Public Health And Community Health Education In South Africa

Dr. Daleen Koen

Christian Higher Education,Potchefstroom University, South Africa

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1. INTRODUCTION

The term public health is used today when the health of a population is referred to. Before we look at public health, we should know the meaning of health. It is, however a difficult concept to define. The World Health Organisations definition of health, states that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity (WHO Constitution 1947).

Health, in this context, is placed in an idealistic sphere that is unattainable in everyday life. It also implies a static, rather than a dynamic, situation. Critics of this definition see health as the ability to adapt continually to constant changing demands and stimuli. Betty Neuman, a health theorist in nursing, created the Neuman system model in which health is compared with a state of wellness, viewed on a continuum, (Neuman 1990: 129).

The definition of health however differs along professional lines as well as by culture and age, in other words how you view health is determined by where you come from. Public health can be described as what we, as a society, do to assure the conditions for people to be healthy. It is more than the delivery of health services to the community, it comprises the sum total of all health services as well as all the activities required to meet the populations health needs. It involves governmental, non-governmental, private and individual initiatives. It refers to a comprehensive health care system that provides all people with maximum health benefits, (Dennill *et al,* 1999: 3).

The modern public health system has been shaped over the last 150 years. The two factors that have had the most influence on this development are the growth of scientific knowledge about the sources of disease and the means of controlling these diseases, and secondly the acceptance by the public that disease control is possible and a public responsibility, (Institute of Medicine, 1993: 56). There is a new public health that is based both on scientific discoveries and on social action, which go far beyond disease control and implies an integrated and co-ordinated system with promotive, preventive and curative components.

There are many new threats to the health of the people of the world, such as the AIDS pandemic, injuries as a result of trauma, chronic illnesses, and the toxic by-products found in industrialised countries to name a few. In addition the old threats of lack of safe water, poor sanitation and many others still need to be addressed in the developing countries. All of these factors need to be dealt with through effective, organised and sustained efforts. The total environment, physical, social and economic need to be addressed, if optimal health is to be attained.

By the end of the 19th and at the beginning of the 20th century legislation was enacted throughout the western world which enabled and supported a comprehensive public health system. At this time there was a move towards personal care in the health systems, which marked a shift in public health from disease prevention, to overall promotion of health, (Dennill *et al*, 1999: 5). King (1996: 20) suggests that the following criteria should be included in any definition of public health. The criteria are that public health is population based, advocates a global and social model of health, requires an intersectoral and multidisciplinary approach, emphasises a systems approach to health management to harness the organised efforts of society to promote health and population empowerment.

South Africa, in 1999, remains a land of stark contrasts, between those that have and those that have not. A land where some people have amongst the best standards of living, and good health and access to health services and care, and where some have very poor living standards, a great deal of ill health and poor access to health care.

The life of a family in the rural parts of the Eastern Cape or the Northern Province differs considerably from the life of a family in Cape Town or Johannesburg not only in their day to day life but also with respect to their health. For example, around 30% of the children in the Northern, Free State and Eastern Cape Provinces do not grow to their

full potential, whereas around 10% of children in the Western Cape and Gauteng do not grow to their full potential. When one looks at these figures it is clear that rural Africans have the worst health status of all South Africans.

The WHO have identified five major pandemics which need to be targeted and their trends reversed in order to reduce the burden of disease. They are tuberculosis, HIV/AIDS, malaria, tobacco-related diseases and violence/trauma. South Africa, with the triple burden comprising poverty related diseases, chronic diseases of lifestyle and trauma has an enormous challenge to reverse trends in these five major pandemics. Data shows little sign of control in infectious diseases and suggests that there are extensive variations between the provinces in these pandemics. There is mounting evidence that South Africa is experiencing the fastest growing HIV/AIDS epidemic, with KwaZulu-Natal experiencing a prevalence of 27% in 1997 amongst pregnant women attending public sector clinics. Efforts to control TB are not yet succeeding and several provinces have exceedingly high rates. Malaria remains a problem in Mpumalanga and KwaZulu-Natal.

South Africa has entered a dynamic period of restructuring. It is clear that enormous inequalities in health need to be addressed. These revolve around urban/rural differences, population groups and poverty. Ambitious plans have been formulated that could lead towards improving the health of everybody, particularly the poor. The plans are consistent with the global targets for Health For All by the year 2020. However, it is a major challenge to implement these plans, particularly in the face of the rapidly growing AIDS epidemic. It is essential that the government develops a comprehensive strategy to deal with this tragedy and attempts to reverse the trend.

2. COMMUNITY HEALTH AS PART OF PUBLIC HEALTH

The communitys health is much more than the sum of the health status of all the community members. The community is an entity in its' own right, a unit that can be dealt with as a whole. The three different types of community referred to in health care are:

- people living in a specific geographical area
- people with the same interests

· people with the same needs or health problems.

Previously the definitions of community health emphasised the prevention of disease and the prolonging of life, whereas the later definitions talk of attaining the highest level of health and wellbeing.

Public health and community health have the same aims and objectives. They both strive to promote health and prevent disease, and to maintain the health of the public. Where they do differ however, is that in community health more emphasis is placed on the family and the individual, as units of care. The reason for caring for the family or individual is to attain the goal of a healthy community because each community contributes to the health and welfare of the nation. Public health focuses on the whole population, or a proportion of a population that has a specific problem, with the intention of improving the health and the welfare of the nation. Both community health care and public health require a multidisciplinary and intersectoral approach.

3. PRIMARY HEALTH CARE AND PUBLIC HEALTH

The basic philosophy and principles of primary health care are closely linked to the new public health. Both deal with equity and coverage, intersectoral and multidisciplinary approaches, community participation and health promotion as well as environmental aspects like safe water and sanitation. Primary health care is often individual centred, although like public health, the main aim is to attain optimal health for the community or total population. In primary health care, we formulate and implement policy intended to improve the health of the people, in other words primary health care must be focused on achieving targets that affect the health status of the community. The recent political changes in South Africa highlighted the need to transform and adapt a strategy of health for all and as a result our national health system is firmly based on the primary health care approach.

The concept of primary health care calls for radical changes in both the design and content of traditional health care services. It advocates an approach to health care based on principles that allow people to receive the care that enables them to lead socially and economically productive lives.

The definition of the concept as determined at Alma-Ata is:

Primary health care is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the countrys health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and word, and constitutes the first element of a continuing health care service, (WHO 1988: 15).

The essential care aspect of primary health care consists of eight basic components. These are listed under section VII of the Declaration of Alma-Ata, which states that any primary health care programme should include at least these components. They are:

- education about prevailing health problems and methods of preventing and controlling them
- the promotion of food supply and proper nutrition
- an adequate supply of safe water and basic sanitation
- maternal and child health care, including family planning and care of high risk groups
- immunisation against the major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- the provision of essential drugs.

Other components may and have been added to meet the specific needs identified by a community or country. Primary health care is the dynamic product of the community it serves, as it evolves from the economic, socio-cultural and political characteristics of that community and is based on the needs identified by that community. The development of the health sector alone will not have a significant effect of the health of the people as many needs will not have been met.

