The concept of health promotion in Fiji

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ABSTRACT

Introduction

This paper sets out to describe stakeholders' views of the concept of health promotion in Fiji.

Metholodology

Sixty-one semi-structured qualitative interviews were carried out with participants from all levels of the health sector (National, Divisional, Sub-Divisional and zonal) as well as community members and other sectors that had an involvement in health promotion. Data collected was analysed using grounded theory following the process outlined by Strauss and Corbin.

Results

Participants described a concept of health promotion in Fiji that provides a sophisticated and effective framework for action to improve health. The immediate implication of this paper is that participants view the processes and structures for health promotion in Fiji as currently insufficient to fully implement the concept of health promotion articulated. In particular, the call for health promotion to be at the center of development is not matched by the action required at a regional and national level, the building of staff and community capacity is often ineffective in its current sporadic and intermittent form and the reorientation of the health sector has been hampered by the perception of the health sector as service providers rather than facilitators.

Conclusion

To fully implement the concept of health promotion in Fiji, more attention needs to be given to the processes and structures that direct and support health promotion action. Specifically, there is a need to develop implementation strategies that provide required and timely inputs during the development and ongoing implementation of health promotion activity. This can be achieved by engaging relevant sectors, investing sufficient time and resources into building staff and community capacity and better defining responsibilities.

Introduction

The Ottawa Charter for Health Promotion[1] and more recently, the Bangkok Charter for Health Promotion in a globalised world[2] have established accepted principles and strategies for health promotion action. These charters have set the context for the current understanding of the concept of health promotion internationally. Experience with the implementation of the activities identified in these charters has led to the development of strong evidence that health promotion is effective in delivering health outcomes when undertaken with the required scope, intensity and duration. In particular, it is accepted that to be effective health promotion requires a range of strategies, capacity within both communities and organisations, a high degree of local participation and control in priority setting and implementation and technical support for research and development[3].

The majority of evidence of health promotion effectiveness has been established in developed countries with well established health sectors. However, there remain questions as to the processes and structures required in developing countries.

Coordinated action to improve health in the Western Pacific in the 1980s and early 1990s was undertaken using primary health care and health education models. While informed by evidence and charters that were developed internationally, the need to tailor health activities to the needs of the pacific region led to the development of New Horizons in Health[4]. This document was the basis for a series of declarations and commitments within the pacific region that commenced with the Yanuca Island Declaration in 1995[5]. These declarations and commitments endorsed an 'ecological model of health promotion'[6] that highlighted the linkages between health and the environment as well the importance of culture and tradition to well-being. Through the Yanuca Island Declaration and subsequent commitments and agreements the concept of Healthy Islands evolved. Healthy Islands shifted activities to improve health away from the traditional health education and primary health care models towards an approach that focussed on empowering communities. It also led to the recognition that improving health required collaborative and participatory approaches that could not be achieved within existing organizational structures.

While this evolution was taking place, the principles and strategies of health promotion were introduced through two donor funded initiatives, the Kadavu Rural Health Project[7] and the Fiji Trilateral Health Promotion Project[7]. These projects built the capacity of staff and institutions in Fiji to implement health promotion activities. The parallel evolution of the Healthy Islands concept and the introduction of the principles and strategies of health promotion led to a merging of the two strands of activity and the development of a 'concept of health promotion' specific to Fiji.

This paper forms the first stage of a broader program of research on health promotion in Fiji. Specifically, the paper sets out to describe stakeholders' views on the concept of health promotion in Fiji. At a time where health promotion is on the verge of a new phase of evolution in Fiji, the purpose of this first report is to provide an opportunity to reflect and build on existing knowledge of the concept of health promotion in Fiji, the factors that have influenced its development and to identify implications for the effectiveness and sustainability of health promotion activities within Fiji.

Methodology

Background

The study was developed to describe the experience and behaviours of individuals, communities and organisations who have had roles in the development and implementation of health promotion activities at different levels in Fiji (National, Divisional, Sub-Divisional and local as well as Provincial and District). The qualitative research approach allows an exploration of how participants interpret and interact and it generates 'knowledge of social events and processes by understanding what they mean to people'[8]. As such qualitative research allows the researcher to explore the knowledge, understandings and perspectives of study participants in relation to the concept of health promotion in Fiji.

Sampling

A theoretical sampling strategy with the following elements was used in this study:

(a) Purposeful selections of study participants who were best able to inform the research purpose. Participants from government, non-government, community and traditional sectors that met one or more of the following criteria were selected:
- involvement in a public health issue
- formal responsibility for a health promotion activity
- informal responsibility for a health promotion activity

(b) Ongoing analysis and participant selection was used to determine on analytical grounds what additional data was required to be collected. The combination of purposeful selection with ongoing selection allowed a sample of cases to be planned in advance and subsequently an extension of sampling of individuals who were able to inform the emerging concepts.

