The Role of Policy in Health Promotion - Fiji

Graham Roberts*

Litiana Kuridrani**
*Corresponding Author, PhD, Associate Professor. Email: g.roberts@fsm.ac.fj ** MBA, Department of Public Health, Fiji School of Medicine, Suva, Fiji. Email I.kuridrani@fsm.ac.fj*

Abstract
Our health is impacted by many sectors. The improvement of population health and productivity requires a broad understanding of human ecology and the social determinants of our health. Influencing change across many sectors requires a level of expertise that is currently missing from Pacific health systems – policy advocacy. National health promotion councils or coordinating bodies need to work across and within many sectors – not only the health sector – to bring about wide-ranging changes to our civil and social arrangements.

Introduction

Health promotion is not only a health sector issue. Activities in other sectors impact on population health. The most obvious historical example is warfare – but most social activity affects us in one way or another. Where activities are formalized in the policies of other sectors, health promoters should advise on the potential impacts they will have, but currently we do not. In Fiji, a document entitled Recommendations for Policy to Support Health Promotion in Fiji (1998) includes recommendations that do identify this role, but which have not been acted on:

- "That the National Health Promotion Council be responsible for the development, implementation and review of policy to support health promotion in Fiji, and;

- That the National Health Promotion Council develops for the Government of Fiji a National Health Promotion Policy to coordinate action across sectors"[1].

This paper proposes a policy approach for consideration and adoption by bodies that are responsible for national health promotion activities. The example used is that of Fiji's National Health Promotion Council. It commences from the position that such councils are, by design, multi-sectoral groups with the potential to influence change in a wide range of government and non-government social and health related areas.

Yet governments tend to operate on a 'silo model' of policy and implementation and provide scant budgetary support to cross-sectoral activities and to the non-government sector. This approach to funding limits the ability to work across sectors. Integrated initiatives and programs are seen from within sectors as non-core activities that could threaten sector-specific budgets and functional autonomy. In this sectored environment we see the formation of other committees and groups with specific interests, but which could all be considered under the rubric of 'health promotion'. In such an environment a national coordinating council has difficulty in determining a role for itself.

> *They need advocates to speak for them, mediators to negotiate for them and enablers to provide them with skills.*

All Council member organizations are engaged in health promotion in one form or another. The definition that brings them together is that *'health promotion is a process of enabling people to increase control over and improve their own health*[2].

Most aspects of social, public and private endeavor impact on our health. This *'process of enabling'* requires action by and for people at all levels of society. While some people are able to *'increase control over and improve their own health'*, others are not. They need advocates to speak for them, mediators to negotiate for them and enablers to provide them with skills.

From this viewpoint, a national council has the responsibility to provide health promoting regulations, systems and information for people who can use them to their own benefit, *and* to advocate, mediate on behalf of and enable those who cannot. This approach requires engagement in a range of activities across many sectors, not only to promote health, but to remove or reduce the *obstacles to health* inherent in our social structures and civil arrangements.

Background to the National Health Promotion Council - Fiji

The Council in Fiji is chaired by the Minister for Health. Formally, it is a committee established by the Minister with invited membership from a range of public sector bodies, statutory authorities, NGOs and civil society organizations. The Council is supported in its objectives by a Secretariat staffed by the Ministry of Health and resourced with various media production technologies; and comprising 4 Sub-Committees on Policy, Research and Evaluation, Social Marketing and Community & Organizational Development.

Guiding Framework and Planned Action

The Ottawa Charter for Health Promotion (1986) is a widely accepted framework for the development of national health promotion plans. The Ministry of Health has endorsed this

approach and uses it widely, as do other Pacific nations. The Ottawa Charter is used herein to present our ideas and to make proposals within a well-used and widely-understood framework. The Ottawa Charter has five components: *Building healthy public policy, strengthening community action, creating supportive environments for health, teaching personal skills and reorienting health services.*

This paper deals with the first of these - *building healthy public policy* - as the principle role for the Council, and uses the other components, particularly *creating supportive environments for health* to guide the implementation of a proposed National Health Promotion Policy. In the process of developing the policy we reviewed the publication *Recommendations for Policy to Support Health Promotion in Fiji* (1998)[1].