A comprehensive approach to primary health care is therefore necessary to improve the health status of the community. This requires that health care be part of national political and economic strategies, and through this process the population should find access to employment opportunities, education as well as better living and environmental conditions.

This is an intersectoral and multidisciplinary approach to health care.

Health systems need to be adapted to a more community-based or decentralised system, so that services become available to all.

There is a shift in the emphasis of health care from curative hospital-based care to community-based primary health care. The success of primary health care depends to a large degree on the communitys ownership of its health services.

Primary health care includes such diverse interventions it cannot be implemented by health workers alone. Different sectors have the different resources, skills and technology necessary for the attainment of a health community. It is said that civil engineers have a greater effect on the health of people than health professionals, because of the part they play in supplying the community with safe water and sanitation.

There should be multisectoral input in determining policy which impacts on health or the environment. For example, the health of a community can be affected both beneficially and adversely by the building of a large dam in their area. To enhance the benefit of such a project to the community, a team approach by the different sectors or role players in the project (e.g. from health, engineering, ecology disciplines etc.) is required.

Community participation and active involvement in their own health care is essential. They become partners in health care by generating their own ideas, assessing their needs, making decisions, planning, implementing and even evaluating the care they receive. This process encourages and allows the community to take responsibility of their own situation, thus empowering them. It encourages community development of self-reliance and self-determination.

Changes in Primary Health Care Services now require clinic-based staff to integrate preventive and promotive care with a wide variety of curative services. Today, clinic nurses are expected to provide ongoing care for chronic diseases such as hypertension and diabetes as well as management of tuberculosis, STDs, and HIV/AIDS counselling and care. They are also expected to manage commonly occurring acute diseases such as skin rashes and pneumonia. Baic nurse training in South Africa today does not properly equip nurses to deliver Primary Health Care services. Practical training largely occurs in tertiary hospitals where the focus is on curative services provided under doctors orders. This model of training, although necessary and appropriate for work in hospitals, does not

provide nurses with the necessary analytical and problem solving skills.

There is a need for a shift from content driven curricula to community-based education. This would help ensure that the content is driven by service and therefore, community needs rather than a medical and surgical nursing textbook. Community health nursing is popular as a post basic course and many nurses see this as necessary training for making the move from hospital to clinic nursing.

Existing Primary Health Care programmes can be divided into three broad categories: workshops and short programmes lasting for a few weeks or less, certificate programmes, and diploma programmes ranging from three months to two years. Training is provided by nursing colleges, university nursing departments, schools of public health and health care services offering workshops.

4. PUBLIC HEALTH AS A PROBLEM-SOLVING SYSTEM

To strive to attain conditions in which people can be healthy, an assessment and surveillance of the physical and social environment needs to be done to identify factors that could influence health adversely. Ways to deal with the factors that could have a negative effect on health, can then be determined and plans can be implemented to change the negative factors in the environment into positive factors that will promote health.

5. FACTORS THAT AFFECT HEALTH AND HEALTH CARE DELIVERY

Public health is concerned with maintaining healthy environments and countering hazards in the total environment when they occur. There are three main groups of environmental factors that influence the health of people positively and negatively.

5.1 PHYSICAL FACTORS

This refers to any factor, circumstance or condition in the external environment that can influence a communitys health. These factors are numerous and may include anything to

do with heat, light, air, water, land or whatever affects the places where people live, work or play. Depending on the condition of the environment the effect can be positive or negative. Some common situations in which poor environments can negatively influence health are:

- informal settlements
- overcrowded houses
- unhygienic conditions
- poor working environment
- rural areas with poor sanitation and unsafe water
- industrial pollution
- poor roads

Todays environment is more at risk than ever before because the world ecology is under threat. One example of this is the deforestation for a large tract of land leaving areas barren and unable to grow food to support the population. Another is the thinning of the ozone layer which has resulted in an increase in the occurrence of skin cancer.

5.2 SOCIAL FACTORS

According to Lark (quoted by Spradley 1991: 133) culture is possibly the most important social determinant of community health because it affects diet and eating habits, determines how people feed their children, react to pain and deal with stress and death. Child-bearing practices and traditional medicines can also influence health.

Other important aspects that must be met if people are to attain optimal health are education, employment, adequate housing and recreation needs. However when the social milieu is not adequate then social pathologies like violence, child abuse, substance abuse and dysfunctional families are likely to occur. All these pathologies can influence the health of people negatively.

5.3 ECONOMIC FACTORS

Having adequate financial resources allows for the purchase of commodities that can assist people to attain optimal health. These commodities include adequate housing,

education, good clothing and even health care, if needed. Unemployment, however, is increasing, as is urbanisation, as people move to the cities in search of better opportunities. Poverty is increasing and this results in poor nutrition, making people more susceptible to diseases. It also affects living conditions and makes access to education difficult.

6. THE POLICIES, STRATEGIES AND MANAGEMENT OF PUBLIC HEALTH IN SOUTH AFRICA

On 27 April 1994, the African National Congress came into power with a new health vision for South Africa. This was a system based on comprehensive primary health care that aimed to ensure that resources are rationally and effectively used to make basic health care available to all South Africans, giving priority to the most vulnerable groups (African National Congress 1994: 20).

The dilemma faced by public health in South Africa in this time of transformation, is how best to accept the challenges of the new policy, and yet work at and contain long standing problems.

6.1 A DISCUSSION OF THE CONSTITUTION OF SOUTH AFRICA

(Act 108 of 1996 as amended 11 October,1996)

The Constitution was prepared from a political and juristic perspective to provide South Africa with a legislative basis for the period of transition from apartheid to democracy. It was intended to entrench democratic rights for all the people in South Africa.

Perhaps the most important contribution the Constitution makes to the health of all South Africans is that they are now regarded as equal before the law. This is the basis of equity in health care.

The **Bill of Rights** is the cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.

Section 27 deals specifically with health care, food, water and social security. It states

that everyone has the rights to have access to:

- health care services, including reproductive health care
- sufficient food and water
- social security, including *appropriate social assistance*, if people are unable to support themselves and their dependants.