(c) The researcher identified instances where the content of data collected differed substantially from emerging concepts and could not be incorporated into the existing analysis. These negative cases were used as a basis for further selection of participants and a trigger for the researcher to re-examine the existing data to develop concepts that encompass the negative cases.

(d) The extent of theoretical sampling was guided by the ability of each additional participant to provide theoretical insights into the study issue. Sampling was complete when 'theoretical saturation' was reached. That is, when additional cases failed to provide further insights.

Interviews

During the first phase of data collection from August 2005 to June 2006, 61 semi-structured interviews were conducted (see Table 1). The interviews covered a broad range of issues relating to health promotion in Fiji as part of a broad program of research. Relevant to this paper were questions related to the concept of health promotion in Fiji, the outcomes of health promotion action, the processes and structures that have supported the development and implementation of health promotion activities and the outcomes and benefits of health promotion activities. An interview guide was used to provide a systematic approach for each interview and facilitate the collection of comprehensive data. The interview guide approach was combined with the techniques of informal conversational interview. In this technique the researcher allows questions to 'emerge from the immediate context' of the interview process[8].

Table 1. Study Participants

Participants	First Phase
Environmental Health Officers	11
Nursing/Medical Staff	18
Non-government Organisations/other sectors	16
Ministry of Health/National Centre for Health Promotion Sectors	10
Research sector	6
Total	**61**

Analysis

The QSR Nivo 2.0 computer package was used to manage and analyse data collected using grounded theory following the process outlined by Strauss and Corbin[9]. This approach involves systematically gathering and analysing data throughout the research process to discover concepts and relationships. All interviews, coding and analysis was conducted by the first author. Meanings and interpretations of the data were established through continual reflection and discussion with key informants.

Results

Concept of health promotion

Health Promotion at the centre of development

Participants regarded the concept of health promotion as a potential antidote to many of the issues confronting contemporary Fijians, particularly with regard to enabling people to take control of their lives and work proactively to improve their health and well-being. There was a strong view that the concept of health promotion is about reawakening traditional beliefs within Indigenous Fijians as well as working with Indian Fijians and minority groups to enable them to control and improve their own health.

Participants in the study recognized that enabling people to make decisions affecting their health required participation. Participation in health promotion activities was seen as

the key method of building the knowledge and skills of individuals and encouraging their commitment to health activities.

The focus on participation was seen as a deliberate attempt to shift community thinking away from dependence on government towards a more proactive engagement with health issues. Participants felt that the concept of health promotion involved an optimistic and positive view of the present and the future. This positive attitude towards health issues was viewed as a deliberate shift away from the focus on the negative consequences of specific behaviours and lifestyles that was the dominant approach prior to the introduction of the Healthy Islands approach in 1995.

Participants also emphasized the need to shift the responsibility for implementation to communities to facilitate development, self-reliance and empowerment. To support sustainability and commitment, participants identified the importance of mobilization of resources at the community level to promote health. The recipe for health promotion put forward by the health sector encourages communities to examine their latent or underutilized resources. The focus is on utilizing existing resources effectively rather than seeking resources from government.

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Development of knowledge and skills

Participants identified the development of knowledge and skills both within the health sector and communities as a key component of the concept of health promotion in Fiji. The focus is on transferring knowledge and skills so that individuals and communities develop the capacity for planning, implementation and monitoring of health promotion activities.

This was described as requiring training and capacity building activities that explore the meanings and perceptions of health with communities. The aim is to transfer knowledge and skills that enable communities to act on issues as they arise. Participants indicated that this represented a shift from the didactic unidirectional approach of health education to a partnership approach where the community develops the knowledge and skills to undertake planning and implementation.

Reorientation of the health system

Participants also indicated that the concept of health promotion involved a reorientation of the health system. Participants described the need to shift the interface between the Ministry of Health and the community from a service delivery model to a model that combines service delivery with respect to curative services and facilitation and mobilization with respect to health promotion. It was acknowledged that the reorientation of the health sector required staff with new skills sets as well as an understanding and recognition within communities about the nature of the new relationship with the health sector.

Participants also expressed the importance of reorientating the health sector to better facilitate intersectoral action. There was a realization that issues impacting on the health and well-being of the population are often beyond the scope of responsibility and the financial limitations of the health sector. To address the issues that impact on health intersectoral collaboration is necessary. Frontline staff were particularly vocal about the need to work with other sectors to promote health.