The Social Determinants of Health

This discussion is based on the proposition that promoting the health of human populations requires a broad understanding of human ecology and how humans flourish in the natural world. Some may see this as too broad a vision for health promotion, but with this view we can accept that maintaining human health largely depends on favorable environmental and social factors. Organic factors account for the rest, but many of these also have their origins in environmental insults, or in unhealthy social behaviors or choices. Effective health promotion must, therefore, actively influence the social factors that determine the health of populations and the range of choices available to people.

The WHO Charter defines 'health' as a *"complete state of physical, mental and social wellbeing"*, to which we, in Fiji, add 'spiritual' wellbeing and 'economic' wellbeing. In this paper the concept of 'social wellbeing' is used broadly to include economic wellbeing. The term 'spiritual wellbeing' does not imply conformity to any religion, but is used as an expression akin to 'harmony with our faiths, ourselves and our environment'.

The WHO Charter defines 'health' as a "complete state of physical, mental and social wellbeing", to which we, in Fiji, add 'spiritual' wellbeing and 'economic' wellbeing.

The knowledge that health is closely related to social conditions is ancient. So is the notion that 'the safety of the people is the highest law' (Cicero, c 60AD) and is achieved through social organization. More recently, McKeown (1976) has shown that the main driving forces behind declining mortality in the modern era were improvements in food supplies and living conditions[3].

Evidence now shows that most of the global burden of disease and the bulk of health inequalities are caused by the social determinants of health[4]. Population health can be described on a 'social gradient' where the wealthier suffer less morbidity and live longer than others, not only the poor. Factors such as stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport have all been shown to impact on our health, and all of these are related to social conditions.

Clearly, achieving 'health' requires activities well beyond influencing individuals to change their behaviours. Achieving 'health' requires policy change and activity in, and well beyond, the health sector. Accordingly, the policy direction proposed below is designed to produce policy changes in the many sectors that influence the conditions of our lives.

5. Secular Trends

The term 'secular trends' is used to describe the social changes that occur over time, arising from a mix of influences, including education, urbanization, advertising and market forces. They are most easily visible in changing fashion trends, changing social norms of behavior, uptake of new technology, use of work and recreational time and changing expectations for the future. Secular trends are very powerful and can have either positive or negative effects. The social reaction to passive smoking was a positive secular trend, while the increase in resort to violence among Pacific youth is clearly a negative secular trend.

The important point for health promoters is to identify and use positive secular trends thematically (see below), and to be aware that reversing negative secular trends requires intensive resources and regulatory action across many sectors. It also means that health promoters need to be 'doubly clever' in their selection of strategies and methods to influence a trend at strategic moments and points. We need to be poised and ready to do that.

Intersectoral Action in Health (IAH)

This paper proposes that national health promotion councils become active in public policy development on the social determinants of health. Impressive health and social welfare gains are possible in countries with low GDP per capita. Countries that have successfully implemented 'social determinants health policy' (e.g. Cuba, Sri Lanka, Costa Rica and others) have shared 5 social and political factors[5].

1) A Historical Commitment to Health as a Goal

2) A Social Welfare orientation to development

3) Community participation in health decision making

4) Universal coverage of health services (equity)

5) Intersectoral Linkages for Health

But not all countries exhibit these five features. In Fiji we have asked ourselves the following questions and answered them.

Are we committed to health as a goal for our people? We seem to glorify our youths' sporting achievements but adults maintain relatively poor health and use health services at last resort.

Is our national development orientated to social welfare? We seem to be focussed on economic development while and our social welfare problems continue to grow.

