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A REVIEW OF A HEALTH PROMOTION STRATEGY IN THE DEPARTMENT OF HEALTH

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A research report submitted to the Faculty of Management, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Management, in the field of Public and Development Management.

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Abstract

According to the National Health Promotion Policy (2003) the integration of health promotion with other health programmes in the Department of Health is a strategic goal. This research reviewed the progress made with this aim of integration of health promotion with health programmes. Programme managers for health promotion and health programmes were interviewed to elicit their views on the progress made in the integration and, at the same time assess the standard of practice of health promotion. The research was conducted within a qualitative research framework. The research findings show that the integration was an important aim and that it is happening in the Department of Health. The healthy lifestyles campaign has given impetus to the integration. Roles and responsibilities were alluded to. Planning and formal coordination seem to be lacking as well as advancing health promotion principles and strategies, like equity and empowerment focussed. These can be used more vigorously to further health promotion aims, also in other health programmes.

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For Cimón, who then 7, inspired the direction for this research,

Staff at P&DM, whose kindness, helpfulness and encouragement was an inspiration, and always appreciated.

Dedicated to the above, and Department of Health employees, who always make me laugh.

For Cimón

DECLARATION

I DECLARE THAT THIS IS MY OWN UNAIDED WORK IN PARTIAL FULFILLMENT FOR THE DEGREE MASTER OF MANAGEMENT IN THE PUBLIC AND DEVELOPMENT MANAGEMENT FIELD

Acronyms

ANC	African National Congress
DNHPP	Draft National Health Promotion Policy
PHC	Primary Health Care
RDP	Reconstruction and Development Program
WCDHPP	Western Cape Health Promotion Policy
WHO	World Health Organisation

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CHAPTER ONE
INTRODUCTION

1. Introduction

The study explored the National Health Promotion Directorate of the Department of Health's vision for an integrated health promotion strategy. The study takes as its point of departure the Draft National Health Promotion Policy (DNHPP) (2003). The policy outlines key concerns for the directorate; areas of intervention, objectives for interventions, strategies and priorities necessary to attain the desired outcomes.

The Draft National Health Promotion Policy (2003:14) states that the Department of Health aims to establish health promotion as an integral part of the national health system, thereby contributing to the development and achievement of national health goals and targets.

This study reviewed the extent to which the goal of integration of health promotion with other health programmes had been achieved and the conceptualisation for the realisation of this goal. The research also focussed on the theory and practice of health promotion. i.e. does the practice of health promotion in the Department of Health correspond with the generally accepted theory of health promotion, as espoused in the Ottawa Charter 1986, and also promoted in the policy?

Also incorporated in the policy (2003:9) and a reference point for the policy, and therefore health promotion aims, is the World Health Organisation's (WHO) Africa region strategy. It is also referred to as the regional commitment, with the stated goal of health promotion achieving integration with other health programmes.

The study falls within a qualitative research paradigm because data gathering methods relied on interviewing and interpretation, both on the part of the interviewees and interviewer. The study also has qualities of an evaluation study, because it is a review of progress made against the stated goals in the Draft National Health Promotion Policy.

2. Background

The DHPP (2003:9) incorporated the World Health Organisation's (WHO) Africa Region Strategy for health promotion. The strategy is guided by aims, objectives, principles and priority interventions for health promotion at government level.

The guiding principles of the WHO Africa region strategy (DHPP, 2004:9) include:

- Gaining access to knowledge and skills needed to implement evidence-based health promotion programmes;
- Integration of health promotion into all health programmes;
- Systematisation of the use of interventions to complement priority health programmes,
- A commitment to investment in health to address inequities and support development within communities and countries, and working in partnership with all sectors to promote the prerequisites for health.

The following priority health promotion interventions (DHPP, 2004:9) have been identified as part of a strategy for health promotion effectiveness.

a) Advocacy for health promotion
b) Capacity-building, particularly of people's skills and knowledge to strengthen health promotion actions.

c) Development of National plans of action to strengthen health promotion through integrating it into health systems.
d) Inclusion of non-health sectors in health promotion actions.
e) Use of health promotion methods to strengthen priority health programmes.

The study will explore the context and achievements of identified guiding principles and priority interventions of the strategy related to the goal of integrating health promotion with other health programmes in the Department of Health.

The research will also focus on points c) and d) of the priority interventions; namely, what plans have been developed to integrate health promotion into other health programmes, and presenting examples of where health promotion methods, as set out by the policy document, have been used for priority health programmes.

3. Problem statement

The DNHPP policy (2003) has not featured strongly in the Department of Health as a means of guiding health promotion implementation at regional level. Among the reasons for the policy not filtering through to regional level may be that health promotion management positions that could have taken the policy forward were not filled, as well as the National Office not communicating the policy sufficiently to the Regions.

The writer is employed as a health promotion co-ordinator at Regional level in the Gauteng Department of Health, and in her view, health promotion is not optimised as an integrated programme with other health programmes at this level. Lack of capacity and a limited understanding of health promotion practice on the part of managers and health promotion

officers has hampered aspirations for integration. At best, the efforts denote a community liaison and marketing role on the part of health promotion between the campaign and programme organisers. Health promotion components like skills building, addressing health determinants, advocacy and community development receive minimal priority, also in other health programmes as well. The 'progressive' and multi–dimensional approaches to health promotion have been lost, as well as a 'political' will to implement health promotion according to theoretical understandings thereof i.e. the Draft National Health Promotion Policy (2004) and Ottawa Charter (1986).

4. Research purpose, focus and questions

4.1 Research purpose and focus

This research sought to investigate how the integration of health promotion with other health programmes is perceived at national level, and to review the progress made against the stated goals in the policy at national level. The practice of health promotion in the Department of Health was also reviewed to determine the standard of practice.

The research focus is on the interviewees' perceptions of the progress made with integration, as well as an assessment of the practice of health promotion as stated by the interviewees.

4.2. Research questions

The research was guided by the following main theme:

> A review of the strategy of integration of health promotion with other health programmes in the National Department of Health.

Based on the theme, the following are the questions to be addressed:

1. How far has the Health Promotion Directorate progressed with the implementation of the goal of integrating health promotion with other health programmes?
2. How does the National Department of Health propose the integration with other health programmes should take place?
3. Does the Health Promotion Directorate incorporate health promotion strategies and methodologies as espoused by the Ottawa Charter and policy in their implementation?
4. What are the challenges for health promotion as regards achieving the integration? What has hindered the process, what has advanced it?
5. Examples of where it is integrated?

CHAPTER TWO
RESEARCH METHODOLOGY

1. Introduction to the research

This research is essentially a review of the achievements and interpretations of the Health Promotion Directorate's vision for an integrated health promotion programme.

The aim is a) to gather evidence about the achievement of programme objectives, and b) to contextualise the findings in terms of government interpretation of, and capacity for, health promotion as espoused by the Ottawa Charter.

2. Research design

The research is done within a qualitative research paradigm. This means that the subjects' subjective views, opinions and perspectives on the subject informed the research. The aim of the research was to elicit the interviewees' views and interpretations of the Department's aim of integrating health promotion with other health programmes and examining examples of claims made of health promotion integration.

In the post-positive school of thought, which is also commonly accepted as qualitative research (subjective truth), Cohen and Manion (1995:26) observe that social science is regarded as a subjective rather than an objective undertaking and that consideration is given to the fact that interviewees as well as researchers bring particular meanings, interpretations, values and aspirations to the research that influence the outcomes of the research. This was an original aspiration of the research,

to get to know the interviewees' (department of health officials), perceptions of the integration of health promotion with other health programmes.

Taylor and Bogdan (1975:4) observe that 'qualitative methods allow us to know people personally and see them as they are developing their own definitions of the world.' The aim of this research was to understand health promotion and the achievement of its goals as stated from the perspective of health promotion officials - to get to know to some extent the government's view and standing of health promotion, as currently practiced in the National Department of Health. In the post-positive school of thought, the belief in the relative autonomy of people, and that humans have a subjective and co-creative relationship with the world. This means that health promotion practice and integration is to a certain extent determined by how people perceive it to be, and the practice thereof.

Taylor and Bogdan (1975:4) further observe that qualitative methodologies refer to research procedures that produce descriptive data: people's own written or spoken words; then analyses and interpretation thereof by the researcher. Therefore, subjective understanding and analysis counters any notions of quantifiable objective truth. Taylor and Bogdan (1975:9) point out that the researcher seeks not truth and morality but understanding (op cit: 11), and, 'truth then emerges not as one objective view but rather as the composite picture of how people think 'about the achievement of stated goals for health promotion.

A further objective for the research was to provide a critical analysis of the conceptualisation and practice of health promotion as stated by the interviewees, according to health promotion principles as promoted in the Draft Health Promotion Policy (2004).

3. Issues for validity of findings

Taylor and Bogdan (1975:11) warn that just as different people may interpret the same things differently, so too may the same person interpret things differently at different times. So even though the interviewees were prompted to give examples of stated progress made and practice of health promotion to substantiate their claims and views, it is acknowledged that on a different day of interviewing, their emphasis and feelings about the achievements could be different.

4. The interviews

The open-ended (standardised) interviewing method was used as the research data-gathering method. The open-ended (standardised) interviewing method is essentially about asking all participants the same question(s). Patton (1980:205) observes that the purpose of qualitative interviewing in evaluation is to understand how programme staff and participants view the programme, to learn about their terminology and judgements, and to capture the complexities of their individual perceptions and experiences. The author emphasises the idea that the principle of qualitative interviewing is to provide a framework within which respondents can express their own understanding in their own terms.

Further, Patton (1980:40) says that researchers using qualitative methods strive to understand phenomena and situations as a whole: 'The researcher strives to understand the totality and unifying nature of particular setting.'

Open-ended standardised interviews were held with people in the health promotion directorate as well as managers from other health programmes to elicit their views on the integration of health promotion with health

programmes. The five interviewees (see table 1 below) were from the health promotion directorate and three health programmes respectively. The researcher's assumption was that the director for the health promotion programme would be able to give a better overview of the integration and the deputy director would provide more specific examples of the achievement of the goals.

Three interviewees were from health programmes; nutrition, chronic diseases and communication. Although Communication is not a health programme, the researcher decided to include the Communication Department in the research because it became apparent that they had a role to play in the integration. They were mentioned by three different interviewees as important role-players in the achievement of programme objectives.

Table 1: Interviews schedule

Directorate	**Position**	**Time of interview**
Health Promotion	National Director	1 hour August 2005
Health Promotion	Deputy Director special Health Programmes	1 hour September 2005
Nutrition	Deputy Director	1 hour September 2005
Chronic diseases	Deputy Director	1 hour September 2005
Communication	Assistant Director	1 hour September 2005

Interview process

The interview process was based on the five sub-questions presented above in 4.2.

The interviews were tape-recorded and then transcribed. All transcribed interviews appear as an addendum to the research.

5. Evaluation

The research has qualities of an evaluation study as this is a review of progress made against stated goals in the policy.

The following categories identified by Gephart and Patton (in Cole, 1984 in Ewart-Smith) guided the interpretation and writing up (data presentation), of the study.

a) Operational- how is it done? (the aim of achieving integration with other health programmes)
b) Componential - what is in the programme? Of what is it made up?
c) Ostensive - what is a particular programme like?
d) Classical - Have goals/objectives been met?
e) Valuative - How worthwhile is it?
f) Decisive - how can this problem be solved?
g) Useful – who cares, so what?
h) Obstacles – what is holding the programme back?
i) Enablers – What opportunities are present to advance health promotion?