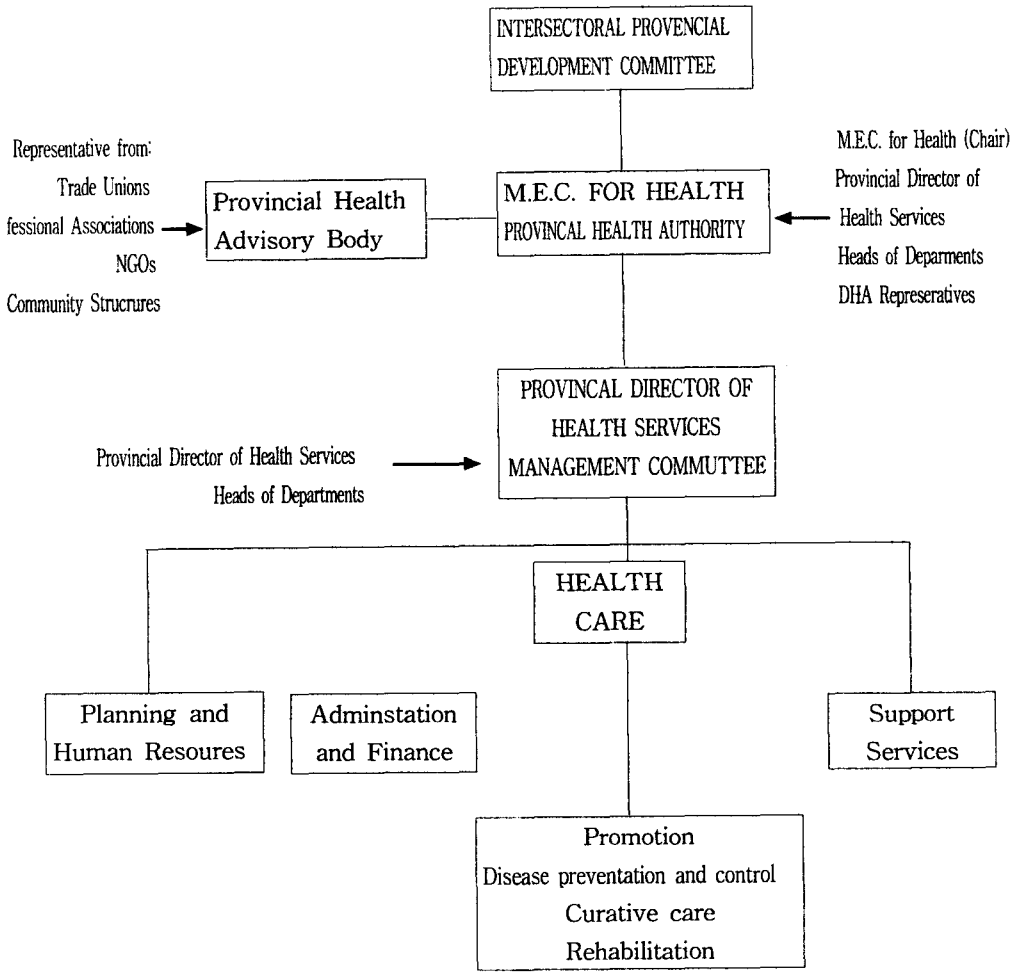
The state must take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of these rights. No one may be refused emergency medical treatment. The following rights can have a direct, or indirect, impact on peoples health:

- the right to respect and the protection of dignity (Section 10)
- the right to life (Section 11)
- the right to privacy (Section 14)
- the right to fair labour practices including the right to join a trade union and to strike (Section 27)
- the right to an environment that is not harmful to their health and wellbeing (Section 24)
- the right to have access to adequate housing (Section 26)
- the right of children to basic nutrition, shelter, basic health services and social services (Section 28)

These rights make it possible, in principle, for individuals and groups to demand certain basic health care services and an environment that is not harmful to their health and wellbeing, to challenge the state when these are not provided. Health workers may join trade unions or other collective bargaining groups, and strike if satisfaction is not obtained.

6.1.1 GOVERNMENTAL LEVELS OF RESPONSIBILITY

All the provinces have been decided into regions to assist with administration. In some provinces, the departments administer health and welfare and in others only health. This arrangement leads to some confusion and difficulty as directives from the national level come from two different departments.



6.1.2 District level

- According to general guidelines issued by the Department of Health, a district health system is defined as comprising:
- a well defined population living within a clearly delineated administrative and geographical area
- all the institutions and individuals providing health care within the districts, including all health workers and facilities, up to and including, hospitals at the first referral level, and the appropriate laboratory and other diagnostic, and logistical support services.

The responsibility to provide health care is divided between the three tiers of government. The constitution makes provision for different levels of government: national, provincial and local (also referred to as a municipality). The constitution does not clarify

the role of the national level of government in health care. It does refer to a local level of government while in other government health policies and documents the district level is mentioned as the third tier of government. The role of the private sector in health care is also not clearly defined in the Constitution. This lack of clarity can affect the delivery of health services in South Africa and is currently receiving attention.

6.2 THE SOUTH AFRICAN GOVERNMENTS ROLE IN PUBLIC HEALTH

South Africa is undergoing profound social and political changes. Health services are being restructured with the aim of attaining equity of accessibility to health services for all the people of the country. The emphasis of the new health policy is to move away from a curative approach. The fragmentation of services inherited from the previous government, and a lack of appropriately trained managers have been two important factors that have inhibited the progress of the transformation.At all levels, the governments core functions in public health are assessment, policy development and assurance.

6.2.1 National level

The Department of Health is the central force in public health and must bear ultimate responsibility for the health of the nation. Since