Do we encourage community participation in health decision making? Yes, but much of it is passive participation. The use of the 'settings' approach is strengthening active participation.

Do we have universal health coverage? Yes, we are quite good at it despite geographical difficulties, but we base it on low hospital costs and Medical Superintendent's discretion to waive fees.

Do we have strong intersectoral links? We seem to be developing in separate sectors, although society itself is relatively seamless.

Rosenfield (1985) found that IAH was the weakest component of the strategies associated with 'Health for All by the Year 2000'[6]. We know now, in 2007, that 'health for all' was not achieved – far from it. IAH was found to be weak when it was implemented in isolation from the other 4 factors. IAH also suffers from difficulties in providing evidence of its effectiveness, due to the complexities of measuring the many social processes that affect our health. As mentioned above, there are few budgetary or economic incentives for IAH.

> *The effort is and should be multi-pronged and as diverse as the many health and social welfare interests that emerge.*

With Rosenfield's analysis we can identify why we have struggled with IAH here in Fiji. We must strengthen the factors in which we are weak: our commitment to health as a social goal; our national development orientation, active community participation and intersectoral linkages.

A role for a national council clearly emerges: *policy development to strengthen health as a social goal, reorientation of our national development towards social welfare, and improving the active participation of the community and their organisations.*

Accepting the many emergent interests of civil society does not mean a fragmented national health promotion effort. The effort is and should be multi-pronged and as diverse as the many health and social welfare interests that emerge. For the Council to play an effective role in assisting all of these diverse interests it will need to operate at a higher level of influence and provide a channel of communication for them all. Only then may we expect some enthusiasm for IAH - when diverse interest groups find value in working together towards achieving common goals.

What Strategies?

The proposed role has several features we need to consider carefully. It is necessarily 'political' in its need for social adjustments and increased equity. As such, it questions the notion that market forces alone will solve our social ills and health problems. It is comprehensive in scope in that it acknowledges that policy change in many sectors impacts on the health of the whole population. Yet it also acknowledges that, despite limitations in delivery, selected and specific health and disease information is needed by the general community to assist people to make healthy choices.

It seems then that a national health promotion council and its members must engage in strategies at three levels; comprehensive national policy development, community participation in social change, and the provision of selective disease orientated information for individuals.

The Selective Approach: Should we focus on a small number of cost-effective time and resource limited interventions?

Strong evidence now shows that community–based health promotion campaigns have small effects for only short periods[7]. Merzel and D'Afflitti (2003) conducted a review of 32 community-based prevention programs implemented over the last 2 decades in the United States. They start with the uncomfortable fact that many community health promotion programs have *'produced only modest effects in changing population risk behaviors'.* The majority of large well-designed programs for cardiovascular disease and smoking cessation produced only small, short-lived effects.

The evidence for success is poor indeed, partly because of the limited ability to evaluate campaigns. But the exception to this appears to be in diseases where the consequences of acquiring it are both immediate and large. Merzel and D'Afflitti identified three main contributing features of successful HIV prevention programs, which, interestingly, did *not* including the provision of information alone.

Emphasis on modifying social norms to change the social context in which health risks occur.

Use of formative research to continually adapt a program to the needs of the recipients.

Understanding the nature of the risk, which tells us that people can perceive and act on the difference between immediate risks with serious consequences from few actions; and, long-term risks that may or may not happen even after taking the risk many times.

Their findings suggest that if we are to conduct community-based campaigns in Fiji we ought to focus our activities on the social context in which risks occur – and not just behaviour change. Again, even in proposing selective interventions we are pointed towards activities that will change the *social determinants* of risk taking behaviour.

A Mixed Selective/Comprehensive Approach: Should we apply comprehensive approaches in selected settings?

The application of the 'settings approach' falls between selective interventions (such as a health promotion campaign) and comprehensive interventions (such as policy change). It is selective in that it selects one setting (e.g. a school or a market place) within a community; and, comprehensive in that it addresses a wide range of health policy issues within the selected setting.