Indicators to determine successful health promotion interventions have been identified. These indicators served as benchmarks for health

promotion effectiveness. The DNHPP (2003:14) states that health promotion programmes should reflect the following:

- Equity: addressing social inequality and critically intervening according to priorities, epidemiology, and health promotion criteria;
- Empowerment focussed: educational, development of personal skills, fostering ownership;
- Advocacy: evidence of health promotion strategies and methodologies in other programmes;
- Implementation invoking a participatory and needs-based approach;
- Building networks and alliances;
- Conferring with other programmes regarding how far health promotion is integrated with their own objectives and implementation.

6. Data presentation and data analysis (discussion)

6.1. Data presentation

The raw data was sorted according to themes that came out of the interviews. The themes were identified and written according to:

a) General comments about the integration
b) Issues that have a bearing on the questions asked, e.g. advancements made with achieving goals, collaborative factors to integration and the challenges.
c) Issues that have had some agreement amongst the interviewees.
d) Issues that the interviewees felt strongly about.
e) Ways of achieving integration (according to the interviewees).

6.2. Data Analysis

The data analysis is the discussion part of the research. It provides the interpretations and analysis by the researcher, based on what the interviewees had said, put in the context of the aims of the research and health promotion, and the literature review. It was done according to:

a) Identifying underlying themes and assumptions of the interviewees.

b) Lining up 'said' health promotion methodology of interviewees with health promotion methodology according to theory. i.e. Identifying gaps in the indicated methodology and identifying strengths according to theory of health promotion practice and the literature review.

c) Conclusions made, analysis of response (the why aspect) and recommendations.

7. Limitations

Only two health programmes in the Department of Health were interviewed for the research. If more health programmes' managers had been interviewed they could have given better perspectives of the problems encountered with an integrated approach, and also a more detailed account of what is needed for an integrated approach.

A prepared group interview (health programmes and health promotion together), could perhaps have given a more focussed, spontaneous response, with responses based on their working experiences together. Instead the interviewees had no time to prepare for their responses to specific questions, and therefore their responses could have been less

spontaneous and more based on projections and weakly considered actual experiences. The interviewees were, however, informed beforehand on the topic of the research.

Some of the tape-recorded interviews were not of a good quality - some comments were lost and one interview had to be redone. The researcher took notes and transcribed the interviews as soon as possible after the interviews were held.

CHAPTER THREE
LITERATURE REVIEW

1. Introduction

The literature was arranged according to the context of health promotion in the South African government, themes that elaborate on the concept of health promotion as well as health promotion methodology and practice. Themes were further identified that had a bearing on integration of health promotion with other health programmes.

On the whole, the literature can be divided in three parts, with the following themes:

a) Health promotion and its political background

- Background on policy development and health promotion
- Health promotion in the South African government context
- International context for health promotion.

b) Aims and principles of health promotion and its implications for practice.

- Health promotion aims
- Practice of health promotion
- Ottawa Charter for health promotion
- Principles of health promotion
- Self-help initiatives in health promotion
- Health promotion imperatives.

c) Factors advancing integration

- Advancing co-operation
- Promoting shared values
- Health promotion approach and theory development.

2. Background on policy development and health promotion.

The Draft Health Promotion Policy (DHPP, 2003) was initiated and developed in 1997 in response to the need to guide the new Health Promotion Directorate post-1994 with the implementation of health promotion. Health promotion structures were established during 1995 at national, provincial, and regional government level. At regional level, health promotion is a support programme for health programmes. At provincial level, health promotion is a sub-directorate of the Public Health Directorate.

Health promotion, based on the principles of Primary Health Care (PHC) and the Ottawa Charter to achieve the ‘’Health for All’’ goal is one of the main features of the health care goals of most countries (WHO, African Regional Strategy, 2001).
According to the Ottawa Charter (WHO, 1986) and the WHO's Health Promotion Glossary (1998) health promotion is a process of enabling people to gain and maintain good health through promoting a combination of educational and environmental supports, which influence people's actions and living conditions.

Health promotion has political connotations and its origins can be found in the acceptance of the Primary Health Care (PHC) approach in addressing health, also known as the 1978 Alma-Ata Declaration. PHC moves from the curative, treatment-oriented model of health care to a holistic approach that advocates for the accessibility of services, involvement of

communities in the provision of health care, availability of health information and education, disease prevention, and fostering principles of equality. Principles of equity, a multi-dimensional and inter-sectoral approach to PHC goals, also guide health promotion interventions.

It is generally accepted that health promotion as a profession incorporates multi-disciplinary approaches to achieve its goals and borrows from fields such as education, sociology, psychology, philosophy and politics, amongst others, for theoretical accountability and wisdom.

WHO Africa region (2001:3) recognises that the development of health promotion has been greatly influenced by the evolution of other broad approaches to human development such as:

a) Increased demand for social justice and for the rights of women, children
   and minorities.
b) The ‘’health for all’’ concept
c) Movements to protect and improve the physical environment, and
d) The increased attention being paid to poverty as a major underlying cause of illness.

The text above contextualises priority interventions and aims for health promotion.

PHC and health promotion associates the causes of ill-health also with political and social concerns, also referred to as the social determinants of health. The social determinants of health refer to a range of economic, social and environmental factors, which determine the health status of individuals or populations. Dahlgren and Whitehead (1991) further identified determinants of health as individual lifestyle factors.

The new government that came into power in South Africa in 1994 deliberately brought about political understandings of the determinants of health and means to address these, and advocated health promotion and PHC as a way to address it. This has become apparent in the Reconstruction and Development Programmeme (RDP) of the country (1994) and the African National Congress (ANC) Health Plan.

The DNHPP (2003) states that the South African Health Promotion Policy is thus set within the framework of RDP (1994) and the White Paper on the Transformation of the Health System in South Africa – aiming to work within a developmental framework, and also emphasising the significance of meeting the fundamental preconditions to health and well-being, that is; food, shelter, income, a stable eco-system, sustainable resources, peace, social justice and equity (Ottawa Charter, 1986). The DNHPP (2003) draws its frame of reference from the Ottawa Charter and the socio-political context of health and ill-health.

Naidoo and Wills (2001:277) observe that the WHO has been the most influential in defining health promotion and its Ottawa Charter (WHO 1986) is probably health promotion's most important document.

The White Paper as well as the Ottawa Charter (1986) recognise the importance of combining educational and environmental support to influence people's actions and living conditions, as well as a skills-building approach, with the goal of empowerment of communities to take ownership of their own health in partnership with other role-players. The policy incorporated these understandings as a means to promote health.

The Lalonde report (1974) also laid the foundation for health promotion and public health for countries around the world. Naidoo and Wills (2001:277) state that the most radical feature of the Lalonde Report was its assertion that an improvement in health would come not from a greater

expenditure on health services but from a new perspective that directed money to prevention.

3. Health promotion in the South African government context

3. 1. Primary Health Care

The DHPP (2003:12) states that the RDP of the ANC recognised that the Primary Health Care (PHC) approach was adopted in South Africa as a means of addressing inequalities. The Western Cape Draft Health Promotion Policy (WCDHPP, 2002) explains that PHC focuses on social justice and development and provides a particular perspective on the goal of achieving ‘’health for all”. It is an approach to improving the well-being of people by focussing on health development. Health development is understood to be dependent on, and contributing to, overall social development and the development of communities (WCDHPP) (2002). Health promotion is one of the main pillars of the PHC because it also aims to address the determinants of health and underscores health development.

The White Paper on the Transformation of Health Services (1997) states that “the transition to democracy, reconstruction and development and the principles elaborated by the RDP are in themselves important cornerstones for developing necessary health promotion initiatives” (DHPP, 2006:10). The principles of health promotion, to follow later, will more clearly illustrate these points. They refer to a human rights and right to health approach.

3.2. The District Health System

The District Health System is based on PHC and promotes health promotion as a way of addressing health. WHO Africa region and the

Ottawa Charter (1986) states that integration of health promotion methods and actions at several levels (including district) results in increased health knowledge, skills and community participation, healthy public policies and environments, which are supportive of health.

McIntyre and Gilson (2002:1643) state that The White Paper on Health identifies the district as the ‘‘major locus of implementation’’ for the health system, enabling the development of a single, unified health system, emphasising the PHC approach and facilitating community involvement in “the planning, provision, control and monitoring services”.

4. International context for health promotion

The DNHPP (2006) indicates that a number of international documents, charters and declarations have been developed over the last 30 years. These have informed and guided health promotion practice internationally and in South Africa.

The following is a summary of key recommendations and developments (DHPP 2006:9, WHO, 1998)

a) Ottawa Charter 1986. This Charter was developed at the Health Promotion Conference in Ottawa, Canada. It laid the foundations for the practice and guiding principles of health promotion. The Charter was adopted internationally by countries attending the conference. WHO (1998:43) observe that in the wake of adopting the Charter, a new approach to improving and promoting public health was developed: settings for health, such as schools, health promoting hospitals, workplaces and healthy cities. Five essential strategies for health promotion were identified: formulate healthy public policy, create

supportive environments, strengthen community action, develop personal skills, and reorient health services.

b) Adelaide Conference, Australia (1988). The conference started from the position that health is a fundamental human right and a sound social investment. The conference urged governments to promote health through linked economic, social and health policies.

c) The Sundsvall, Sweden (1991) conference highlighted the essential link between health and the physical environment.

d) The Jakarta Declaration (1997) placed health promotion at the centre of health development. Evidence was presented to show that comprehensive approaches to health development are the most effective (WHO 1998 in DHPP2006:9)

e) Mexico Conference (2000) focussed on building effective infrastructure and ensuring that health promotion is on the agenda of bureaucracy and political circles.

f) Bangkok Charter for Health Promotion in a Globalised World (2005), Thailand, identifies actions, commitments and pledges required to address the determinants of health in a globalised world through health promotion.

5. Aims of Health Promotion

Naidoo and Wills (2001:277) explain that health, as understood in health promotion, is a complex of bodily, mental, social and spiritual states rather than just the functioning of the body. 'Instead of the clinical gaze of medicine, which focuses on a body with disease, there is a biographical

approach viewing the individual as a whole person, embedded in his or her gender, culture and society.' This view of approaching health has implications for health promotion aims.

The DHPP (2003:14) outlines key principles for health promotion that sets a precedent for health promotion action. The DNHPP (op. cit) states that health promotion programmes should:

- Focus on *health determinants,*
- Contribute to broad *social development,*
- Strengthen community action to *enable and empower*,
- Reflect a commitment to *equity*,
- Contribute to *health literacy,* and
- *Mediate* between various stakeholders to facilitate inter-sectoral approaches.

These principles advance a critical approach to health promotion. A question to be considered for the research is – do health programmes reflect these principles and aims of health promotion?

5.1. Reflections on health promotion action (in the future).

Douglas (in Jones and Sidell, 1997) calls for a political commitment to health promotion in the form of a national strategy for health. The author says health promotion strategies must be developed which address inequalities, particularly those due to income, social and economic disadvantage and racial disadvantage. Nettleton (in Jones and Sidell, 1997:276) agrees that if we want to promote health effectively the two most important things that we need to do are work towards the elimination of poverty and the reduction of social inequalities. 'The impact of material

deprivation, social exclusion, bad housing and poor environments on health are well documented, and their effects on health and well-being are more profound than so-called 'unhealthy' behaviour.

