., 2000; Lusthaus, Adrien, Anderson, & Carden, 1999; McKinsey & Company, 2001; Watson, 2006). Hawe et al. (2000) suggest that CB be broken down into several action areas, such as organizational development, workforce development, and resource allocation. CB also taps into culturally related principles and values, e.g., reducing social inequalities and empowerment. In conclusion, CB has to be specified, translated, and adapted to the particular context.

7.3.6 Interim Conclusion

Multiple, co-existing concepts have emerged in the process of converting CB from policy into practice. Although these CB concepts are expressed at a high level of abstraction, it should be possible to derive shared key principles of CB. We propose the following working definition:

Capacity building is an intentional developmental approach adapted to and specified with respect to the relevant context:

1. Addressing both process and outcome(s) of the development process,
2. Comprising multi-level-interventions,
3. Referring to systemic thinking, and
4. Enabling all relevant stakeholders.

7.4 Capacity Building Applied to Organizational Health Development

In the following, we apply CB to organizational health development (OHD), adapting it to the OHD context as required by the working definition. We then show how CB contributes to OHD on the basis of the key principles.

7.4.1 Capacity Building Adapted to the OHD Context

As shown above, OHD "is both the ongoing re-production and targeted improvement of health in organizations as social systems, based on the interaction of individual and organizational capacities" (Bauer & Jenny, 2012). It consequently refers to a naturally ongoing process between individual and organizational health capacities as well as to a targeted process of change within organizations that builds on and develops these capacities. To implement the latter process, all key principles of CB (see above) can be adapted to the context of organizational health development.

Adapted to and specified for the context of organizational health, capacity building is an intentional and targeted OHD approach that:

1. Addresses both the process ("building") and the outcomes of OHD ("health capacities"),
2. Comprises health-oriented and health-relevant interventions on multiple levels, i.e., the organization, its units and teams, its members (individuals) as well as relevant environments such as families, customers, governmental agencies, etc.
3. Refers to systemic thinking by viewing organizations as complex social systems in which reciprocal relationships and multiple perspectives are to be considered, and
4. Enables the organization and its members to deal with internally defined health-relevant issues and become free from external support.

7.4.2 *Conceptual Framework for Capacity Building in the Context of OHD*

As a conceptual framework for further specifying CB in the context of OHD, the Organizational Health Development Model by Bauer and Jenny (2012) is presented. This model has been developed for research and evaluation purposes (Bauer & Jenny, 2012; Jenny et al., 2011; Jenny, 2009; Bauer & Jenny, 2007). It links the perspectives of the health sciences, psychology, sociology and economics. The model builds on a general model of health development (Bauer, Davies, & Pelikan, 2006) and the New Management Model of St. Gallen (Rüegg-Stürm, 2004), which is committed to the more recent systems theory (Luhmann, 1984) and structuration theory (Giddens, 1984). The OHD model depicts factual and social working processes as interactions between organizational and individual capacities: These capacities shape and guide the working processes and are, in turn, influenced and shaped by these processes. Following the logic of the Job Demands-Resources model (see section X by Schaufeli & Toon in this edition), the OHD model classifies these working processes into job demands and job resources. In expansion of the original Job Demands-Resources model, the OHD model defines a pathogenic path leading to negative health and a salutogenic path leading to positive health, respectively. Following again the conceptualization of the Job Demands-Resources model, both the negative and positive health paths jointly contribute to sustainable performance of the organization. Although the OHD model depicts only the impact of the negative/positive health paths on sustainable performance, it also allows us to explicate and study immediate, not health-mediated effects of factual and social work processes and of the individual and organizational environment on sustainable performance.

The model broadly defines six dimensions of capacity, i.e., three individual and three organizational health capacities that are relevant to OHD: the organization's structure, strategy and culture, and – in a mirrored way – the competence, motivation, and identity of its members (Fig. 7.1).

The dimensions of organizational health capacities (structure, strategy, culture) are derived from the underlying New St. Gallen Management Model (Rüegg-Stürm, 2004). The individual health capacities (competence, motivation, identity) refer amongst others to an integrative framework of salutogenesis (Antonovsky, 1997; Faltermaier, 2005) comprising individual health resources (e.g., coping skills, self-efficacy), identity (e.g., health awareness and knowledge, sense of coherence) and behavior (e.g., general and specific health behavior). Regarding latter, the model concentrates on the motivational aspect of readiness for change (Weiner, Lewis, & Linnan, 2009).