Its inherent limitation is that it is selective. Not all schools and market places within the community are involved, although in time they may be. But its strength lies in community participation, one of the 5 factors identified by Rosenfield

(1985)[6]. But the greatest risk to the 'settings approach' is that participation may be passive rather than active.

The Kadavu project (Roberts 1997) demonstrated that the active involvement of the community's legitimate structures was critical to the project's success[8]. *"The essential activity was to provide information on village health issues to people who were endorsed to make decisions within existing local government and traditional structures"*. The Kadavu Project provided a model upon which much of the application of the settings approach in Fiji has been based. Already, successful and unsuccessful projects are distinguishable by their degree of active community participation.

Proposed changes to the administration of Fiji's Provinces now lend themselves to broadening the settings approach along with the decentralization of development. Strengthening provincial administration provides a greater opportunity than previously for the application of the settings approach to entire provinces, not just to the institutions within them. In this way the selective settings approach would become more comprehensive and could steer the development of provincial and national policy towards social welfare and achieving health as a social goal.

A Comprehensive Approach: Should we address the social roots of unfair and avoidable human suffering?

If a national health promotion council is to contribute to addressing the social determinants of health it must become involved in comprehensive, high level policy strategies. Yet this is possibly the Fiji council's weakest point. To date the Council has not become involved in the broad debate on the direction of national development, yet it does have the potential to provide a powerful influence.

Before it can make effective contributions to national policy orientation and development the Council needs to strengthen itself in three areas: strategic positioning, policy advocacy and policy expertise.

Strategic positioning

The Council is strategically well-positioned but it remains an invited committee of the Minister for Health and with no substantive authority of its own. Although the Council is chaired by the Minister it does not yet have any representation on the Cabinet Sub-Committees or Task Forces. This is where policy is debated and prepared prior to submission to Cabinet and, as such, it represents the Council's best opportunity for strategic influence.

Policy Advocacy

Advocates create winning arguments and present them to people in position to influence a decision. Advocacy is a 'small p' political activity in that it is not party political; it serves to present the concerns and proposals of interest groups to decision makers, regardless of political alignment. The skill of advocacy is to remain unaligned and to build constructive relationships with everybody.

In health promotion, where we talk of 'changing the social determinants of health', it becomes easy to confuse a concern for the safety of the people with the socialist side of politics. Already in this discussion we have made comment on the limitations of the economic focus of neo-liberalism to produce short-term health and social outcomes. Advocacy is a skill that maneuvers through such political traps and concentrates on representing the concerns of the interest group, regardless of the political orientation of government.

Fulfilling such a role is easier from the position of a corporate body or a statutory authority than from a government Ministry. Public sector employees can be constrained from advocating policy change. This is one reason why we propose that health promotion councils need to be independent of government - and also a reason why health promoters need to be brave people. By *'leaving policy to the policy makers'* we limit our ability to influence change in the social determinants of health.

Policy Expertise

Health promoters in the Pacific are quite limited in policy analysis expertise. Until this is strengthened they are unable to contribute much in the way of policy advice or impact analysis. Young policy analysts start by drafting policy from guidelines and learning how the national policy process works. With more experience they learn to read the secular trends, the social climate, the mood of government and the potential for particular interests to be progressed or delayed.

So, what would these experts do? In terms of the 5 areas of the Ottawa Charter they would represent health promotion concerns in the following ways:

Public Policy Development. Engaging in cross-sector policy advice through Cabinet Sub-Committees and Task Forces and through formal and informal liaison between government and non-government organisations.

Creating Supportive Environments. Providing information to all levels of government on issues related to health and productivity, in order demonstrate the economic importance of healthy populations and to encourage national commitment to health as a social goal.

Strengthening Community Action. Strengthening of urban, provincial, district and village level participation in health promotion and social welfare.