Douglas (in Jones and Sidell, 1997:275) says the development of strategies to reduce inequalities requires the concerted efforts of a range of organisations at all levels: international, national, regional and local. The author further asserts that health promotion must involve local people and communities in assessing health promotion needs and setting priorities for health promotion. This means there needs to be collaboration between voluntary organisations and community groups, statutory organisations and research establishments and academic organisations. Research should involve local people in assessing health promotion needs and evaluating the effectiveness of health promotion programmes and policies.

6. Practice of health promotion

6.1. Introduction

Although social marketing is an acceptable way of communicating in health, the WCDHPP (WCDHPP, 2002:7) draws attention to the often misconstrued understandings of health promotion. It points out that:

> Too often the word promotion, when used in the context of health promotion, is associated with sales and advertising, and taken to mean a propaganda approach dominated by the use of the mass media. This is a misunderstanding. By promotion in the health context we mean improving health: advancing, supporting, encouraging and placing it higher on personal and public agendas. (WCHPP, 2002:7)

Further understandings and elaborations of health promotion have been neglected in government due to the lack of understanding of health promotion, capacity, and will. This study explores how this has changed – or not.

6.2. Ottawa Charter for Health Promotion

The Ottawa Charter for Health Promotion (1986) says health promotion means the following:

- **Mediation**: promoting, co-ordination and co-operation across agencies, networks, and departments, because health is influenced by a multitude of factors and needs to be addressed as such. The need for the integration of health promotion with health (and other) programmes comes to the fore here, as well as the consideration to bring about structural changes of a socio and environmental nature - to bring about living conditions to be healthy – that a health programme on its own is unable to achieve.
- **Enablement:** Health promotion focuses on achieving equity in health. Providing information and education on health matters empowers people to take action / control of their health. When one analyses what involves enablement (health education and sometimes behaviour change strategies) it becomes apparent that many factors need to be considered when planning a behaviour change (or enabling) intervention, that requires planning and communication skills, inputs from theoretical perspectives, as well as ongoing support and follow-up.
- **Advocacy:** Political, economic, social, cultural environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health. This means advocacy for change in socio-economic environmental conditions. It also refers to advocacy for addressing social inequality, promoting rights of women,

children and marginalized people, whose health is/could be affected because of their status.

6.3. Health promotion action

Health promotion action therefore means, according to the Ottawa Charter for Health Promotion, 1986:

Healthy public policy.
Health promotion goes beyond health care. Health promotion puts health on the agenda of policy makers in all sectors directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.
Creating supportive environments.
Health cannot be separated from other goals. The inextricable links between people and their environments constitutes the basis for a socio-ecological approach to health. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.
Strengthening community action
Health promotion works through community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems strengthening public participation and direction of health matters.
Developing personal skills
Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.
Re-orientating health services.
The responsibilities for health promotion in health services are shared amongst individuals, community groups, health professionals, health service institutions and governments. Health services need to embrace an expanded mandate, which is sensitive, and respects cultural needs, and is curative to disease prevention.

7. Principles of health promotion

Principles of health promotion often guide interventions, and meanings attached to health promotion. The WCHDP (1997:9) identifies the following principles of health promotion.

The right to health

The opportunity to attain health and access to health care are universally recognised as fundamental human rights. The realisation of human rights in general is recognised as a prerequisite for health.

Social inequality

The health status of populations is overwhelmingly determined by their economic and social status and fundamentally influenced by factors such as gender, ethnicity, social cohesion and social exclusion.

Health promotion is **holistic** and **promotes the concept of wellness.** Health is a positive concept emphasizing social and personal resources as well as physical capacities.

Empowerment, respect, and self-realisation through participation

Health promotion advances the control and responsibility that communities have for their own health through:

- full participation of communities in determining needs, actions and outcomes;
- advancing ownership of projects, peer support and education, and autonomy;
- transfer of knowledge and capacity-building;
- supporting community action that supports health; and

- encouraging and enabling marginalised groupings to speak for themselves.

Social development and inter-sectoral action

Health promotion does not stand alone, it contributes to and is dependent on other initiatives for overall social development. It undertakes specific action in partnerships with other sectors with a view to mutual benefit and support.

These principles of health promotion illustrate values and aspirations for health promotion that should guide and drive the programme, and also to instil these purposes in other health programmes.

7.1. Equity

Health promotion is founded on the principle of working towards equity in health. WHO (2000:948) says that equity in health reflects a concern to reduce unequal opportunities to be healthy that are associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women; and rural residents.

Structural sociological critiques of health argue that attempts to prevent illness and to promote health should take into account the material disadvantages of people's lives; the political, social and physical environment.

Whitehead and Dahlgren (2001:316) highlight the need to take into account the structural barriers to healthier lifestyles and the need for the creation of supportive environments. The authors say that evidence reinforces the need for combining structural changes related to economic,

living, and working conditions with health education efforts when trying to influence lifestyle factors such as smoking, use of violence, alcohol intake, diet, and sexual behaviours. Furthermore, general policies for health promotion and disease prevention need to be based on the reality experienced by socio-economically less privileged groups rather than that of the middle classes (Townsend, 1987: 1993).

Mooney (1996, in McIntyre and Gilson, 2002:1639) motivates that vertical equity should receive more attention as a health policy goal, particularly in countries where there are substantial differences in health status between different groups in society. This implies that those groups with the poorest health status must receive specific and particular attention in policy formulation in order to be favoured over others by policy action and so counter the legacy of disadvantage from which they suffer. This relates to the ideal of diversifying the target group for which health messages and interventions are intended and paying more attention to the most needy and those most at risk. Is there evidence that health promotion interventions are guided by these concerns?

Östlin, Braveman, and Dachs (2000), argue that striving for equity in health care is one aspect of the wider concept of equity in health status, and implies that health care resources are allocated and received according to need, and financing is according to ability to pay. Health promotion and other health programmes would, as a health promotion principle and policy issue, do good to allocate resources and efforts to meet needs to those with the greatest health needs and the least resources.

Mooney and Jan (1997, in McIntyre and Gilson, 2002:1639) suggest that in determining resource allocation patterns that reflect vertical equity goals, it is important to consult widely within a society to identify which groups should be prioritised in policy action and how much additional

weight they should receive compared to other groups. Gilson (2002:1639) goes on to say that from this perspective (vertical equity) promoting equity requires the active engagement of all citizens in determining how their own actions as well as those of the state can most effectively meet needs, particularly that of the poor and deprived. 'All actors affected by the changes participate in their development. All actors in the project participate in the planning and setting of goals.' A health promotion goal of community participation in identifying needs and ways to meet them, as well as creating opportunities (empowering) communities to learn about and address their own concerns is advocated. National health promotion campaigns can strive to achieve this goal more vigorously.

Nettleton and Bunton (1995:44, in Bunton and Macdonald, 1992), argue that by definition, health promotion is concerned with the twin goals of changing both lifestyle and socio-economic- political structures. Kelly and Charleton (in Nettleton and Bunton, 1995:90) refer to Giddens' (1992) contribution to sociology and its relevance to health promotion practice. Kelly and Charleton observe that human agency (choice, imagination and ingenuity) is necessary for understanding and predicting human behaviour but it is not enough. The authors say that sufficient understanding would include a consideration of social structure, the individual's comprehension of this structure and how it impinged upon their life. Such a dynamic and reciprocal analysis of the individual set into context they believe ought to be at the heart of health promotion.

8. Self -help initiatives in health promotion

Even though the links between poverty and ill-health are well understood, Leon, Walt, *et al.,* (2001:593) quote Lanata (2000) that even among those living in absolute poverty, there seem to be differences in the extent to which parents are able to use their scant resources to influence their children's morbidity and mortality. They say that this underlines the need

to develop people's capacities and resourcefulness within broader strategies to reduce the effects of deprivation on health.

This underscores the high priority that self-help initiatives should have in health promotion and health programmes' initiatives. It is also one of the principles of health promotion, empowerment of communities to take forward initiatives for their own health and development.

9. Health promotion approach and theory development

Naidoo and Wills (2001:19) describe modern public health as a complex field drawing on a range of disciplines. Inevitably its theoretical base is equally diverse. The authors name the theories that have informed health promotion as:

- Theories that explain individual health behaviour, e.g. the health belief model;
- Theories that explain change in communities, e.g. the Diffusion of Innovation;
- Theories that explain how communities can be mobilised for action, e.g. Achieving Better Community Development;
- Theories that guide the use of communication strategies, e.g. social marketing;
- Theories that explain changes in organisations, e.g. Force Field Theory.

The authors (op. cit) observe that theory can help at different stages of programme development from initial conceptual thinking through implementation design to evaluation. The authors (op. cit) say that theoretical frameworks illustrate the key assumptions about how the programme will achieve the desired outcomes. These frameworks have

also been developed to assist in achieving the desired outcome. The authors thus argue in favour of health promotion practicing from theoretical frameworks and professional conduct to achieve its aims.

Naidoo and Wills (2001:19) explain that during the 1980s, numerous models of health promotion emerged in an attempt to define and clarify practice. They explain that the Beattie's model shows how health promotion is embedded in the socio-cultural and political framework, and state that the field of health promotion clearly reflects the tension between different value positions of power, knowledge, responsibility and autonomy.

10. Health promotion imperatives

10.1. A non-medical approach

According to the WHO Africa region (2001), health promotion was motivated by the recognition of the impact of social, behavioural, economic and organisational factors on health status. A consequence was the move away from individualistic and deterministic approaches of understanding behaviour change, and therefore health outcome, to more holistic appreciations of educational implications for health (promotion).

Conventionally, health has been viewed and approached from the bio-medical perspective with emphasis on a cure. A Working Paper for Health Promotion in Developing Countries (WHO, 1989:2) warns that health departments may also fall into this category of perspectives; and one of the challenges to the health systems is for its leaders to be oriented towards health promotion, because health systems policies are still heavily influenced by leaders accustomed to a medical, disease-orientated approach to health.

A call is made for an integrated and well-balanced approach combining medical care with preventative and promotional public health activities (WHO, 1989:3).

10.2. Needs assessment

The recognition of the right to participate in defining health needs and health care was acknowledged in the 1977 WHO Alma Ata declaration (PHC approach), and one of the underlying principles of ''Health for All'' is community participation. The first phase in health promotion planning can be identified as needs assessment of the population group for whom the health promotion is intended. Community development and participation are also important components of health promotion because they foster ownership of each person's own health, and make interventions relevant to the needs of the population group. A question to be considered is whether other health programmes work according to some kind of needs analyses, and community development approach for interventions.

10.3. Behavioural change theories

The way in which we believe that people change their behaviour will also inform interventions. Macdonald (2000) names the following behavioural change theories that have informed health promotion practice:

Social learning theory: The author suggests that the notion of reciprocal determinism, whereby an individual learns continuously to assess his or her interaction with society and the environment, and sub-consciously to accept behavioural influence, is central to health promotion practice.

Self efficacy proposes people will only undertake behaviour change if there is a belief that they could be successful, which links to the health

belief model and the stages of behaviour change model, which both reinforce social learning theory.

The **theory of reasoned action** first proposed by Ajzen and Fishbein (1975) is predicated on the assumption that the intention to act is the best way to determine action or behaviour of the future. This intention is in turn regulated by attitudes and beliefs about behavioural change (will the change be of benefit), and by behavioural controls (the development of self-esteem or internal locus of control), which determine the degree to which individuals feel that they have control over a behaviour and which is closely linked to self-efficacy.