All organizational and individual health capacities can be measured by generic or context-adapted, evidence-based indicators. They include (e.g.,) formal latitude and rigidity of roles (structure), transparent goals (strategy), employee orientation (culture), job-crafting skills (competence), readiness for change (motivation) and a sense of coherence (identity). Further examples are given in section X of this edition (Bauer, Lehmann, Blum-Rüegg, & Jenny), which covers a systemic OHD consultancy approach guided by the model.

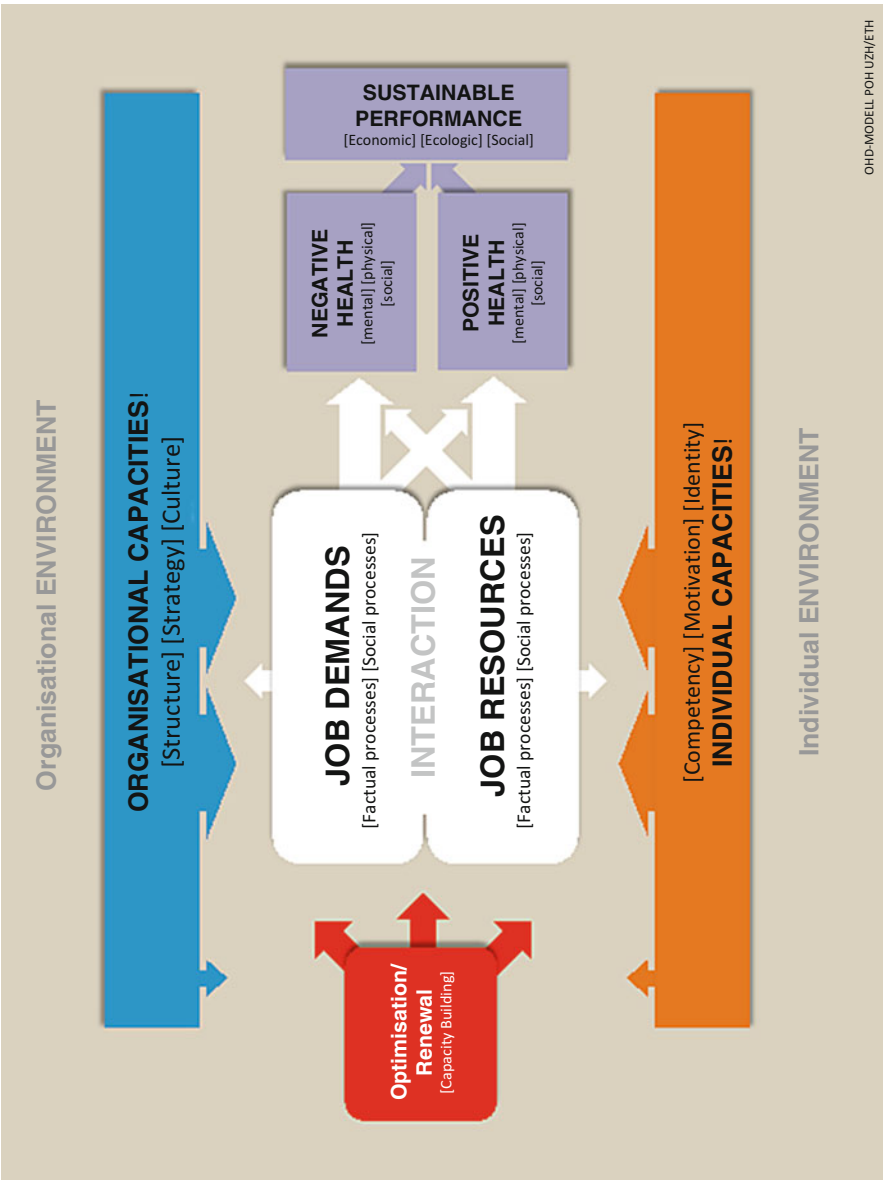

Fig. 7.1 Organizational Health Development Model (schematic version for research and evaluation purposes; Bauer & Jenny, 2012; Jenny et al., 2011)

7.4.3 Capacity Building Contributes to OHD

Applying the principles of CB to the context of OHD highlights and justifies several elements of this model. The first CB principle of *addressing both the process* ("building") and the *outcome* of OHD ("health capacities") makes it necessary to

specify, assess, and build on both individual and organizational health capacities as relevant targets to be enhanced by the CB process.