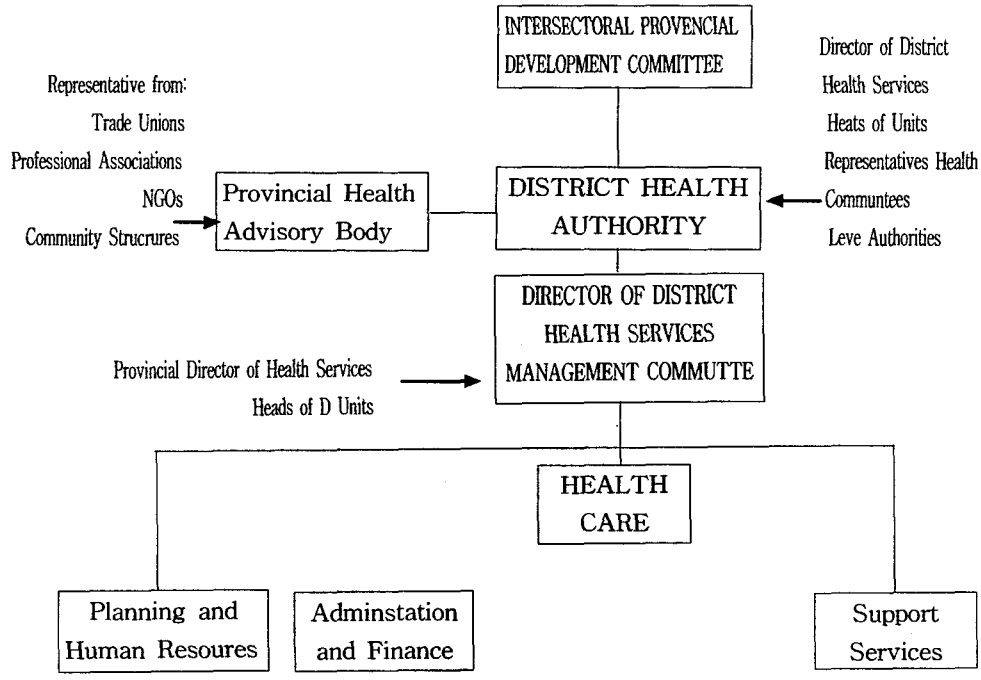


Figure 2: The district health system in South Africa

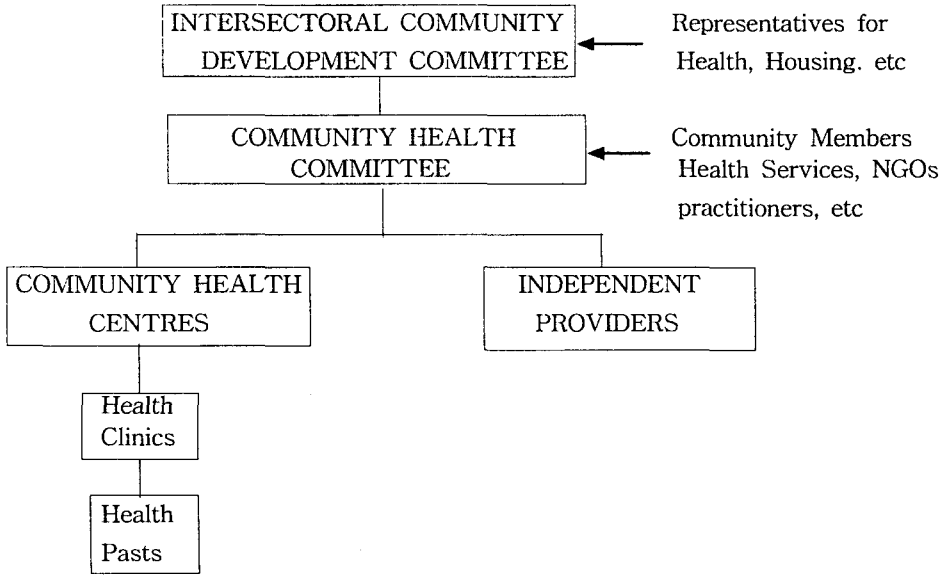


Figure 3: The health system at community level

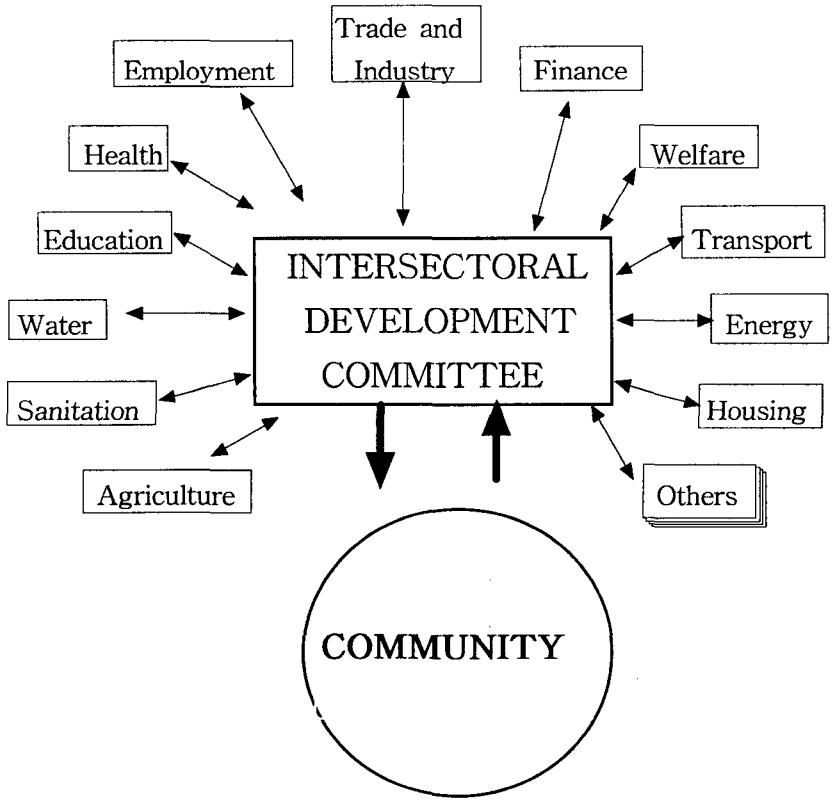


Figure 4: The intersectoral development committee

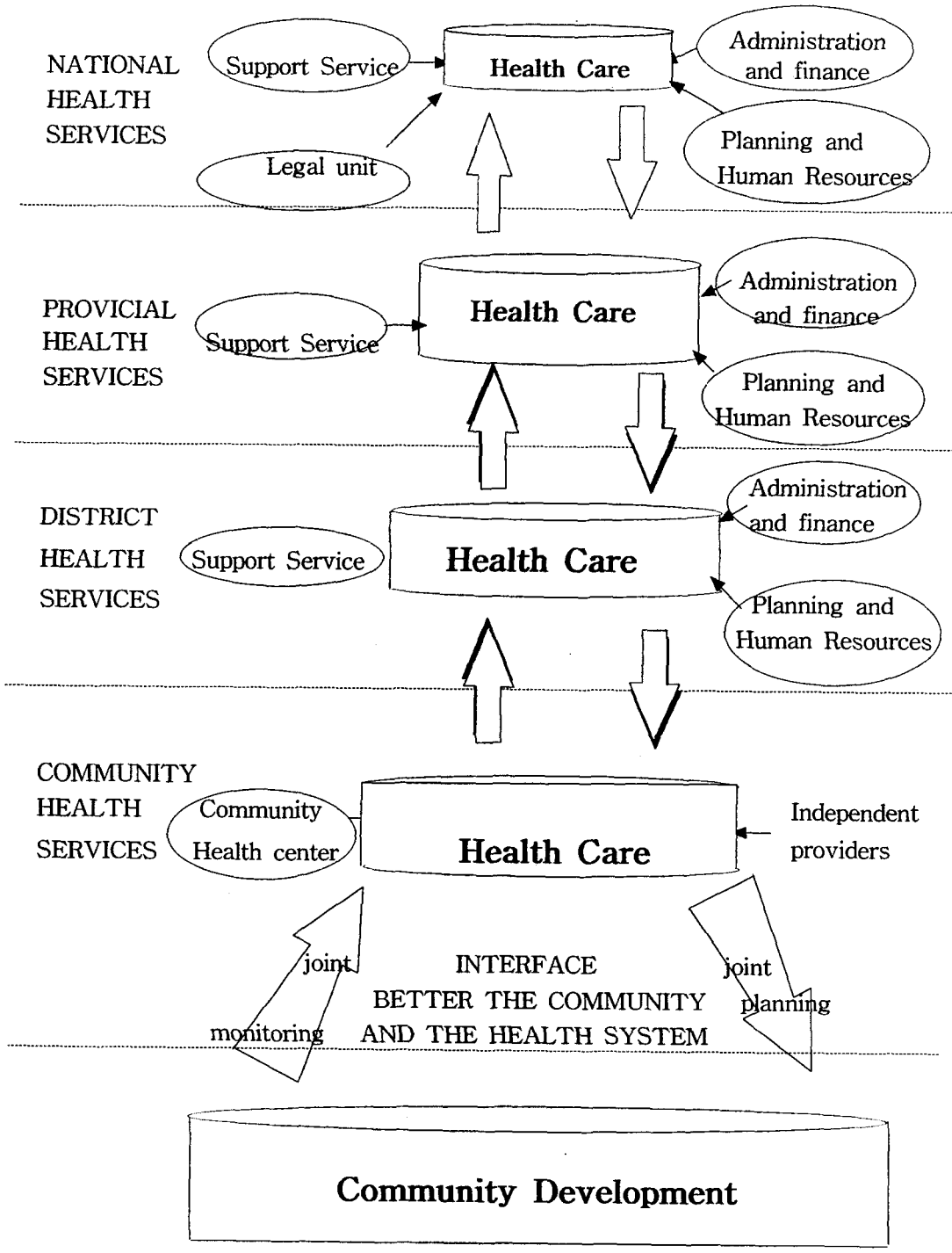


Figure 5: Different levels of the health system.

taking office the ANC government has fulfilled its task to develop guidelines, norms and standards to apply throughout the health system as was stated in the ANC National Health Plan (African National Congress 1994: 68)

A committee of inquiry into a national health insurance system was set up under the chairmanship of J Bloomberg and O Shisana and produced the report *Restructuring the national health system for universal primary health care* (South Africa Republic Department of Health 1995).