Behaviour change theories are related to what has become known in the South African context as life skills education, prominent in the education of HIV/AIDS and health-related matters. If health promotion is to be effective, behaviour change theories need to be considered for implementation of health promotion actions.

A publication of the Department of Health on Youth Risk Behaviour (2002:16) states that a focus on health-related education requires a systematic planned approach to intervention development, implementation and evaluation. 'Effective development, implementation and evaluation of behaviour change interventions involve a systematic, stepwise planning and evaluation process.'

Application of the above model for planning and evaluation of interventions requires that several questions be addressed.

Step 1: How serious is the health, social or developmental problem?
Step 2: Which health-related social behaviours are involved?
Step 3: What are the determinants of those behaviours?
Step 4: Which interventions might change the behaviour?

Step 5: How can the intervention be implemented?

This implies that behaviour change interventions require systematic planning and thought. How much emphasis does the Department place on strategising for behaviour change?

11. Advancing co-operation

A challenge to the health promotion directorate with its goal of integration with other health programmes would be how to achieve good cooperation between the different programmes and how to ensure optimal achievement of programme objectives.

11.1. Clarification of co-ordination and responsibilities needed

Blaauw, Gilson, *et al.*, (2004) in a paper about government co-ordination says the nature of the co-ordination needs to be defined. They comment that some relationships simply need better communication and information-sharing whereas others may require joint decision-making. It could mean that health promotion with the different health programmes needs to be clear on the nature of their relationship needed to advance co-operation, whether formal or informal.

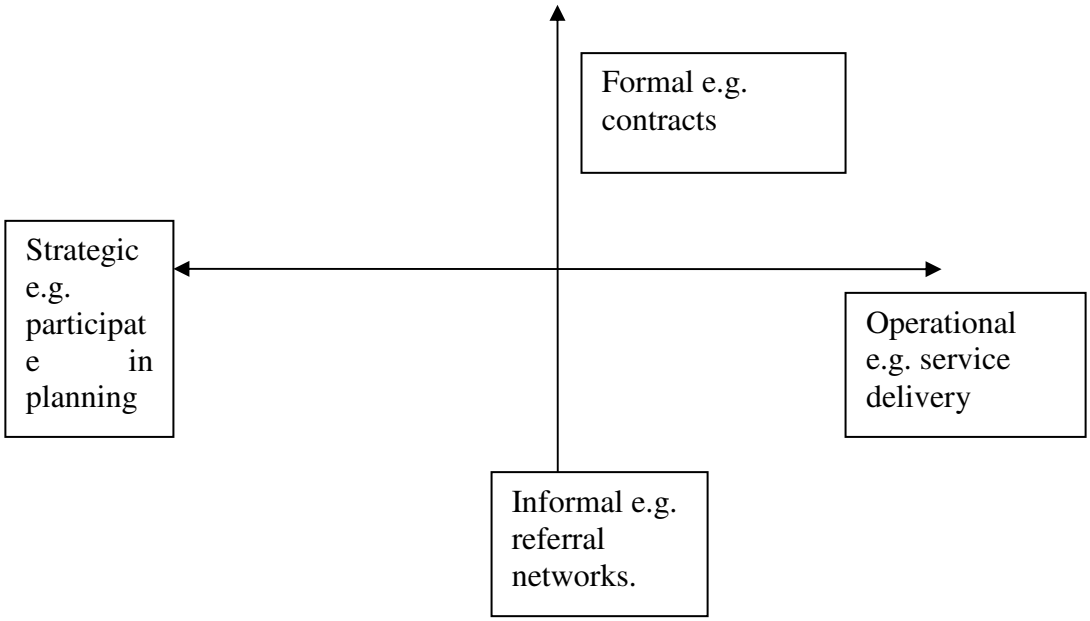
There also needs more attention to the ‘’coordination of coordination.’’ Blaauw, Gilson, *et al.,* (2004:11) observe that formal structures are frequently seen as the solution to co-ordination problems though they have not been uniformly successful. They say that the co-ordination of co-ordination requires defining clear responsibilities and relationships between different co-ordinating structures. By clarifying their roles both health promotion and the health programmes will be more effective in achieving their objectives, as they will be aware of each other’s roles and not only have limited views of each other’s programmemes. Further,

Blaauw, Gilson, *et al.,* (2004) believe that other mechanisms of co-ordination such as information dissemination or integrated planning should not be neglected. How does health promotion and the other health programmes achieve these goals?

Blaauw, Gilson, *et al.,* (2004:2) observe that the means of co-ordination in governmental co-ordination relationships can be through co-ordinating structures, planning, meetings and informal relationships.

11.2. Forms of partnerships

The graph (Schneider, Akpan and Kellerman 2004:8) shows that partnerships can encompass a spectrum of activities from joint planning and co-ordination, informal information-sharing, creation of referral networks as well as specific processes of contracting. These can be seen as falling along a continuum of informal and formal partnerships on the one hand, and strategic to operational partnerships on the other hand. For strategic partnerships with outcomes-based ideals, the need would be for more formal co-ordination with characteristics of strategic and operational partnerships. This will be the need if there is a need for formal strategic or operational plans.



11.3. Promoting shared values

Health promotion is particularly about a value-based approach to health. Advancing health promotion values such as equity, participation, inter-sectoral collaboration and empowerment (as has been alluded to in previous sections), can assist health promotion and health programmes to achieve their goals. This would be one of the aims of the health promotion programme – to instill these values in other health programmes when attempting to achieve their (health promotion) goals.

Blaauw and Gilson, *et al.,* (2004:12) highlight the need to develop shared values between different spheres of government – the approach to co-operative governance outlined in the Constitution – a shared project of government delivery, rather than rivalry and fighting for own turf. This will be one of the challenges for the co-operation (integration); to aspire to values that would enhance programme achievement and programme co-operation.

Schneider, *et al.,* (2004) advises health partnerships to develop a monitoring and evaluation (ME) culture within a partnership, so that 'evaluative thinking' becomes integral to ongoing programme planning and implementation of activities. The authors (op. cit; 2004:9) further advise on an approach to monitoring and evaluation 'that one has to ensure that a monitoring and evaluation programme has a utilisation focus, that is, it supports ongoing programme development by providing accurate and timely data that can be actively used by programme stakeholders to inform decision-making, identify problems/successes and contribute to programme effectiveness and efficiency. A mark of good project management and implementation'.

Gilson (2004:78) observes that ME can facilitate co-ordination by providing a focus for engagement and dialogue between the various people within the system that have to work together, and so allow better understanding of each other's needs and constraints. Creating opportunities for ME can thus also provide a structure for determining the needs for integration.

Regarding the need for planning, Gilson (2004:78) observes that to be effective, planning requires a combination of hardware (e.g. frameworks, links to budgets, information) and software (negotiation, dialogue and communication skills, effective relationships). The relationship between health promotion and other health programmes need to be formalised with operational plans linked to budgets being effectively integrated and co-ordinated. Planning also strengthens co-ordination.

WHO (1989:3) says obstacles and constraints for programme effectiveness vary from country to country and may relate to many issues, including resource allocation, institution-building, staff training, social support, inter-sectoral co-operation, programme planning, programme

evaluation and management. Challenges and opportunities for programme effectiveness will be identified in the study.

12. Conclusion

The literature reviewed drew attention to the political context of Health Promotion, especially in the South African Government context, prompting health professionals to address socio-economic concerns when addressing health concerns. Approaches and practice of health promotion were highlighted to demonstrate that the practice of health promotion should be empowering - skills building, educational, participatory, addressing issues that contribute to ill-health, that is, work at environmental support that is conducive to health, strive for principles such as equity, human rights, ownership, human development; advocate for changes through policies and partnerships, and paying attention to theoretical perspectives when deciding on a health awareness campaign, and co-operation and co-ordination through co-ordinating structures, clarification of roles and responsibilities, and promoting shared values that also enhance co-operation.

CHAPTER FOUR
DATA PRESENTATION

1. Introduction

The data from the interviews is presented in this section. The presentation of the data is according to themes that were identified from the interviews. The themes identified relate to the research aim, namely reviewing the strategy of integration of health promotion with other health programmes in the Department of Health. The themes more specifically relate to the questions asked in the research, as well as according to:

1. General comments about the integration;
2. Issues that have had some agreement amongst the interviewees about the integration;
3. Issues that the interviewees felt strongly about.

The research questions were:

- How far has the Health Promotion Directorate progressed with the implementation of the goal of integrating health promotion with other health programmes?
- How does the national department propose this integration should take place?
- Does the Health Promotion Directorate incorporate health promotion strategies and methodologies as espoused by the Ottawa Charter and policy in their implementation?
- What are the challenges for health promotion with regard to achieving the integration? What has hindered the process, what has advanced it?

- Examples of where it is integrated?

The themes identified were substantiated by quotations from the interviewees held. The full transcribed interviews are in the Appendix.

The five interviewees were from Health Promotion, nutrition, chronic diseases and communications as indicated in Table 1.

2. Themes identified

2.1. Integration on track

According to the National Health Promotion Director, the integration of programmes is consistent with departmental objectives. The director describes 'Integrating health promotion at national level into the health system is happening… the World Health Organization also advocates for this integration.' The director feels that at strategic programme level the integration is taking shape. It has become a priority for the whole Health Department. She quoted healthy lifestyles as an example of this goal towards integration. The campaign binds all the different health programmes to integrate the healthy lifestyles campaign strategically into their own health programme, and furthermore, health promotion leads the health programmes with the healthy lifestyles campaign. The campaign is a 'ministerial lead campaign', a priority for the Minister of Health. All the programme managers interviewed commented on the campaign and that it is central to the integration, and have provided impetus for the integration.

The Deputy Director (DD) for health promotion says that the 'integration has always been there'. She points out that 'Since health promotion has been there, there has been integration… because health promotion is a support programme to other health programmes there is integration. You cannot work on your own in a department… if you are in health promotion

or communication it means that you work with those health programme managers… health promotion cannot work on its own because it is not an expert.' She believes that 'integration' is not an issue because the nature of health promotion's function is 'cross-cutting with other health programmes and had compelled it for years to work in collaboration with other health programmes.'

What the interviewees revealed at the onset is affirmation that the integration of health promotion with other health programmes is a priority for the health department. One interviewee in particular felt that the nature of health promotion meant that the integration with other health programmes has always been there.

2.2. Introducing health promotion to other health programmes

During 2005, the health promotion directorate went on a road show to introduce health promotion to other health programmes in the department. Some successes have emanated from this campaign, i.e, better understanding of each other's programmes and closer co-operation. The health promotion directorate found, however, that many of the programmes did not fully understand what health promotion is doing, or is capable of doing. This implies that there is still a lot of work to be done to promote health promotion to other health programmes; to clarify its role and practice and thereby create better understanding of health promotion in other health programmes.

Whether the implementation of the healthy lifestyles campaign went according to the health promotion standard of practice remains to be seen and will be discussed in further sections.

To focus health promotion programmes and set priorities, the Deputy Director for health promotion says that they are working together with

research groups and institutions that help determine focal points for different campaigns and health promotion interventions.

2.3. Collaboration and role definition.

The health promotion director explained that at programme level specific collaboration and co-operation takes place, which constitutes some form of integration. She cited the chronic diseases and nutrition programmes as good examples of this collaboration.
Health promotion does the design, promotional and advocacy side of a campaign, the 'how to achieve it.' The specific programme does the content. The director believes that the health programmes know what the critical issues are pertaining to their own programmes and therefore should give the 'expert' input. The 'expert' input relates to the acknowledgement that persons from a specific health programme know their health programme and the health issues pertaining to that programme and would therefore have the professional knowledge inherent to that health programme.