Development of the concept of health promotion

External Drivers

Externally driven programs and activities were viewed as heavily influencing the concept of health promotion in Fiji. The concept of Healthy Islands was established through a series of regional meetings that commenced with the World Health Organisation sponsored Yanuca Island Declaration in 1995[5]. Participants felt that this Declaration and subsequent commitments disproportionately focused on the importance of the physical environment as a key factor in health and well-being. This focus led to Environmental Health Officers being assigned control over the implementation of strategies arising from the Healthy Islands concept. Around the same time, the processes and strategies of health promotion were introduced to Fiji as part of two donor funded programs, the Kadavu Rural Health Project and the Trilateral Health Promotion Project. Both 'Healthy Islands' and 'health promotion' were seen by participants as new paradigms introduced to replace existing primary health care and health education models.

Participants indicated that the simultaneous introduction of the closely related but different concept of Healthy Islands and processes and strategies for health promotion created some confusion and tension among staff within the health sector over the framework for improving the health of the Fijian population. This confusion hampered progress in implementation and in establishing a broader platform for activity that engaged all sectors of the health system.

Participants described a process where the Healthy Islands concept and the processes of health promotion were eventually merged under the banner of the concept of health promotion.

Environmental health sector

The environmental health sector was seen to strongly associate itself with the concept of Healthy Islands. Participants indicated that the commitment of the environmental health sector to the Healthy Islands concept and led to a concept of health promotion that focused extensively on the settings approach of health villages and healthy communities. It is at this local level that activities to empower communities, build knowledge and skills and reorientate the health sector were being undertaken by Environmental Health Officers.

Due to their dominance of health promotion, staff within the health sector saw environmental health officers as the deliverers of health promotion. The demarcation of responsibilities within the health system was seen

to perpetuate this perception by placing all formal responsibilities within the key action areas of Environmental Health Officers.

National Centre for Health Promotion

The National Centre for Health Promotion (NCHP) was seen as the group responsible for the overall direction of health promotion activity in Fiji. Although most implementation activities are undertaken by Environmental Health Officers, health promotion expertise and advocacy activities are recognized as the domain of the NCHP. They are viewed as both the owners of the health promotion concept and the holders of health promotion knowledge. As with other parts of the health promotion effort in Fiji, the NCHP is dominated by staff from with backgrounds in environmental health.

Participants indicated that the NCHP has found it increasingly difficult to control and direct the health promotion effort in Fiji due to its small staffing numbers and the geographical distances between health sub-divisions. There is a recognition that for the concept of health promotion to be effective the NCHP need to broaden the involvement of other specialties within the health sector.

Ministry of Health

Participants indicated that the Ministry of Health has attempted to frame the concept of health promotion through strategic plans and mission statements that outline priority areas for action. Formal documentation within the Ministry of Health point to health promotion as one of the key pillars of activity within the health sector. While this creates a context and framework for health promotion action, participants expressed a view that there was a substantial difference between the rhetoric of the Ministry of Health and activities actually undertaken. Participants indicated that the dominance of the environmental health sector continues to skew health promotion activities towards environmental health issues and limits the activities relating to other priority health issues specified in key Ministry of Health documentation including non-communicable diseases, mental health and injury.

The pigeon-holing of health promotion into an environmental health function presents a significant barrier to broader sectoral approaches to promote health.

Implications of the current concept of health promotion
Pigeon-holing of health promotion into environmental health

Participants indicated that the strong linkage between the concept of health promotion and the environmental health sector has been a stumbling block to embedding health promotion into the responsibilities of a wider pool of staff within the health sector. In particular, as a result of the prominent role of the environmental health sector, health promotion activities have disproportionately focused on environmental health issues, specifically sanitation and water supply. The pigeon-holing of health promotion into an environmental health function presents a significant barrier to broader sectoral approaches to promote health. This has limited the ability of the health sector to extend from local actions to broader intersectoral and policy activities. Participants reported that it has also created the unintended difficulty of other members of the health sector viewing health promotion as outside of their responsibilities and therefore not requiring their contribution. There is a recognition within the health sector that for health promotion to extend beyond environmental health there needs to be a substantial and prolonged engagement with a wider range of staff within the health system regarding their role in health promotion action. Staff within the health sector remain unclear about their roles and contribution to health promotion activities. Needs analysis and planning approaches are viewed as lacking flexibility and insufficient in their consideration of issues outside of environmental health. This perception creates an obstacle to the development of health promotion activity that has the required scope and reach to deliver effective outcomes.