In November 1996, the ninth draft of the National Health Bill was made available for comment and the new National Health Act should be available by the end of 1999.

6.2.2 Provincial level

- The rationale was that provincial health departments would take control of all health services in the province, but that once

The setting up of boundaries for districts is in progress. In some provinces the districts have corresponded to one or more local authority boundaries and in others there is no correlation at this stage (Health Systems Trust & Department of Health 1996)

The district is the foundation for the South African health system because it is at this level that primary health care is implemented. However, this is the level where the least progress has been noticed. The functioning of these services is being hampered by the following issues:

- Lack of facilitating national and provincial legislation.
- Lack of uniform conditions of service between provincial and local government resolved questions on governance.
- Lack of uniform local government restructuring processes.
- Lack of clarity over local government boundaries and overlapping boundaries.
- Unresolved questions on governance.
- Varying capacity of local governments to manage districts.
- A delay in delegation of authority and budgets at all levels within the health system.
- Decentralisation not always under the control of the health department.
- Budget constraints.
- Delays in staff appointments.
- Incomplete referral systems owing to delays in the hospital restructuring process.

7. HEALTH POLICIES

Policy making is a function of the Department of Health and the implementation of policies a function of the provinces. Many policies relating to public health practice have been introduced since the implementation of the new health system.

7.1 TRADITIONAL HEALERS

The Department of Health recognises that traditional healers have a role to play in health care and has initiated the following investigations and programmes to accomplish this:

- The Executive Council of Health has been requested by the Minister of Health to investigate possible ways to register traditional healers. At present the province of KwaZulu / Natal is licensing traditional healers.
- A Human Resources Development Committee was appointed by the Minister of Health to develop a draft policy regarding the whole spectrum of human resources in health care as well as to examine the role of traditional healers in a new health service dispensation.
- Training programmes for traditional healers have been developed. These cover topics such as HIV-AIDS, mental health, rehydration programmes, cancer treatment, tuberculosis and aspects of maternal and child health care.

Various universities have initiated research programmes into the use of traditional herbal remedies and the National Botanical Garden at Kirstenbosch has a programme on the study of herbal plants.

7.2 WOMENS HEALTH

The Beijing Womens Conference was held by the United Nations in September, 1995. The focus of the conference was on practical ways to implement womens full and equal partnerships in development, politics, decision making, and in international co-operation to achieve world peace.

The South African government committed itself to adoption of all parts of the platform of action. This means that the Government will ensure that the problems listed below will be addressed:

- the persistent and increasing burden of poverty on women
- unequal access to and inadequate educational opportunities
- inequities to health and related services
- violence against women
- inequity in womens access to, and participation in, economic structures and policies, and the productive process itself
- lack of awareness and commitment to internationally recognised human rights of women
- womens contribution to managing natural resources and safeguarding the environment
- persistent discrimination against, and the violation of, the rights of the girl child (Beijing Conference 1996: ii).

7.3 THE POPULATION POLICY

A draft White Paper for a Population Policy appeared in the Government Gazette on 31 October 1996 (South Africa 1996). The vision of the policy emphasises the attainment of a high and equitable quality of life for South Africans, and forms part of the national development strategy. It acknowledges that population, sustained economic growth and sustainable development and the environment are intricately interrelated. The paper also highlights the point that all of the South African public must have access to information concerning government policy and its implication for their lives, as well as information on population and development issues. It acknowledges that all couples and individuals have the basic right to decide, freely and responsibly, on the number and spacing of their children, and to have the information, education and means to do so.

8. THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)

The Reconstruction and Development Programme (RDP) is a socio-economic development programme which has had, and will continue to have, a positive impact on

the health of the people of South Africa. The programme is aimed at promoting community participation in development programmes, and on redistributing resources, where necessary, to attain a more equitable democratic, non-racial, and non sexist future. It is a nation building exercise, which integrates, growth, development, reconstruction and redistribution.

The main objective of the RDP is to improve the quality of the life of all South Africans and in particular the poorest and the marginalised sections of the community. Priority is given to programmes aimed at meeting basic needs, such as:

- land reform
- housing and services
- water and sanitation
- energy and electrification
- telecommunications
- transport
- environment
- nutrition
- health care
- social security and social welfare

Through these development programmes, the total environment of people will be improved and their health will benefit.

9. HEALTH PROMOTION AS PART OF PUBLIC HEALTH

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective for living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-style to well-being.

Health is the most precious resource that humankind has, it is a basic human right and essential for social and economic development (as stated in the 1997 Jakoarta declaration on Health Promotion into the 21st Century). Health must be regarded as something positive, an asset, rather than as an absence of ill health. In order to promote a populations health, one must ask yourself what are the major causes of ill health. Patterns of health and illness around the world are related to the economic and social development of societies. Major causes if ill-health shift according to a variety of societal factors. These may include how wealthy a country is, systems of medicine practised in a country, and the sort of lifestyle lived. Poverty is recognised internationally as the major cause of ill-health in the world in the late twentieth century. Individuals, communities and countries with the least resources unfairly carry the burden of ill-health and mortality.

A national household survey of health inequalities conducted in South Africa in 1995 found that almost a quarter of the African respondents said they were too poor to feed their children properly. Cardiovascular disease and cancer are major threats to the health of populations in developed countries. They are considered to be lifestyle diseases because their cause is to be found in unhealthy working conditions and living habits. For example, poor diet, smoking, and alcohol misuse, as well as the stresses and strains of modern living.

In the so-called developing world where resources are scarce and poverty often endemic, infectious diseases continue to be major causes of ill-health. Poor environmental conditions, such as lack of clean water and proper housing, reducing the populations resistance to infection. In addition, poor countries do not have the resources to provide comprehensive treatment and immunisation programmes. But the populations of developing countries are also becoming increasingly susceptible to lifestyle diseases. Tobacco companies and breweries are targeting developing countries; and unhealthy work patterns and fast foods are increasingly a way of life for rapidly urbanising communities.