The nutrition manager remarked that health promoters deal with so many topics that it is impossible to know all the topics. 'They need experts as partners, so health promotion must come up with a health promotion plan.' The interviewee meant that it cannot be expected from health promotion to know the substance of the messages that must be conveyed to the public from the health programmes' side, and the health programmes need to inform health promotion about the content.

The chronic and non-communicable diseases manager said on the collaboration and integration with health promotion that she 'had got to know health promotion and realised that they have a part to play, realised that they have a role to play in reaching the community.'

The managers from other programmes acknowledged the need to have health promotion expertise and practice in their own programme. The nutrition manager indicated that 'we are trained in nutrition not health promotion… nutrition messages must reach the public through health promotion... it is important to work together; communication, advocacy and promoting health; we provide health promotion with the appropriate nutrition information... obesity, people losing weight, dealing with hypertension, dealing with diabetes, we know the nutritional benefits that you need to have to live healthy, what you should eat, when and how much.' According to interviewees from nutrition and chronic diseases, health promotion's role in their own programme is community outreach, mobilisation, advocacy and raising awareness at community level of their health issues. 'Health promotion should help to mobilise communities to reach those recommendations made for healthy living by nutrition' and, 'I see their role, most of our programmes do not reach the public. Health promotion can mobilise people to do things for themselves, to social mobilise. I think they are good at it.'

The Deputy Director for health promotion also agreed that health promotion is involved with social mobilisation. She observed '….they (health promoters) do door-to-door campaigns, social mobilisation and education programmes through the SABC.' According to the Deputy Director, health promotion is at community level, comprising task teams, the private sector, NGOs, and CBOs 'Task to look at issues around health and health promotion, facilitating and then do the campaign… it is important to involve local management and local leadership in the campaign.'

The aim of health promotion, according to the Deputy Director, is 'to enable people to take control of their own health.' She points out, for instance, that 'Education is the core of health promotion, a big part of health promotion… it is about interventions telling people about

consequences… enable people with creative environments... not end with health education. Also, show people how to do gardens because all do not have money to buy vegetables. Come with experts for instance how to start the community-based physical activity… enable them‘ (to take action for their own health)’.

The Deputy Director for health promotion recognises that ‘Health promotion enables people, by creating supportive environments and provision of infrastructure, by for example mediating and advocating for the provision of clean water, and access to sanitary facilities in communities.’ The manager acknowledges that health promotion is about enabling people to make healthier choices by giving them skills and ensuring that their environments are health-promoting.

The Deputy Director for health promotion observed that the national health promotion directorate is involved with major one–day events; raising awareness of a topic, province-to-province, where the minister addresses people and the campaign is launched. The ‘official’ collaboration in the department between health promotion and the health programmes is about these campaign days, raising awareness in specific communities. Health programmes bring specific content (health messages) and organisational input (budget and events organisation), to the campaign and health promotion the advertising and marketing side of the event, as well as ‘reaching the community’ through education and social mobilisation.

In the communication officer's view, health promotion does ‘face-to-face’ communication, and tells the audience about the health programme. ‘Health promotion is a vehicle to community.’ She gives a personal ‘face’ of the health-promoting activity through the health promoters.

The communications manager alluded to some health promotion principles. She feels that health promotion should know ‘how community works, their mindset.’ and the need to be relevant to the audience; ‘for international health days choose themes that are relevant to South Africa.’ This is a health education principle, which relates to values such as needs-driven, relevance, ownership and self-realisation through participation. ‘You need to involve community leadership so that whenever you have an event you involve them… they can assist in calling meetings, relay messages to the community‘. A community-based approach and partnerships are important values here.

The communications manager further commented about the importance of having the right attitude towards the community being served. ‘Attitude should not be negative or snobbish. Be friendly, receptive to what you tell them.’ Principles of respect, right to health, knowledge and empowerment is important here.

About the education method used, the communication officer recommends ‘create interesting activities where people are going to participate… try and internalise for them the message that you give to them… sometimes they do like drama or songs or something interesting.' This according to theory helps people internalise messages because the audience is involved on many levels; emotionally, intellectually, socially and spiritually.

The chronic diseases manager was very specific about what messages health promotion should focus on in her programme. ‘Prevention, early diagnosis, treatment.’ Again this highlights health promotion’s role as a vehicle to reach (educate) the community and promote the prevention of diseases.

Health promotion has, according to the interviews, a clear role of community outreach, education and mobilisation. ‘Health promotion taking the health messages to the communities’ communication’s manager.

2.4. What is integration?

The director from the health promotion directorate says that integration takes place where there is some understanding between parties. ’There should be clarity of what is needed and what is expected of the different parties, for instance agreement that the issues will be addressed in a certain manner and agreement on principles to be followed.’ She says, ‘collaborate, co-operate then integrate. Integration is about two programmes that were not working together before. ‘She suggests that for collaboration to work, you need to formulate the integration. ‘Put down what principles are to be followed, what is integration and what shape the programme will take, because you have to take a new focus.’ She says various concerns must be taken into consideration, for example why the need for integration, and how it should be done. She had observed that people do not always know why integration is important. This is an important goal for her to achieve integration; clarity on why the integration is needed, purpose, roles and responsibilities clarified principles to be followed and how the integration would be achieved.

Regarding integration in general, the director felt that ’Integration has to be at all levels… programmes and projects should be mounted together.‘ This means that from the inception of projects and development of strategic objectives, health promotion together with the health programmes should be doing the planning together to function as an integrated programme. Furthermore, ‘Programmes and/or projects usually end with collaboration and co-operation.’ She could have been referring to the one-off campaigns of the health programmes.

The director believes that integration should happen at implementation level in particular, that is at local and district level. She believes that there is co-operation at this level. An example presented of good health promotion integration at this level is the health promotion education at hospitals and at clinic level. Policy dictates that health promoters are placed at health care facilities to render health education and promotion at the clinics. This means integration of health promotion at clinic level and thus with the community and other health programmes at clinic level, such as TB programmes.

Furthermore, for integration to be successful, the director for health promotion believes that the programme must be sustained. She advises that 'you need to look at the broader picture and aims of health promotion'. The example of an empowerment programme for women in the Western Cape was given. A project was undertaken where women were taught to grow their own vegetables and then to sell them for income. Good nutrition and sustainable income to sustain the access to good nutrition were the goals. She encourages projects that are self-sustaining and impart skills and empowerment to people that foster goals of autonomy, growth and self-reliance.

The communications manager's observations on integration were that 'it is not about integration but about working together as a team, whether you are integrated or not you must work together.' According to this manager, the integration of health promotion and communication means health promotion mobilises communities at ground level and communication takes on broader mobilisation. Networking is is also an important contributor for integration. This could suggest methodologies of inter-sectoral collaboration and partnerships to achieve health promotion goals because health concerns need to be addressed through a multi- focus perspective.

The Deputy Director for health promotion concludes that in her view integration means programmes implemented by relevant stakeholders, for instance the integrated nutrition programme. ‘All partners have one vision, mission and goal to achieve.’ The nutrition programme already has good examples of integration within the programme. When the manager spoke about nutrition goals and priorities, she spoke about the healthy lifestyles campaign, obesity, people losing weight, addressing diabetes and hypertension. She was providing evidence that nutrition is working across and within other health programmes, contributing to the objectives of other health programmes.

2.4.1. What has advanced the integration?

It became apparent that knowledge about health promotion and what health promotion can achieve will (and does) advance integration. The nutrition manager would like to work with the health promotion directorate. She believes that ’people in nutrition do not know the role of health promotion.’ She says that it is important for people to clearly identify their roles. ‘I think to have an open mind of knowing how we can benefit from the relationship. Some people don‘t get it, but you have to be more open-minded and understand what health promotion does. It is important for health promoters to make us see the value of their programme, so that we can use it to the best, have benefit of it.’ It is important for the health programmes to have knowledge of health promotion as well as role and function clarification of the respective programmes.’ It will help me to understand exactly what health promotion has been trained on, to say this is what they can do. I will buy in because I want to understand it more. I see their role.’ Implicit in these comments is an acknowledgement that that there are some (inaccurate) assumptions about health promotion (methodology) and possibly prejudice about what health promotion is able to achieve.

2.4.2. Health promotion and the Communications Department

All the interviewees talked about the important role of the communications department. Three interviewees, from health promotion and nutrition, advised that health promotion and health programmes include the communications department in the organisation of events and campaigns. The nutrition manager emphasized that 'for any programme to be successful we need health promotion and communications to work together with the programme.'

The health promotion officer commented on the good co-operation and integration with the communications department, and explained that health promotion worked with communications on a number of campaigns.

The interviewee from communications felt that the reason for such a good relationship between communications and health promotion was that 'When a programme manager wants to initiate a programme, communications advises the programme manager to involve health promotion. Communications and health promotion advises the programme manager how this campaign must happen. Health promotion mobilises at ground level, while communication will take on broader mobilisation.'

The nutrition manager also commented that in her view there there is a lot of overlap of functions between communications and health promotion. The director for health promotion says that health promotion develops messages and communication popularises the message. Communication is a vehicle for health promotion and assists with technical and communications backing for campaigns, such as conveying messages through electronic media, radio, TV, and print media.

The communications officer commented that health promotion and communication is 'the same stuff.' Health promotion focuses on people and communication on the media'.

The director for health promotion says that at national level a task team looks at strategy and campaigns. The campaigns are also informed by the health calendar.

2.5. Problems, challenges and future plans for integration

2.5.1. Formal strategies

There do not seem to be formal meeting structures for co-operative planning of different health programmes for health interventions. According to the interviewees, it is mostly taken for granted that there is collaboration between health programmes and health promotion, who come together for specific campaigns. The collaboration and working together are all verbal co-operation and agreements and there is no written operational planning that binds or directs the programmes for the collaboration. The programme persons from chronic, nutrition and health promotion stated that the co-operation is mostly taken for granted by both programmes; 'co-operation and collaboration is part of that programme without having to say it.'

The nutrition manager suggested that the directorates plan together for the following financial year. She also suggested that every health programme receives a budget for health promotion objectives within a financial year. She believes this will further advance the collaboration between health promotion and other health programmes.

2.5.2. 'Battle of the budgets'

Some of the interviewees said that budgeting for health promotion campaigns needed attention, as that influences ways of co-operation, feasibility of planning, ownership and responsibility issues.

The health promotion director observed that the battle of the budgets is also about 'optimizing available limited resources.' Some of the interviewees suggested that specific budgets for health promotion campaigns be allocated to each programme, so that it can be accessed for campaigns and health promotion interventions.

2.5.3. Protection of 'own turf'

According to the director of health promotion, the health programmes still work in silos; this means that they work on their own in their own programme. There is no co-operation and cross-fertilisation of each other's programmes. She believes that health programme managers still regard health promotion as 'outside' of their own programme and do not fully appreciate its value. She believes that there is the protection of 'own turf'. 'Managers are still worried that you want to take over their programme or role.' This suggests that there could be mistrust of the motives and capabilities of the different departments, and that the fear of people that you 'may take their jobs' can be overcome by explaining what your goals are, what health promotion can do and what health promotion is aiming at.

The communications manager commented on the problem of managers not attending and supporting each other's programmes. The director commented that these managers probably have their reasons for not doing so. Health promoters, according to other health programmes, also have a tendency to work on their own without involving other partners. The nutrition manager observed 'It is important to have people who know the

importance of working together to nurture the relationship because it can grow. It can be an enriching relationship if it is used properly.'