CB as a *multi-level approach* is a reminder to combine health-oriented interventions on multiple levels, as well as interventions targeted at relevant "environmental" issues, such as work-life balance, customer satisfaction, laws on health, and safety regulations, etc. On an organizational level, CB refers to a cross-level and a cross-hierarchy approach that supports OHD by increased networking within organizations (European Network For Workplace Health Promotion, 2001; Hemsley-Brown, 2004) and by intra-organizational dissemination of OHD-related actions across hierarchies.

As a *systemic approach*, CB also highlights strong participation and good communication between the members of the organization, respecting multiple (even contradictory) perspectives and awareness of reciprocal relationships (Bauer & Jenny, 2007, 2012; Nielsen, Randall, Holten, & Gonzalez, 2010; Noblet & Rodwell, 2010; see also Chap. 8 in this edition by Bauer, Lehmann, Blum-Rüegg, & Jenny).

The *process* of CB as an *enabling approach* reduces the dependence of companies on external support. Workplace health promotion and occupational health interventions are traditionally dominated by expert-oriented approaches (Bauer & Jenny, 2010), i.e., a consultant or advisory agency usually accepts a contract from a company to improve the health of their employees. Consultants connect to the company, focus on relevant health issues – more or less interactively with the employees, and disconnect from the company when the intervention is completed. This tends to lead to non-sustainable implementation of OHD interventions. In contrast, CB aims to build up and ensure a self-driven optimization process (Bauer & Jenny, 2012) that is driven and owned by the organization – and only supported by external agencies and experts. In this process, the OHD model with specified organizational and individual health capacities helps to reflect key action areas, e.g., individual competencies or organizational strategies, and related processes for CB to be considered during the interventions. The model assures consistent communications between professionals and non-professionals on potential health issues and relevant targets during every phase of the OHD process. It proposes a common wording and a mapping of organizational health issues adapted and specified for each company, promotes project ownership by the organization, encourages it to set priorities and to decide how and to what extent capacities should be improved. Accordingly, there is no predefined and determined level or value for the capacities, nor any suggested minimum or maximum – although expert knowledge might help to prioritize health-relevant capacities.

As the *CB process* builds on existing capacities, it can be seen as a resource-oriented approach that supports the inherent salutogenic perspective of OHD. Furthermore, since the quality of change processes in general influences employee health both directly and indirectly (Müller, 2011; Polanyi, Frank, Shannon, Sulliban, & Lavis, 2000; Van den Heuvel, Demerouti, Schaufeli, & Bakker, 2010), the resource-oriented and enabling nature of CB processes could have a health-promoting quality of their own.

As a generic development approach, the intended *aim of CB* could cover all organizational targets and objectives, not only health outcomes. When specified within

the OHD model, organizational and individual health capacities are built up to contribute to reduced negative health and improved positive health of the individual as well as to the "organization's effectiveness and sustainability in relation to its mission and context" (Hailey et al., 2005; James, 2001).

7.5 Conclusion

OHD as a targeted change process within organizations builds on and develops individual and organizational health capacities. Following this idea, this chapter showed how the CB approach can be adapted gainfully as a key mechanism of OHD. Originally a generic development approach, the concept of CB bridges knowledge of change processes from areas such as economic development, public health, and health promotion with the organization-specific OHD approach.

Reviewing the CB literature, we identified several guiding principles of CB that can be applied to OHD as a sustainable development and intervention approach. Accordingly, CB for OHD covers both the development process and its outcomes, comprising health-oriented interventions on multiple levels. CB refers to systemic thinking, because it views organizations as complex social systems and enables the organization and its members to deal with health-relevant issues and gain autonomy on this issue. Further guidance for CB is provided by the underlying OHD model, which describes six capacities as relevant targets and outcomes of CB for OHD: individual competencies, motivation, and identity, as well as organizational structure, strategy, and culture.

Overall, the CB approach contributes to OHD as it offers an appropriate, generic guidance for company-driven health intervention planning, program design, and communication. It offers guiding principles for OHD interventions, reflecting critically on multiple levels, reciprocal relationships, different perspectives, as well as enablement and ownership issues. In practice, applying and adapting the CB approach to the specific context will assist organizations in gaining long-term ownership of and influence on "their" OHD. For research purposes, following the CB approach for OHD facilitates well-structured, theory-driven intervention and evaluation research.

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