By the 1970s, the effectiveness of the medical models therapeutic approach to health care as a public health measure began to be questioned. People started to realise that despite staggering increases in health costs, coupled with more and more sophisticated surgical and therapeutic techniques which could bring relief to individuals (for example, the first heart transplant which was done in SA in the 1960s), the health of populations did not seem to improve markedly. Around the world, planners and policy makers began to realise that scientific medicine, whilst extremely effective in treating many acute cases

of sickness, had in fact very little to do with health.

Health promotion is necessary if we want to improve the quality of the populations health. Three tools are identified as being core to effective health promotion:

- **Advocacy** political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion advocacy is about trying to create conditions which are favourable.
- **Enabling** in recognition of the inequalities of health, health promotion attempts to enable all people to achieve their fullest health potential. People are not able to do this unless they can control those things that determine their health. Health promotion thus needs to give particular attention to those who are least socially and economically powerful in society.
- **Mediation** health promotion demands co-ordinated action by a wide range of bodies over and above health personnel, including governments, NGOs, local authorities, industry and the media. Health promotion is concerned with mediating between different interests in society in pursuit of health.

The Ottawa Charter then goes on to prioritise five action areas for health promotion:

1) Build healthy public policy

Given the importance of social and environmental influences on health, public policy is of crucial importance. Key action areas were identified in the African National Congresss (ANC) National Health Plan and as part of the Reconstruction and Development Programme (RDP). Examples include the need to build millions of new houses, and to ensure clean and accessible water supplies and proper sanitation.

2) Create supportive environments

Health promotion concerns the quality of life, and will intervene to encourage healthy living and working conditions which are safe, stimulating, satisfying and enjoyable. Health promotion also attempts to ensure that natural environments are protected. In South Africa, like everywhere else in the world, a balance needs to be found between economic development, such as the steel works in Saldanha Bay, and conservation of our rich natural environment.

3) Strengthen community action

Health promotion works through concrete and effective 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, their ownership and control of their own activities and future.

4) Develop personal skills

This is the part of health promotion that is consistent with the old health education model. Health promotion supports personal and social development through information, education for health and building life skills. This will increase the options available to people in exercising more control over their own lives. Information and education for health should be available in schools and community settings. To enable individuals and communities to utilise health information, the building of life skills becomes important. Life skills education also has a natural home in the school setting.

5) Reorient health services

Health services need to move beyond the clinical and curative services that they currently provide to embrace a philosophy and practice which is health promoting. Specific action is required with regard to education and training of professionals in order to bring about a change in the attitudes and organisation of health services. These changes need to include an understanding of the social and environmental causes of ill-health. One also needs to move away from viewing the body as independent of the mind and spirit, to a practice that treats individuals as integrated whole beings.

The 1997 Jakarta declaration of Health promotion into the 21st century identifies the following:

five priorities for health promotion:

- Promote social responsibility for health.
- Increase investments for health development and reorient current investments both within and between countries, ensuring a multi-sectoral approach.
- Consolidate and expand the number of people working together for health, both between different sectors, as well as at all levels of governance and society.
- Increase community capacity and empower the individual. Social, cultural and spiritual resources need to be harnessed to maximise access to the decision making process for marginalised communities.

· Secure an infrastructure for health promotion locally, nationally and globally.

Health promotion is therefor a multifaceted approach for the prevention of ill health and the promotion and maintenance of well-being. This approach includes strategies like education, community, development, mass communication, self-help, public policy development and even organisational change (Wardrop 1993: 34). Health promotion therefore advocates social as well as individual responsibility for health and is a vital part of primary health care.

9.1 The history of health promotion in South Africa

The introduction of the modern discipline of health promotion to the health system is fairly recent in South Africa. Today there is a National Health Promotion Directorate and a clear policy for health promotion based on the Ottawa Charter.

9.1.1 Health in the apartheid era

Although the history of discrimination against black South Africans predates apartheid legislation, the apartheid years resulted in further discriminatory measures. More workers became migrant labourers, for example, during this period. In the 1960s the increasingly repressive laws of apartheid resulted in the forced removal of people from their land and other measures. An enormous amount of poverty and suffering was caused by these policies, this poverty and suffering is still very evident today.

The health care provided by the apartheid government was racially-based with large well-equipped hospitals emerging in Afrikaner strongholds such as Pretoria, Stellenbosch and Bellville, while the facilities in the homelands were under-funded, under equipped and under-staffed. In addition, the facilities were based on race so that there were often two facilities within a kilometre of each other, but serving different race groups. Health promotion was largely just health education and in black communities typically addressed one topic, that of population control This was seen by the government of the day as a critical issue as the growth of the black population made white people an ever-decreasing minority. The legacy for health education and promotion in government is both didactic and racist.

There is widespread agreement that the policies of the apartheid government contributed significantly to the legacy of inequity in the South African health sector. This is manifested not only by maldistribution of certain categories of health care personnel between the public and private sectors, but also through an inequitable distribution of public sector resources along geographic, racial, gender and level of service/care divisions.

The Regional Health Management Information System (ReHMIS) database, for 1994/95, provided the first detailed review of the distribution of health care human resources in South Africa. In 1994/95, the majority of health care personnel, with the exception of nurses, were employed in the private sector which served only 20% of the population. The investigation revealed that:

- only 42% of medical doctors and specialists were located in the public sector, with the greatest proportions being located in Gauteng (41%) and the Western Cape (22%);
- 86% of nurses were in the public sector, of which the greatest proportions were located in KwaZulu-Natal (23%) and Gauteng (22%);
- only 11% of dentists worked in the public sector of which the greatest proportions were located in Gauteng (47%) and the Western Cape (23%);
- only 6% op pharmacists worked in the public sector and the greatest proportions were located in Gauteng (43%) and the Western Cape (18%).

9.1.2 Post-apartheid South Africa, primary health care and development

As the apartheid regime fell into greater crisis at the end of the 1980s, there was a shift away from oppositional politics towards development. When President FW de Klerk finally unbanned the liberation movements and embarked on a process to repeal apartheid legislation, even his own government was talking about changing the health system towards primary health care. In a response to the government launching its own primary health care philosophy a group of people from NAMDA and the Health Workers Association started an organisation called the National Progressive Primary Health Care Network (NPPHCN). This network aimed to promote a more far-reaching concept of primary health care, which included preventive and promotive health and a commitment to equity in health.

9.1.3 Health promotion policy in the new South Africa

The first significant piece of new policy for health promotion in South Africa appeared in the ANCs health policy document. The ANC recognised the significant contribution that health promotion could make to strengthening its commitment to improving the health of South Africans and its vision for primary health care.

9.2 ANC Health Promotion Policy

Promoting good health and preventing disease is central to the success of Primary Health Care. However, health promotion is not well understood in South Africa and many people equate health promotion with health education. Health promotion combines

diverse approaches such as legislation, fiscal measures such as taxation, intersectoral programmes, environmental monitoring and education. The principle tenets of the policy on health promotion include the following:

- Health promotion is central to the success of primary health care.
- Within primary health care the role of health promotion should encompass responsibility for community participation, community development, intersectoral development, education, mass media campaigns and disease prevention and health promotion in specific area such as womens health, HIV/AIDS, adolescent health etc.
- Health promotion requires the skills of a multi-disciplinary team of workers from different sectors e.g. teachers, drama specialists, workers, community organisers, advertisers, health workers etc.