The director for health promotion says that with the HIV/AIDS directorate there is no collaboration or integration. Health promotion helps with the designing of materials, but nothing else. This is a cause of concern. It shows that health promotion is not taken seriously as an ally in the health department. HIV/AIDS is the biggest health challenge for the department and should in theory have health promotion as a partner, considering the multi-disciplinary approach of health promotion is also needed in HIV/AIDS prevention.

The director says that a contributing factor to poor integration with this directorate is the outsourcing of resources. The Health Departments' own resources are not optimised.

2.5.4. Monitoring and evaluation

The Deputy Director for health promotion explained that until now there had been no monitoring of progress made with the integration or campaigns implemented. For the communications manager, there is not enough monitoring and evaluation taking place to give the directorates an indication of whether their interventions are successful or not, and whether it is appropriate to the needs of the audience. 'Before they have health education awareness campaigns or talk to people they should do research in that area where they are going to be implementing their project. After implementing, evaluate whether there is a change in knowledge or behaviour. Ask ourselves are we making a difference? Scientific evaluations, not just a thumb-suck; so that you know whether people understand your messages.'

Other health programmes have not raised the issue of evaluation.

The communications department is planning to do evaluations on at least two campaigns. She appeals to health programmes to evaluate impact of message, for instance correct language use; '…are people understanding your messages, is their a difference after interacting with the messages? It is about informing people to make good choices… well-informed choices. Questions to be asked are ''are people enabled?" Do they have access to services? Informing them is also about the clinics and medication compliance.'

2.5.5. Human resources

The communications officer commented that there is 'not enough personnel to go to communities; a human resources problem. You cannot rely on volunteers. To interact with people you need a lot of people.'

Regarding health promotion competency, the communications officer believes that health promotion is not qualified and competent enough in health promotion. 'We need to have health promotion qualification and training. Knowledge of health promotion is needed. Applicants do not have a health promotion qualification.'

Could the officer mean that health promoters are not knowledgeable and skilled enough for health promotion work? She said 'even applicants for new posts are not adequately qualified in health promotion.'

2.5.6. Behaviour change

The manager from chronic diseases explained that it is difficult to change people's behaviour. 'We need tools to help people change. Provide technical support... a rural focus.' She acknowledges that changing behaviour is a complex issue that is difficult to achieve. The interviewee

also observed that implementation is slow. None of the health promotion interviewees referred to behaviour change as a health promotion goal.

CHAPTER FIVE
DATA ANALYSIS

1. Introduction

This section of the research discusses and analyses from the researcher's point of view the findings of the research. The section will interpret the research questions posed and themes identified in the interviews; a discussion of a) the progress made with the integration; b) How the department proposes the integration takes place and what the integration is; c) The role of health promotion (in health programmes) will be discussed, simultaneously with the practice of health promotion; and d) the challenges.

2. Progress made with the integration

According to the interviewees the integration of health promotion with health programmes is happening. The Healthy Lifestyles Campaign, a ministerial project has given impetus for the integration and advanced the health programmes working together. The campaign is about promoting health across the programmes by focusing on good nutrition, exercise, reduction of the use of harmful substances and safer sexual practices. Health promotion is leading the campaign.

For some of the interviewees, the integration of health promotion with health programmes has always been there, the need is obvious and therefore collaboration and co-operation is taken for granted.

The health programme managers were very supportive of the integration of health promotion with their programmes and the need for health promotion to assist them in reaching their objectives. The communications

department seems to have an important role in health campaigns, and in advancing the integration.

The quality of the integration and whether health promotion is integrated with other programmes remains questionable. Further, the researcher got the impression that the integration of health promotion with other health programmes was not the most important priority for the health promotion directorate.

3. Challenges identified

Although there is agreement on the need for integration, the interviewees implied that this co-operation and collaboration between programmes is taken for granted. There are no formal plans and agreements that bind and direct the programmes to working together. Specific campaigns come up that necessitate the programmes working together.

This casual collaboration can be problematic for the following reasons:

a) Outcomes: The national director commented on how, for interventions to be successful, health promotion needs sustainability of projects and interventions; which is also a health promotion goal and approach.
b) Planning: Setting priorities and working systematically i.e, setting goals and objectives to reach outcomes, accountably, can be a problem if there is no formal planning.
c) Monitoring and evaluation: Because there is no formal planning that directs campaigns with stated goals and outcomes, the monitoring and evaluation of a project can be a problem. Only the communications officer expressed the need for monitoring and evaluation, to assess whether interventions are meeting their objectives or not.

d) Level and quality of intervention: one-day campaigns and interventions may not be good enough for reaching health targets and health promotion goals.

Some interviewees alluded to the need for thought through long-term goals, i.e. sustainability, reaching the community, self-help, and advocacy. One wonders how achievable this is if there are no strategic plans to achieve this or planning structures to discuss it proactively. In-depth planning seems to be lacking. Desired outcomes in sustainable projects are usually achieved over a period of time, with concomitant co-operation and involvement of communities and stakeholders that usually takes time to elicit. There is also continuation of the project after initial intervention, needs planning and involvement. Sustainable projects would also mean that various health promotion approaches be used to meet desired outcomes. The co-operative interventions between health promotion and the health programmes do not reflect a varied use of health promotion methodologies to achieve the goals.

If participatory and needs-based approaches, for instance, are adopted to achieve aims, which theoretically are health promotion aims and also assist, as has been argued, with achieving equity, ownership, health literacy, social development, and behaviour change, then the Department needs to rethink its health promotion approaches and interventions, and strategic co-ordination with other health programmes. Deliberate planning to use health promotion approaches needs to be considered.

Taking time to plan for interventions has not been mentioned as an activity for any campaign by any health manager. Planning will involve information about the target group and their concerns/issues related to the health issue, for instance addressing concerns that perpetuate the health issue. The Youth Risk Behaviour Survey (2002) recommends that interventions for health-related education need to consider, amongst others, the health-

related social behaviours involved in the health problem and the determinants of those behaviours and interventions that may change those behaviours. None of the managers implied that this is an activity that guides their interventions.

Gilson (2004:78) observes that to be effective, planning also requires a combination of frameworks, links to budgets, information and software (negotiation, dialogue and communication skills, effective relationships).

The manager from nutrition commented that health promoters are not experts and that nutrition and/or any other health programme should be health promotion's ally in assisting with the content of the respective health programmes' campaigns – an indication that planning and formal co-ordination should be integral to health promotion and health programmes' co-ordination, and that the programmes could assist health promotion when embarking on an education campaign (i.e. determining some of the questions that will help direct where and how to focus an educational campaign).

Health awareness launches and one-day-awareness-campaigns for specific communities are problematic, and seem to have become the health promotion and health programmes' interventions; this typifies the health campaigns of the Department of Health, is problematic and will (according to evidence) not achieve health promotion ideals and health development that the Department hopes for, as had been referred to in the DNHPP (2006). Addressing health concerns successfully needs to be considered from different perspectives, socio-economic-biological. Different approaches can address these needs (perspectives differently by employing different strategies).

WHO Africa region and the Ottawa Charter (1986) state that integration of health promotion methods and actions at several levels results in

increased health knowledge, skills and community participation, healthy public policies and environments, which are supportive of health. Again, emphasising that health promotion aims are not just about creating one-off awareness campaigns, regarding a health issue, but need to be approached / armoured, with different health promotion approaches and principles; that is, advocacy, empowerment-focussed, equity, that address social inequality, and critically intervene according to priorities, epidemiology, and health promotion criteria, supportive environments and social development, amongst others.

Health promotion, by definition, as has been argued by Nettleton and Bunton (1995:44, in Bunton and Macdonald 1992) and throughout this research, is concerned with the twin goals of changing both lifestyle and socio-economic- political structures. These twin goals for health promotion may have been alluded to by the interviewees as theoretical health promotion aims, but it is not clear whether these are properly considered aims for the department in conjunction with well-developed plans, done in collaboration with the other health programmes.

Tang and Beaglehole (2005:884) state that the Bangkok Health Promotion Charter calls for sectors to invest in sustainable policies and actions and conscientious effort to sustain the effectiveness of health promotion by developing benchmarks for monitoring and plans for implementation to fulfill its four commitments. Setting objectives is thus important so that the intervention can also be monitored to assess whether the outcomes have been achieved, as regards the efforts made, how it has been achieved, and how can it be achieved better?

Regarding monitoring and evaluation Gilson (2004:78) reminds us that monitoring and evaluation can also facilitate co-ordination, by providing a focus for engagement and dialogue between the various people within the

system that have to work together, and so allow better understanding of each other's needs and constraints.

The manager from nutrition called for a need to do yearly strategic planning with the health promotion directorate – that budgets need to be allocated to the different health programmes for health promotion collaboration. These budgets could also be earmarked according to communities that are most needy and at risk, and health promotion priorities – an attempt to address the health concerns holistically. Working according to budgets can also assist with annual evaluation purposes.

4. Integration at what level?

Two out of the five interviewees commented that the integration is happening and that it is 'taken for granted' that there is integration and co-operation. One wonders though at what level this integration is, if it is 'taken for granted' and 'co-operation without having to say it.' Also meaning (interpreted) then, 'not having to plan for it, evaluate it, talk about it?' This attitude and way of doing things can lead to other problems such as accountability, clarification of roles and responsibilities, professionalism, setting specific targets, or attempting to achieve a certain standard of practice and tracking progress.

It is important to clarify roles and be strategic, for integration purposes as well as professional reasons. Health promotion has a reputation to set right. Three of the health programmes interviewed alluded to 'not knowing what health promotion does', 'health promotion not being qualified enough', 'health promotion likes to work on their own'. By being strategic and practicing what they preach, i.e. the Ottawa Charter, health promotion would start to mean something to other health programmes; they will be more professional and respected for a discipline with strategies that could contribute to being more successful.

A better understanding of health promotion will also promote the fuller picture of health promotion; that health promotion is not just about organising campaigns or distributing education material but that it has other aims as well that include advocacy, striving for equity, skills building, networking, addressing the determinants of health, working towards self-reliance, and ownership of interventions. It is acknowledged that the process of becoming more strategic and professional is time-consuming, and the kind of collaboration and integration needed will not happen overnight.

The communications officer also suggested that health promoters are not professionally qualified for health promotion work. The Gauteng Provincial Office, together with the University of the Witwatersrand, is offering health promoters in Gauteng the opportunity to study for a two year diploma in health promotion. Hopefully, this will contribute to a better standard of practice of health promotion, and the professionalisation of health promotion in government. It is hoped that other provinces will also be afforded the opportunity for professional training.

5. Role of health promotion

How the interviewees see the role of health promotion says a lot about how they perceive the practice of health promotion, even if that perception does not accord with the reality of the practice. Surprisingly, the managers were very precise about what health promotion should do. They were clear about the role of health promotion in their programmes; community outreach for education and awareness campaigns, and using terms such as ‘social mobilisation’ and ‘reaching the community’.

Social mobilisation has a strong association with activism and community involvement in bringing about change. So there is some kind of perception

that health (promotion) is about mobilising communities and communities taking action - responsibility - in bringing about health. This is in line with health promotion practice and policy objectives for the department. One of the Ottawa Charter's strategies for health promotion is strengthening community action, by having communities set priorities, make decisions and implement, thus empowering communities to know about health issues and to address and help solve them.