Demarcation of responsibilities

Participants reported that one of the purposes of facilitating participation is to transfer the responsibility for health promotion activities to the community. This is a common theme reported across the health sector that has its roots in trying to empower communities to be proactive and address their own needs and move them away from a dependence on government. However, the enthusiasm to ensure the involvement and participation of community members in health promotion has led to the perception that 'people are responsible for their own health'. Participants indicated that his approach shifts accountability and responsibility for health promotion activities away from the health sector towards community members. It also makes it possible for staff to assign difficulties associated with implementation of particular programs to a lack of capacity or understanding within the community.

Where implementation efforts are unsuccessful communities are seen to be 'delaying and not cooperating because they didn't grasp the concept'. The response to the failure of health promotion activities in local settings is mixed. Some health sector staff are mystified by the lack of uptake in the community 'we have tried to get across…that health is not just the Ministry of Health's business it's everyone's business'. Others recognised that the shift in responsibility to communities has happened too quickly for many communities who lack the confidence and capacity to undertake health promotion activities independently of the health sector. There is also a growing perception that the transfer in responsibility to communities has not been supported adequately by processes and structures for monitoring and support. Communities that have been able to take on responsibility have had long-standing support that is readily available and proactive at critical times. It was recognized that communities require prolonged engagement with the concept of health promotion and genuine opportunities to build the necessary knowledge and skills. Participants indicated that without continued impetus provided by the health sector, activities 'fizzle out'. Effective

interaction is focused on facilitation and mobilisation skills. To transfer responsibility for activities before the community has had the opportunity to develop sufficient capacity and understanding was identified as a significant risk to effective implementation.

Health sector skills and capacities

The shift away from health education and direct service provision towards partnership and facilitation has created tension within the health sector over the new skill sets and knowledge required to be an effective facilitator and empower communities to exert control over their own health. Participants indicated that this new role sees some health staff who lack the confidence and skills to perform in a facilitation role subsequently handover all responsibility to communities. This is compounded by the limited access in regional areas to health promotion expertise and advice. It was indicated that formal communication is slow and often ineffective leading to a fragmented system where staff have different conceptions of the role of a facilitator for health promotion.

Participants described opportunities for the development of health promotion skills and capacities as limited. Training and implementation are often combined. In many cases staff within the health sector are learning the concepts of health promotion as they are given the responsibility for planning, implementation and monitoring. This often leads to staff feeling overwhelmed and overburdened. The elements of the concept of health promotion that involve enabling staff and community through development of appropriate skills and experience are not adequately realized.

Unsupported, health promotion 'fizzles out' in local settings. There is a gradual reduction in the quantity and frequency of activity until it ceases completely.

Engagement with health promotion within the health sector

The enthusiasm for the concept of health promotion varies substantially across the health sector. Participants with a long-standing involvement and engagement with health promotion and strong linkages with the National Centre for Health Promotion indicated a strong commitment to health promotion. Staff that were isolated from the National Centre for Health Promotion, had limited opportunities for interaction and discussion of health promotion and limited experience with the concept showed a very low level of interest. The National Centre for Health Promotion plays a strong advocacy role in supporting the development of a commitment to health promotion among staff within the health sector.

A further factor impacting on the enthusiasm of staff was their traditionally perceived roles. Environmental Health Officers have been traditionally responsible for protecting the community from health risks. To shift the role of Environmental Health Officers to a new partnership approach where the knowledge, attitudes and decisions of the community hold substantial power and influence was seen by some as a challenge to their authority. Participants that had limited opportunities to develop capacity for health promotion were more comfortable reverting back to their traditional roles rather than focusing on mobilizing communities and building capacity. Health promotion is seen by some environmental health officers as a new approach that is at the periphery of their work. The core of their activities is seen to be protecting the community from health risks.

Counteracting the lack of engagement with the concept of health promotion was group pressure for action applied by staff within the health system. Where advocacy for health promotion from the National Centre for Health Promotion had been effective and engaged a broad spectrum of staff across a specific regional area a strong base of support for health promotion was established. Environmental Health Officers and other responsible staff were then given a new context for action as now there performance in health promotion was being judged directly by their peers.

Intersectoral action

The statement that 'health is not the Ministry's business it is everybody's business' is frequently cited by health sector staff at all levels to indicate the importance of working together for health outcomes. However, this view is not widespread outside of the health sector. Where staff from other sectors recognize the importance of their involvement in health, this involvement is often disrupted by the priorities of their own sector and the performance measures to which they are held accountable. Although the health sector places health promotion at the centre of development in Fiji, other sectors are not yet willing to do so.