10. PROMOTION HEALTH EDUCATION AS AN INSTRUMENT IN HEALTH

Health education is an essential component of health promotion and primary health care, (Tones, 1987).

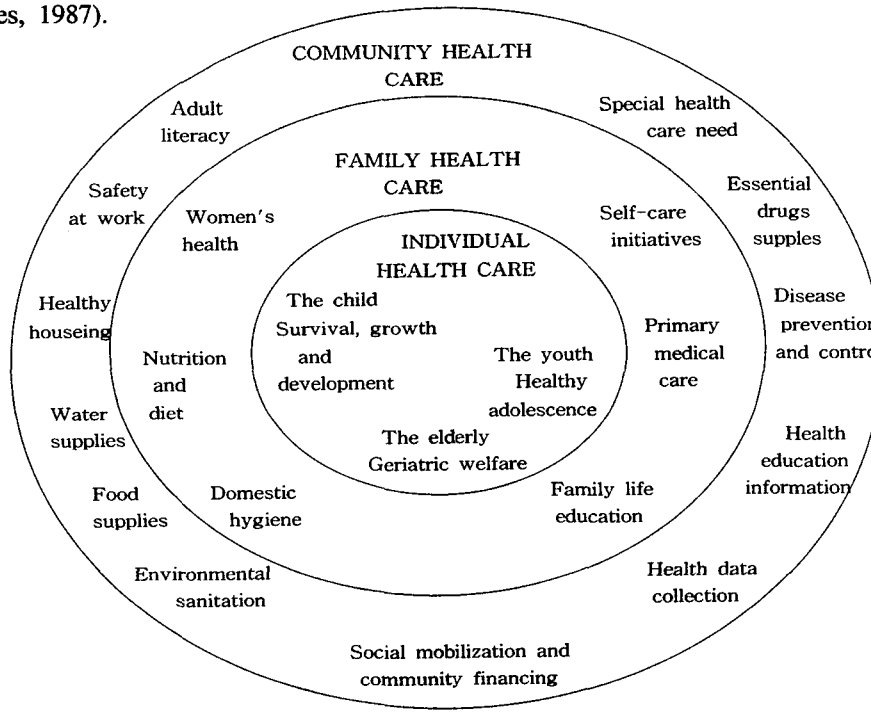


Figure 6: A functional breakdown of the goal of health for all.

Health education assists people to facilitate changes to more helpful behaviours. This may be achieved through the use of the educational process by a variety of learning experiences. Health education can be viewed as the process of influencing behaviour and producing changes in knowledge, attitudes and skills required to maintain and improve health, by the use of the education process (Rankin & Stallings 1990: 85 86). Health education requires an ongoing assessment of the clients attitudes, knowledge and skills, because it occurs over a period of time. In addition it is a process that frees people to voluntary adopt or alter behaviours that will improve or maintain their health. Emphasis need to be placed on health education programmes as a positive health activity (Dennill et al, 1995: 86).

A programme can be described as a standing arrangement that provides a social service. Health education programmes are planned opportunities for people to learn about health and to undertake voluntary changes in their health behaviour. These programmes may include providing information, exploring attitudes and values, making health decisions and acquiring skills to enable behavioural change to take place. Such programmes involve promoting self-empowerment and self-esteem so that people are enabled to take action about their health (Hayes & Fors, 1990: 208 211).

Health education in health education programmes can be on a personal one-to-one level, on a group level or by means of reaching large audiences through the mass media, exhibitions and health fairs.

Having identified that health education, expressed in health education programmes, is a positive health promotion activity, lets look at the skills and methods to put it into action.

Ewlers & Simnett (1992:29)

- *Managing, planning and evaluating.* Effective and efficient health education programmes need systematic planning and managing of resources such as money, manpower, facilities and equipment. All positive health activities need evaluation.
- *Communicating.* Competent communication is essential, because health education is working with people in a one-to-one situation or with groups in various formal and informal ways.
- *Educating.* Teaching about health requires good communication but also additional educational competence, because health educators have to work in different settings such as group discussions, formal lectures or informal groups.
- *Marketing and publicising.* These competencies would, for example, enrol local radio

and the local press in giving coverage to health issues which would benefit from wider publicity.

- *Facilitating and networking.* When working with communities, these competencies will help people promote their own health and that of others by sharing skills and information and consequently building up trust and confidence.
- *Influencing policy and practice.* Health educators influence broad plans of action and practices which affect health.

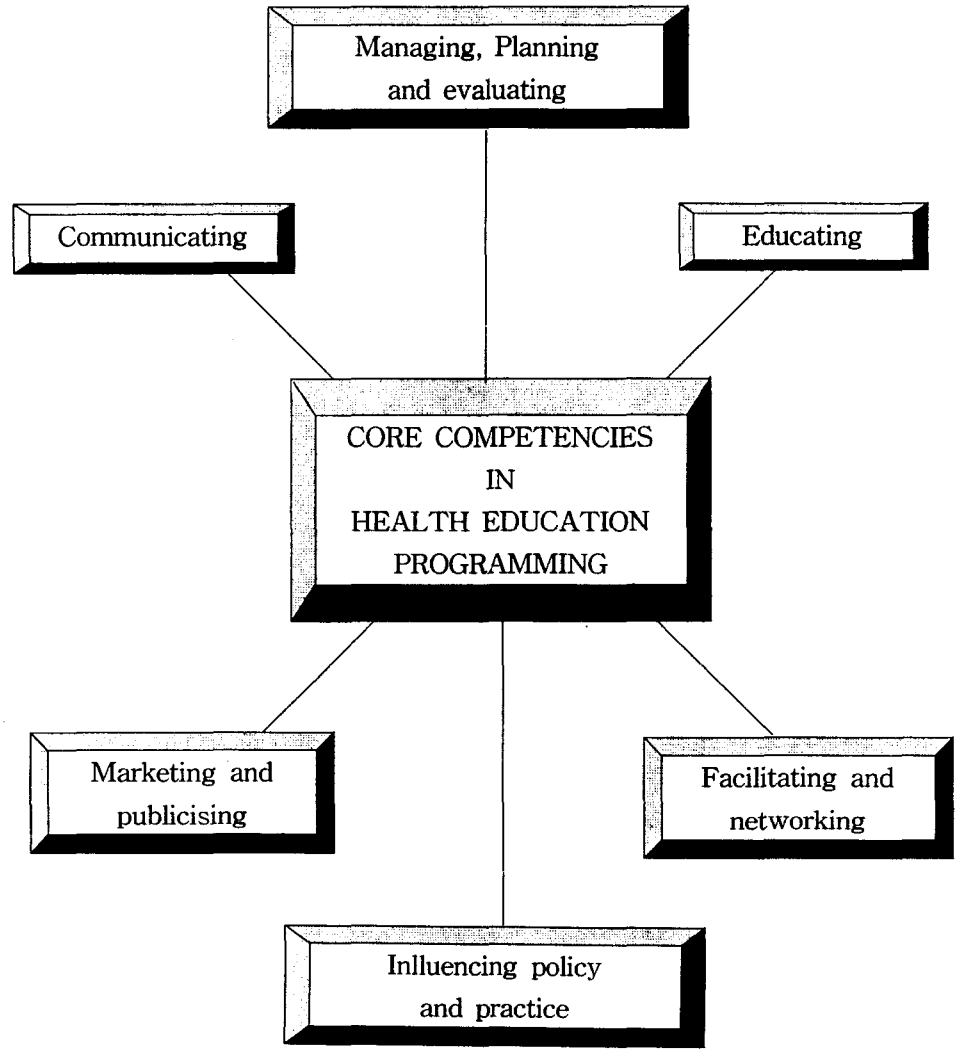


Figure 7: Core competencies in health education programmes

All six of these areas of competence are fundamental to health promotion activities. Cultural sensitive and well-planned health education programmes can promote peoples confidence and self-esteem, empowering them to take more control over their own health.