Expectations of the health programmes about health promotion is also that health promotion can socially mobilise. Examples of this: 'I see their role, most of our programmes do not reach the public. Health promotion can mobilise people to do things for themselves, to socially mobilise. I think they are good at it.' The question remains whether the health promotion directorate, together with other health programmes, can achieve this in their campaigns, taking into account the lack of proper strategic planning and the tendency for a top-down approach to health campaigns, for example, the healthy life-styles campaign and specific one-off campaigns that are targeted for interventions, that already have agendas set, with hardly any needs assessment, audience-targeted strategy, or community participation.

The health programmes also made it clear that health promotion is an outreach for their own programme to the community and needs to be informed about the messages of their own programmes. Further, the health programme managers felt that health promotion's educational role is about prevention and early diagnosis. The manager acknowledged that behaviour change is difficult to achieve, but she understood that when you do health education you equip people with tools/skills to help them achieve the desired behaviour change.

At the same time, health programmes need to be informed about the whole idea of health promotion, that it is not just health education, but also

networking, drawing in other sectors, advocacy, strengthening community action, and reorienting the health services. These services need to support health talks.

Advocacy is one of the five elements of health promotion in the Ottawa Charter, as well as inter-sectoral collaboration. The health programmes managers have not mentioned the role that health promotion can play in advocacy for policies to bring about health and prevent diseases, as well an inter-sectoral collaboration. The Deputy Director for health promotion alluded to the role of health promotion thus: 'these people they do not have houses, clinics, and then you are able to mobilise on behalf of them together with the community that services should be there.' And, 'enable with creative environments'. 'Health promotion does some of these elements, not in-depth.' There was a view that health is not just a health sector issue but also housing, social development and education amongst other, and has a strong advocacy role.

6. What is integration and how can the integration be improved?

The director for health promotion commented that integration for her means an understanding between parties – an understanding that then should take forward the needs, and (cross-cutting) responsibilities and aims of the respective programmes, which requires knowledge of each other's strategic objectives and operational plans in order to be successful.

The director also asserted that programme integration must be sustainable, and that the reverse may then also be true, that sustainability encourages integration. This is an argument in favour of health promotion adopting long-term sustainable projects that address health concerns holistically and that strategically incorporate health promotion approaches, such as the Ottawa Charter recommendations.

The director argues that the nature, principles and values of integration need to be determined and understood by all the parties concerned. The director admitted that the programmes need to commit to paper the principles to be followed, and further define 'working together' or collaboration. It is important, therefore, for the health programmes to clarify their purposes, roles and responsibilities. These are basic management tools that require the clarification of missions, visions, goals and objectives, which will also serve as reference points.

Other health managers also noted that knowledge of the programme advances integration. There was also a need expressed that the knowledge should be reinforced. The director for health promotion explained that the directorate had been on a roadshow in 2005 to promote health promotion to other health programmes. It is advisable, however, that health promotion again introduces the programme to other health programmes in the department so that they all have a better understanding of the role of health promotion and how health promotion can be of benefit to their particular programmes.

7. Co-ordination

It seems as though the Health Department could be clearer on what co-ordinating relationships are more informal and what co-ordination needs more formalisation.
Clearly more formal co-ordination is needed between health promotion and other health programmes to be more successful. It is advisable for the programmes to have management structures in place for co-ordination and planning.

The co-ordination of the different health programmes also requires defining clear responsibilities and relationships between the different co-ordinating structures. This need was expressed by especially the health

managers, that health promotion should clarify its role. By clarifying their roles, both health promotion and the health programmes will be more effective in achieving their objectives, be more aware of each other's objectives, and be knowledgeable about each other's programmes; this will help in understanding needs and objectives. It can also help eliminate the fear of 'taking over each other's jobs' and 'not knowing what the other's role is' that the director for health promotion had pointed out as being fairly common.

7.1. Developing shared values

Health promotion theory particularly advises that health issues be approached with certain principles and values in mind. As previously mentioned, advancing health promotion values such as equity, participation, inter-sectoral collaboration and empowerment can assist health promotion and health programmes to achieve their goals.

However, it would seem that health promotion and health programmes do not approach their interventions with a view to ensuring community participation in identifying needs and ways to meet them, as well as creating opportunities, and empowering communities to learn about and address their own concerns. Health programmes expect that this is what health promotion should do – namely, community mobilisation. It is possible that health promotion at local level, with support from national level, may be able to play a role in assisting policy-makers to prioritise the needs of certain communities and ways to meet them, for example, through community structures, as had been alluded to by the Deputy Director for health promotion, or by initiating participatory processes around information-sharing, work experience and knowledge of specific communities; this would make social mobilisation a reality and a goal for health promotion at local level.

The advocacy role of health promotion would also be useful to address 'the societal and political structures and relationships that differentially affect people's chances to be healthy within a given society.'

All in all the principles of health promotion and the goal of strengthening health promotion in health programmes to achieve departmental objectives are worthy aims and can assist any health programme to achieve its aims more successfully.

8. Role of the Communication's Department

The communications department is very knowledgeable about health promotion as well as supporting its involvement in other programmes. It would seem that communication is an excellent ally in the health promotion health campaigns. Communications is able to support a health promotion campaign with the necessary messages to communities through the print and electronic media. The knowledge and support that the communications department has of, and for, health promotion most likely gives health promotion the edge of confidence in the collaboration between health promotion and health programmes.

9. Strengths of the health promotion programme

The health promotion directorate seems to be realistic with regard to what they can achieve. While they do not have over-ambitious goals and strategies, budgets, manpower, and capacity seem to place limitations on what they can achieve. There also seems to be a common-sense approach to their work; 'cannot work without integration' 'it has always been there' 'doing it without saying.'

Theoretically speaking, they acknowledge that health promotion is about sustainable, empowerment-focussed interventions.

There seems to be good communication and co-operation between health promotion, health programmes and communications.

The healthy lifestyles campaign seems to have helped the health programmes in working together and integrating prevention issues into health campaigns.

CHAPTER SIX
CONCLUSIONS

1 Introduction

The study reviewed the integration of health promotion with other health programmes in the Department of Health and the ways in which it had been achieved (or not). The WHO Africa Region Strategy's guiding principles and priority interventions for health promotion refers to the necessity of the integration of health promotion with other health programmes; this is also referred to in the health promotion policy and was a point of motivation for this study. Two points are made in the strategy, namely

a) gaining access to evidence-based health promotion programmes; and

b) systematisation of the use of interventions to complement priority health programmes, has not been achieved based on conclusions made in this research. Integration as referred to in this research will mean a health programme that will have health promotion strategies and practice integral to it. Based on the research findings, conclusions and recommendations can be drawn and are presented below.

2. Conclusions

Although it is evident from the research that the department is working towards, and is desirous of achieving the use of health promotion interventions in other health programmes, and achieving some kind of synergy with these programmes, health promotion programmes as has been argued, are not subjected to strategic planning with other health programmes and monitoring and evaluation, that can reflect evidence of effectiveness of

programme achievements. Furthermore, health promotion practice as outlined in the policy and the Ottawa Charter is not evident in the integration, or the practice of health promotion.

Attempts by the health promotion directorate to address socio-economic concerns, in order to improve health, seem weak. One would expect that it is at national level that the Department would rally around advocacy work and add their voices to the chorus of requests, to bring about education, housing, proper living conditions, health care and socio-economic services, amongst others, to improve people's health, as has been argued in this research.

There is no doubt that health promotion should be more disciplined and professional in its health promotion approach, methodology and management. Perhaps there is a need for more professional training and input, as well as more manpower.

Health promotion is in many ways a radical approach, calling for disciplined and strategic interventions, a move away from the curative approach to prevention, empowerment and inter-sectoral collaboration. The health promotion directorate has developed a policy over the last 10 years to guide its practice. The policy outlines the Reconstruction and Development Programme and Ottawa Charter, amongst others, as overarching ideological goals for health promotion. However difficult it may seem, the Department believed that this was the way to go to achieve its aims. The Department is also a role model for how health promotion is practiced in other health programmes, and at provincial and local level. To practice real health promotion in the Department of Health may make a major contribution to the future health of the country.

3. Suggestions for the integration

a) Managing the integration of health promotion with other programmes seems weak. Strategic plans need to be drawn up that include clarification of roles; and knowledge about health promotion should be communicated to the health programmes.

b) The health programmes have a good idea of health promotion's role in their own programmes; reaching the community, creating an awareness of a health concern to communities, and social mobilisation. Greater articulation is needed, though how this can be achieved more successfully is not clear. Moreover, the health programmes are keen to incorporate health promotion strategies in their programmes. They acknowledge the need thereof to achieve their own goals. The health promotion directorate needs to be strategic on how it can structure and support these programmes more efficiently.

b) It seems as though the health promotion directorate is not applying the principles of health promotion – participation, empowerment, equity and inter-sectoral action in their own campaigns or advancing these to other health programmes. Strategically, the directorate needs to apply health promotion approaches as constituted in the Ottawa Charter more vigorously in order to achieve its goal.

c) There is a need to continuously rally around promoting the aims of health promotion practice in the Department of Health.

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APPENDIX

INTERVIEWS

Interview 1

Director: health promotion

Integration very important drive in the department. Ministerial priority, integrating especially the healthy life styles campaign with other programmes in the department.

At programme level integration takes place. Specific collaboration and operation.

Example of health promotion and nutrition collaboration. Health promotion does the design promotional side of a campaign. The specific programme does the content. They are the experts. They know what the critical issues are. Policy and material development.

Integration should especially happen at implementation level. Local and district level. There is that cooperation.

What it should look like, ideal model of integration? Programmes and projects.

Also various concerns and considerations need to be taken into consideration. I.e. why the integration, and how it should be done. People do not know why the integration or how it should be done.

Needs to take place where there is already an understanding between parties.

There should be clarity of what is needed and what is expected of the different parties. I.e. this issue is going to be addressed in this manner.

Integration = understanding between parties. Agree on principles what we are doing.

It is also a battle of the budgets, integration of budget, integration of human resources, to optimize (maximize) the available limited resources. (networking)?
What health promotion should be?

Example health promotion within Department of Water and sanitation. Health promotion enables people, creating supportive environments, provision of infrastructure.

Problems

Programmes still work in silos. Put hp outside do not appreciate the value of health promotion.

No strategy works on a strategy.

Good programme integration communication – specific programme for specific time. cuts across programmes. Hp develops messages and they popularize it. Communication is a communication vehicle for hp, media, newspapers,

Chronic diseases also a good programme. Programme gives specific information for hp. Specific campaigns. Health promotion an advocacy role.
Collaborate cooperate then integrate. Integrating two programmes that were not there before. Put down what principles to be followed, what is integration and what shape will the programme take. Because you have to take a new focus. Integration: programme must be sustained.

Programme/ project usually end with collaboration and cooperation. Proper integration at programme and project level. Other health programmes bring content and health promotion how to achieve it.

Partnership, co-operation, and collaboration. (part of that programme without saying)

Strategy healthy lifestyles into chronic diseases. Joint programmes.

Health promotion at national level into health system is happening.
Example of good health promotion integration. Hospital and clinic education.

Step by step process. WHO advocate.
At local level expedite ensure.

Chronic getting there slowly. Happening at programme level, no strategic plans together.

HIV/AIDS collaboration no integration. I.e. Help with designing material nothing else. (Problem health promotion should be a strong ally. Health promotion helps with skills building, education information distribution.
Resources outsource.