Teaching Personal skills. Teaching leaders, policy-makers and senior officials the methods to calculate the health costs and benefits of their policy proposals. Teaching advocacy and collaboration skills to health promotion champions in government and non-government.

Reorienting Health Services. Advising government and the Ministry of Health to work to a broader definition of 'health work' in order to also address the social determinants of health.

> *Advocates create winning arguments and present them to people in position to influence a decision.*

Councils would need to budget for engaging such expertise or build it into their staffing arrangements. But more importantly, councils will need to lobby government for the inclusion of such expertise, wherever it is sourced, in the policy development process. A minimal outcome would be for Cabinet to require policy proposals to be vetted by health promoters for their cross-sector potential for adverse health and/or social impacts.

Engagement in the Public Policy Process

Public policy is developed by government bodies and officials for purposive action by or for governments. It includes subsequent agreements related to its resourcing, implementation and enforcement. To succeed in achieving an impact on a problem, public policies require components of community education and enforcement, which may, in turn, require organizational changes to resource and implement. Seen in this way policy is far more than a mere statement of intent.

It is recommended that:

> **Recommendation 1.** Pacific health promotion councils identify personnel to be trained or engaged in advising governments on the role of the social determinants of health in population health and national productivity.

> **Recommendation 2.** Pacific health promotion councils place representatives on government's policy development committees and relevant task forces.

> **Recommendation 3.** Pacific health promotion councils' public policy advice places emphasis on policy being conducted as *a set of activities* that includes policy definition, community education and the allocation of resources for effective implementation and enforcement. (A public policy should not be considered 'in place' without all of these components operating).

Regulation

The approach of 'regulation alone' has several notable failures in Fiji. Recently, it came to light that there had been no prosecutions under the Tobacco Control Act and the sale of cigarettes to minors was continuing. Seat belt legislation has not been enforced. Dangerous products like paraquat are still available 'off-the-shelf'. Excessive motor vehicle exhaust emissions continue to pollute our daily lives. Yet there is ample evidence from elsewhere that regulation, public education and enforcement together do work to reduce illness and trauma.

These failures of 'regulation alone' underpin the approach suggested above; that the public policy process is a *set of activities,* and more than the mere passage of a piece of legislation or statement of intent.

Episodic interventions

These usually take the form of community-based campaigns designed to inform people of a specific health risk and to propose alternative behaviours and choices. Episodic interventions are normally time and resource limited. Ideally, they are evaluated during and after the episode, but commonly they are not evaluated at all. An example is an anti-smoking campaign targeted at youth, which may run on television and radio for a defined time. These are the 'health promotion campaigns' we are all familiar with.

But the 32 campaigns reviewed by Merzel & D'Affliti (2003) suggests that episodic interventions have very limited effects and for only a short time, and that they need to be developed according to the nature of the disease and the immediacy of the risk. Different strategies are needed to address different problems. 'Campaigns' should take several forms and be tailored to the needs of the hearer.

'Campaigns' should take several forms and be tailored to the needs of the hearer.

The diversity of the population of Fiji extends well beyond the 3 languages and cultural groups. It is simplistic to think that there are only three major population groups in Fiji. Within each there are further sub-divisions, all of which are complicated by varying stages of development and issues of access, religion, literacy and age. A single 'health campaign' in Fiji has far less potential to reach all groups than in a more homogenous society. Targeting messages to particular groups and then tailoring it to their needs may be more effective than broad based community education campaigns.

But Merzel & D'Affliti also draw attention to the methodological difficulties in evaluating community-based health campaigns, in particular in accounting for the powerful effects of secular trends. he anti-smoking campaign in Pawtucket demonstrated an 8.9% decrease in smoking, but in the comparison city smoking decreased by 8.2% due to an anti-smoking secular trend. The secular trend was far more powerful than the campaign.