Participants outside of the health sector indicated that the terminology of the concept of health promotion is laden with health specific concepts and perspectives while acknowledging the important links between health and other sectors. It was felt that communication of the concepts of health promotion needed to be reorientated to a discussion that emphasised the higher order social and economic objectives and removed any health bias. The effect of this shift in presentation of the concept of health promotion is to move responsibility away from the health sector and create a context for shared responsibility for a range of social and economic objectives that are at the core of Fijian development.

Cyclical nature

Unsupported, health promotion 'fizzles out' in local settings. There is a gradual reduction in the quantity and frequency of activity until it ceases completely. Participants described a cycle of health promotion activities whereby there was often widespread enthusiasm and support for the concept of health promotion following training and capacity building activities. However, this initial enthusiasm slowly drained away when support was not continued and sustained at key times. There was a view that this was in part caused by the externally motivated and directed nature of the

concept of health promotion. Local staff and community members are given limited opportunities to internalize and own the concept of health promotion during training and development opportunities. A similar situation was expressed by participants even in the prolonged engagement associated with donor funded projects including in the Kadavu Rural Health Project and the Taveuni Rural and Community Health Project where participants indicated that local staff and communities were driven externally and as a result health promotion activities were significantly reduced in the absence of these external drivers.

Participants indicated that follow-up and support at key times during the cycle of health promotion activity was required to sustain implementation and ensure ongoing activities to promote health. This follow-up and support was only likely to occur when the concept of health promotion was embedded in the work of locally based staff both through formal recognition and performance measures as well as the informal expectations of both staff within the health sector and community members. These informal responsibilities were especially important in geographically remote areas with limited communication networks and linkages with other parts of the health sector.

Discussion

Participants described a concept of health promotion in Fiji that provides a sophisticated and effective framework for action to improve health. The immediate implication of this paper is that participants view the processes and structures for health promotion in Fiji as currently insufficient to fully implement the concept of health promotion articulated. In particular, the call for health promotion to be at the center of development is not matched by the action required at a regional and national level, the building of staff and community capacity is often ineffective in its current sporadic and intermittent form and the reorientation of the health sector has been hampered by the perception of the health sector as service providers rather than facilitators. Participants indicated that these difficulties can be traced to several factors including, the over reliance on the environmental health sector to direct and implement health promotion activities, the lack of confidence of staff to act as facilitators and the limited capacity of communities to plan and undertake health promotion activities independently.

This study has several methodological limitations. Firstly, it was not possible for an independent coder to analyse the data collected. Instead, frequent meetings were held with key informants to test emergent understandings and interpretations arising from the data. Secondly, interviews with participants were retrospective and conducted only once for most participants. Health promotion is the subject of extensive activity and reforms in Fiji and the concept of health promotion along with implications for action are constantly evolving. The study would benefit from examining the changes to the concept of health promotion over time to better elicit the trends in its evolution in Fiji. Thirdly, the English language was used in all interviews. None of the participants indicated any difficulties in being interviewed in English, however, for some it was a second or third language. The use of a Fijian interviewer would benefit future research.

Conclusion

To fully implement the concept of health promotion in Fiji, more attention needs to be given to the processes and structures that direct and support health promotion action.

Specifically, there is a need to develop strategies that provide required inputs during the implementation of health promotion activity by engaging relevant sectors, investing sufficient time and resources into building staff and community planning and implementation capacity and better defining organisational responsibilities.

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References

1. WHO. The Ottawa Charter. 1986. Available from http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
2. WHO. Bangkok Charter for Health Promotion in a Globalised World. 2005. Available from http:// www.who.int/healthpromotion/ conferences/6gchp/bangkok_charter/en/
3. International Union for Health Promotion and Education. The evidence of health promotion effectiveness : shaping public health in a new Europe : a report for the European Commission by the International Union for Health Promotion and Education. Vanves, France : International Union for Health Promotion and Education; 2000
4. WHO. New Horizons in Health. Manila: Regional Office for the Western Pacific; 1995.
5. WHO. Yanuca Island Declaration. Manila: Regional Office for the Western Pacific; 1995.
6. Nutbeam D. Healthy Islands—a truly ecological model of health promotion. Health Promotion International. 1996; 11:263–264.
7. Australian Agency for International Development. Developing Integrated Rural Health Care Systems: An evaluation of the Kadavu Rural Health Project in Fiji. 2000. Available from http://www.developmentgateway.com.au/jahia/Jahia/pid/1922
8. Ulin P, Robinson E, Tolley E. Qualitative methods in public health : a field guide for applied research 1st Edition. San Francisco: Jossey-Bass; 2005
9. Strauss A, and Corbin J. Basics of qualitative research : grounded theory procedures and techniques. Newbury Park: Sage Publications; 1990