Challenges

People are uncomfortable scared you may take their jobs. Protecting their turf.

Overcome it by explaining what our goals are, what hp can do, what we are aiming at. The integration needs to be formulated; it is not on black and white.

Sustainable programmes are success stories.

Look at broader picture.

Empowerment programme in the Western Cape. Teach women to grow own vegetables gardens and then to sell them for an income. Also started a food gardening project in a school. School feeding scheme under way.
All nor perfect force partnerships. Road show. Went from programme to programme to introduce health promotion to other programmes. Programmes do not have a full picture of what hp is doing. Network.

Interview 2

Assistant Director - Nutrition

Integration

We are trained in nutrition not health promotion. Nutrition messages must reach the public through health promotion. Important to work together, communication, advocacy, promoting health, we provide them with the appropriate information. Nutrition issues, important collaboration. Nutrition goals and priorities? Healthy lifestyle campaign. Obesity, people losing weight, dealing with hypertension dealing with diabetes, we know the nutritional benefits that you need to have to live healthy, what you should eat, when and how much. Health promotion should help to mobilize communities to reach those recommendations.

Like to work much more closely with health promotion; do not always work together. Negotiations, campaigns planned together. What must happen for it to work better? ‘Planning together for following year otherwise can be hijacked or, say these are the activities planned for following year, put money aside both parties.’ ‘We have been communicating, not started planning, informal communication. Communication unit also involved. Overlap between health promotion and communication. Not sure about the exact roles of health promotion and communication.

Nutrition (her) understanding of health promotion. Health promoters trained in how to mobilize, how to advocate, how to create an awareness of a health issue at a community level. Health promotion also involves many other topics. Nutritionists are specialists; they need to provide information together with health promotion this is what we would like to create awareness on. And how we will on it.

Health promoters are used more as health educators. Health education is what I would teach on different topics. I do not expect health promoters to have all the knowledge - I would teach them. Nutrition can provide more detailed information on nutrition but cannot expect that from health promoter.
One to one educator professional or dietician dealing on that but on a larger scale health promoter promotes fibre. Broadly.
Working together

Health promotion's role in assisting people to access food? Food security component of nutrition. Access to food at all times. Work together with health promotion ensure people are aware of the importance of having their own food gardens,

Challenges for the integration.

People working in nutrition do not know the role of health promotion. Health promoters have a tendency to promoting health alone, without involving the other partners. It is important to have people who know the importance of working together to nurture the relationship because it can grow. It can be an enriching relationship if it is used properly. Important for people to clearly identify their roles. Health promoters deal with so many topics that it is not possible to know all. Need the other experts as partners. Come up with a health promotion plan.

Integration has to be at all levels,

Responsibility of health promotion to make other programmes aware of them, of what they can do, how we (nutrition) can support them. We do not know what skills health promotion has, for me health promoters have the responsibility to tell others how they can enrich the programme. (health promotion needs to know their own programme well for others to have full benefit of health promotion function.)

What has advanced the working together.

I think to have an open mind of knowing how we can benefit from the relationship. Some people don ‘t get it, but you have to be more open mind and understand what health promotion does, Important for health promoters to make us see the value of their programme, so that we can use it to the best, have benefit of it. Appreciation of what the programmes can do

What you would like health promotion to do.

It will help me to understand exactly this is what we have been trained on; this is what we can do. It will make a big difference. I will buy because I want to understand it more. I see their role. Most of our programmes do not reach the public. They are somewhere in clinics (and I have a feeling) programmes at community level, Vitamin A supplementation, people aware of what we are offering, that health promotion create awareness mobilise people to do things for themselves health promotion to social mobilize people. I think they are good at it. Focus on it. Use continually with service provision. Nutrition to keep on providing the service,

Need to plan together from beginning. Your role, my role this is the message I want to sent out how best to do it. This is our priorities for next year, how do we link up.
Events planned together. No written plans to share. Difficult to tell role of health promotion and communication.

Budgeting; each programme from the beginning allocates a percentage of budgets to health promotion. There is no policy, not aware of a guiding point just aware that we are working together.

See health promoters inappropriately because we are not getting the best out of them
Interview 3

Assistant Director - Non communicable diseases. Chronic, disability, the elderly.

Hypertension, diabetes, cancer control.

National level, education, advocacy policy planning, support.

Combined effort, everybody knows each other. Did work in silos. Overlapping Got to know health promotion and realizing they have a part to play. They focus mainly campaign days, raising awareness

No policy skilled in various areas.

Lekgotla last year. WHO and minister priority diet, physical activity and health. Healthy lifestyles campaign. Appointed health promotion to take charge of that campaign. . Goals objectives

Developing strategy for everybody. Timeframes set etc. Involvement of other partners in planning and execution, pharmacy, NGO's.
Inclusive healthy lifestyles document overarching in all programmes.

Operational plan three year strategic plan. Healthy lifestyle relevant chronic diseases.

Aware of importance of health promoters on board. Understanding of health promoters. Promoting health, Reaching people. Healthy lifestyle whether it works or does not work is a different story. Behaviour change difficult to achieve. Need tools to help people to change. Provide technical support. Rural community focus.
Implementation slow.
Challenges
Overcome the emphasis on HIV/AIDS.
Focus - prevention – guidelines, prevention early diagnosis. Health education.

Integration cooperation is there do not have to think about it?

Interview 4

Deputy Director - Health Promotion

Integration has long been there. Since health promotion has been there has been integration. Because health promotion is a support programme there is integration. You cannot work on your own in a department. If you are health promotion or communication it means that you work with those health programme managers. So the integration is a given, compulsory. It has been there. Health promotion cannot work on its own because it is not an expert. You mandate programme to disseminate information to communities and to other stakeholders re health issues. And it is not health it is social development health promotion really social issues. Integration is compulsory irrespective of where you do health promotion. Which department she knows that in health promotion for 18 years. Can't be a health promoter alone. No proof.

Are there structures/ strategies in place? Planning together.

Not a structure. She is a manager for campaigns. Depends what campaign she does for chronic or has to work together with chronic diseases and communication because they are the experts. Tell us what are the issues to discuss, what are the problems. What issue to take forward to the communities? Come up with strategies communication and health promotion.
Health promotion and communication lead.

According to your research that you have done as an expert, where should we focus when we do our social mobilization when do our press release, door to door, sabc education, what are your programmes.

Healthy life style campaign, good nutrition, physical activity, tobacco control, alcohol and drug abuse.

Informed by the departmental strategy, to say healthy lifestyle and focus on four areas. Started 2005 have not monitored progress so far. No documentation, there are interventions that we have done.

Integration in her unit. Campaigns and healthy life styles campaigns.

Take policy down to communities.

Task team at national level that looks at those components. Strategy and campaigns.

Also informed by the health calendar.

World no tobacco day check what is the theme.

When we go down we need to get the local management and local leadership.
Forming a task team at community level. Facilitating to educate them to say
There is a world no tobacco day and then Lets talk - targeting 5000 people

Who implement local community leaders,

role and function: community development not health promotion's role.

Health promotion is more on making people aware of health issues, change behaviours like if you tell people about risky behaviours their able to make

choices to change their behaviour also you motivate people to have healthy behaviour to go to the clinic. Help them to have informed decision. Community development is about putting resources in the community more than a health issue it is a government issue. Health promotion preventative work? We are aiming to prevent people not becoming ill. We aim to prevent and reduce diseases. That is not community development. Promote good health.

These people they do not have houses, clinics, and then you are able to mobilize on behalf of them together with the community that services should be there. Health promotion does some of these elements not in depth.

Where there is outbreak for instance malaria outbreak you have to check whether people have clean water. If not you are able to liaise with the local municipality so that people will be provided with clean water. Because if you have Education and no clean water…..

Mobilizing communities to help themselves, healthy behaviours to prevent illnesses.
Conduct screening hypertension diabetes strategy for prevention provide service now they know.

Objective has been reached of integration part and parcel of other programmes.

Visions for health promotion.

See people modified behaviours, healthy behaviours, enable people to take control of their own health. Modify rather change. You won't make sure that people will modify their behaviours

Interventions tell about consequences. Education core of health promotion - big component of health promotion. Enable people with creative environments. Obesity at community level. You want to educate people. What causes and so on. Not end with health education. Also show people to do gardens because all do not have money to buy vegetables. Come with experts where educate people how to start the community based physical activity. Enable them.

Chronic, mental health, skills building enable? Health promotion staff limited in the country.

Determining needs

What integrated programme

Programme implemented by relevant stakeholders. i.e. integrated nutrition programme.

All partners have one vision and mission and goal to achieve.

Problems are resources shortage. Not enough clinics, water, housing, not enough human resources.
No contraceptives,
Health promotion does door-to-door campaigns, but there is no proper housing, no water, and 35 km to clinics.
Work with dept. education and sports and rec., social development dept, dpsa, housing, sanitation.
Advocate

Interview 5

Assistant Director - Communication's Department

'Communication's is a support to programmes'
'Communications is the same stuff health promotion focuses on. Health promotion on people and communication on the media.'

'Health programmes taking it to the communities.'

The interviewee further states that both programmes focus on health programmes. 'Communication focuses on policies and legislative framework.' Example was given of the health charter that is in the process of being finalised, and then marketed by communication's.

'We help with programmes; take on their content to the media, write a script.

'Health promotion's duty is to go the public. Do face-to-face communication and tell them about the programme.'

'Health promotion is a vehicle to the community.'
Communication's role. Take message, electronic messages, radio, TV to communities. Health promotion help communicate with communities.'

For any programme to be successful need health promotion and communication to work together with the programme.

Why good relationship between communication and health promotion?
When a programme manager wants to initiate a programme communication's advises programme to involve health promotion. Communications and health

promotion advise programme manager how this must happen. Health promotion mobilising at ground level, communication will take on broader mobilization. 2 advisors to programme managers on how

Challenges for health promotion.

'Not enough personnel to go to communities; human resources problem. You cannot rely on volunteers. To interact with people you need a lot of people.'

'Need to have health promotion qualification and training. Knowledge of health promotion is needed. Applicants do not have a health promotion qualification.'

Monitor

'Before they have health education awareness or talk to people they should do research in that area where they are going to be implementing their project. After implementing go back and evaluate whether there is a change in knowledge or behaviour. Ask ourselves are we making a difference? Comment other person. I think our hands are also tied because we are so short staffed. Scientific evaluations not just a thump suck; so that you know whether people are understanding your messages. (Has not come out from other programmes.) Communications is planning to do evaluations on at least two campaigns. Correct language, people understand your messages, is their a difference after interacting with the messages? It is about informing people to make good choices. Well informed choices.
Enabling? Access services. Informing them about the clinics and medication compliance.

Health promotion should do?

Know community work, their mindset. Health education principle.
National theme for South Africa this theme we have this problem.

Health promotion should do?
Attitude shouldn't be negative or upstairs. Be friendly receptive to what you tell them involve community leadership so that whenever you have an event you involve them cause call meetings help to give message relay to community. Create interesting activities where people are going to participate. Try and internalise the message that you give to them. Sometimes they do like drama or songs or something interesting.

Problem of managers not attending and supporting programmes and utilizing opportunities to get their own messages across - piggy backing on other programmes' projects. She comments that these managers probably do have their reasons why they do not want to.

'It is not about integration but about working together as a team whether you are integrated or not you must work together. '

Falling under different cluster managers have own clusters project form a team work together.

With integration it is health promotion and communication fall under one cluster.

Did not know what health promotion is but now that she knows them they are more active.