Thematic interventions

These attach themselves to secular trends and social concerns, such as safety, family values, pollution or human rights. For example, 'passive smoking' campaigns succeeded because they attached to the issue of the rights of non-smokers - to clean air. The competing rights of smoker and non-smokers were 'weighed in the balance' and smokers were seen to be intruding on the rights of others. So now we have non-smoking zones in restaurant, public transport and offices. Thematic approaches appear to be more successful that episodic, especially when backed by regulation. Thematic interventions may also take the form of community campaigns, but they need to be sustained until the attached thematic issue has achieved wide social usage. One of the current anti-smoking campaigns *'What don't I do? - smoke'* is attaching itself to the youth theme of 'being cool'.

It is recommended that:

> **Recommendation 1.** The choice of health promotion strategies and methods are informed by social marketing research that identifies and utilizes secular trends, thematic interventions and strategic opportunities.

> **Recommendation 2.** Health promotion campaigns are targeted to specific population sub groups and then tailored, through formative research, to be delivered in modes that best meet their needs.

Conclusion

This paper supports the idea that the first objective of health promotion councils should be 'to promote health and prevent illnesses', but it proposes that, to do this effectively, councils should be involved at high levels of national policy development. To date, the Council has not had the expertise or vision to provide policy advice to government or to advocate for its interest groups at the political level.

The question for the Council to consider is whether, or not, it sees policy involvement as a role for itself. If it does, it will need to do it well enough for its members and the many other health and social welfare organizations to perceive value in associating with the Council to further their own objectives. If it doesn't see a role for itself at the policy level it is left with little else but to support its technical staff. Attempting to coordinate the activities of its various organizational members would be a thankless, difficult and needless task. But if the Council does see policy level involvement as its role, it will need to prepare for it by identifying or training policy analysts and advisors and by lobbying government for positions on, or access to, policy development sub-committees and task forces.

The need for policy advice to influence these trends in the social determinants of health will continue to be needed, and, until provided,...

Whatever the Council decides, the secular trends impacting on Pacific populations will continue to produce both negative and positive health effects. The need for policy advice to influence these trends in the social determinants of health will continue to be needed, and, until provided, will leave the Council and the MoH 'holding the wrong end of the stick' – trying to overcome negative effects after they have occurred.

Positive secular tends offer some hope that the value of health will increase as an individual and social goal. But even positive trends need to be mediated and facilitated if they are to last into the future as new social norms. Regulation needs to follow and to be resourced.

But above all, if the Council does not accept a role at the policy level, it will have compromised two of the most important principles of health promotion – advocacy for those unable to speak for themselves, and the intersectoral collaboration needed to address fundamental human issues that 'transgress' the artificial boundaries of governments, agencies and even countries.

References

1. Health Promotion Policy Advisory Committee, Recommendations for Policy to Support Health Promotion in Fiji, 1998, Ministry of Health

2. Ottawa Charter on Health Promotion, WHO Geneva, 1986. http://www.who.int/hpr/backgroundhp/ottawacharter.htm

3. McKeown (1976). the Modern Rise of Population. Academic Press, New York

4. Wilkinson R & Marmot M (eds) The social determinants of health: the solid facts, 2nd edn, WHO Geneva 2003.

5. Commission on Social Determinants, Action on the social determinants of health: Learning from previous experiences, http://www.int/social_detrminants/en/ ,WHO, 2005.

6. Rosenfield P. (1985). The contribution of social and political factors to health, in Halstead S, Walsh J, Warren K (eds), New York Rockefeller Foundation 1985, pp 173-85, cited in Action on the Social Determinants of Health: Learning from previous experience, Secretariat of the Commission on Social Determinants of Health, WHO 2005 Geneva.

7. Merzel J. and D'Afflitti J. Reconsidering Community-Based Health Promotion: Promise, Performance and Potential, American Journal of Public Health Vol. 93, No4 April 2003

8. Roberts G. The Kadavu health promotion model, Fiji: Health Promotion International, Vol. 12, No. 4, 1997. pp283-290