The planning of a health education programme is a systematic process which ends with a plan to attain certain set goals (Dennill *et al*, 1993: 89).

10.1 Programme Co-ordination in South Africa

Programmes are supposed to be integrated as part of comprehensive primary health care services. The role of provincial programme managers is to provide vertical technical support to the districts and to assist in the monitoring of implementation. As such, provincial programme managers perform a staff and not a line function and have no direct control over programme implementation. National programme directors interact with provincial programme managers in the development of national policy and programme monitoring.

To facilitate the implementation of priority programmes designated health workers in the particular regions or districts assist in co-ordination. It is common for these designated people to be responsible for a number of programmes (e.g. Maternal, Child and Womens Health (MCWH) and STD/HIV/AIDS or STD/HIV/AIDS, Communicable Disease Control (CDC) and EPI), in addition to their normal line of duty, to avoid the impression of vertical implementation.

There are some provinces where district level programme co-ordinators would be preferred but financial and logistical constraints prevent their appointment. The challenge for programme implementation is to ensure smooth communication between the national and provincial offices, the regions and districts. Generally, some systems exist at the various levels of the health systems to allow for communication, albeit compromised by poor information as a result of dysfunctional and fragmented information systems.

All provinces, to varying extents, have capacity problems relating to resources, namely, personnel, finance, transport and training. Some programme managers are overwhelmed, especially those who are new appointees. However, sheer hard word by some programme co-ordinators and health workers at regional and district levels has yielded success in some areas. Technical assistance by national and provincial programme managers, support from senior management, private sector involvement, input from international experts and

linkages to academic and training institutions help facilitate programme success.

10.2 Intersectoral and Interdepartmental Co-operation

A lack of intersectoral and interdepartmental co-operation appears to be a common challenge to some programmes in provinces. There are insufficient structural mechanisms to promote joint programme activities, for example among programmes such as MCHW which greatly overlaps with Nutrition, STD/HIV/AIDS, TB, Mental Health, Health Promotion and CDC programmes.

10.3 Health education programmes in South Africa

The chart below outlines the 1997 programme objectives for ten of the National Department of Healths priority programmes and makes comparisons using success factors and obstacles within each of the programmes. Some of the factors relate to the policy formulation process itself and others to the implementation of those policies at service delivery level.

11. CONCLUSION

The ideology of health promotion is explained as background to a concept that was born in the 1980s and matured in the 1990s. The view of the WHO, as outlined in the Ottawa Charter on health promotion, is linked to the South African situation. The strategy for the implementation of primary health care in South Africa was compiled in 1992 and followed by the Reconstruction and Development Programme and National Health Plan in 1994. The whole national health system of South Africa will be driven by the primary health care approach.

Health promotion is viewed as an umbrella term, encompassing health education programmes as a positive activity for better health. Health education is referred to as a central tool in health promotion, a tool to empower people to make healthier choices easier choices and to increase control over the determinants of health and thereby improve health.

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남아프리카공화국의 공중보건

Daleen Koen 박사

(남아공 Potchefstroom대학과 고신대학교 보건교육학 공동학위 과정 교수)

배경 및 목적

공중보건은 사회생활을 하는 주민들에게 건강한 상태를 보장해 주기 위한 것이다. 현대의 공중보건제도는 공중보건 발전에 가장 큰 영향을 미치는 두 가지 요인을 나타내고 있다. 첫째는, 질병을 억제하는 방법과 질병의 원인에 관한 과학적인 지식의 성장이고, 둘째는 질병을 억제하는 가능성을 공중보건에 의해서 얻게된다는 것이다. 1999년 현재 남아공의 지역은 사람이 살기 좋은 지역과 살기 어려운 지역이 있다. 사람들이 생활하기에 좋은 지역은 건강을 위한 보건 서비스나 치료에 쉽게 접근할 수 있는 가장 좋은 곳이며, 또 다른 지역은 생활이 매우 빈곤하여 건강을 나쁘게 하며 보건의료서비스에 접근하기도 어려운 곳이다.

남아공에서는 빈곤과 관련된 3가지의 질병이 함께 나타나고 있으며, 에이즈가 빠르게 급증하고 있다. 또한 TB를 억제하기 위한 노력이 있으나 아직 성공적이지 못하고 몇몇 곳은 매우 높은 감염율을 나타내고 있다.

도시와 시골, 인구집단 사이의 빈곤이 건강에 대해 커다란 불균형이 나타난다. 정부는 특별히 빈곤한 자를 포함하여 국민의 건강을 증진시키기 위하여 이끌어 낼 수 있는 계획이 필요하고 그 계획이 일정하게 유지되어야 한다는 것을 인식하고 있다. 가족이나 개인을 위한 치료는 개개인의 지역주민을 건강하게하고 건강한 지역사회를 만든다는 목적이다. 공중보건은 전 인구에게 초점을 맞추나 특별히 문제점을 가지고 있는 주민들의 문제를 해결 하므로써 국가의 보건복지를 증진하려는 목적과 지역사회 보건의료와 공중보건 모두 다 복합적인 훈련과 여러 분야가 서로 함께 접근 하도록 하고 있다. 남아프리카의 최근 정책적인 변화는 국민을 위한 건강 전략에 대한 변화와 적응이 필요하다는 것을 가장 강조고 있으며 국가적인 전략으로서

1차 보건의료 접근을 기초로 한다.

남아프리카의 공중보건에 대한 정책, 전략과 관리:

가장 취약한 단체들에게 우선 순위를 주며 모든 남아공의 주민들에게 기본적인 보건의료를 효과적으로 받을 수 있는 1차 진료를 기반으로 하는 원천을 제공해 주기 위하여 1994년 4월 27일에 the African National Congress에 가입 했다. 그러나 남아프리카의 공중보건은 아직도 여러 가지 문제점에 직면하고 있다.

보건제도는 National level, Province level 그리고 District level로 나누어 관리하고 있다. 그러나 District level은 여러 가지 부족한 점들에 의한 문제점을 갖고 있다.

공중보건의 실제와 관련된 여러 가지의 정책들이 새로운 보건제도하에서 수행되어져 왔다. 아직도 KwaZulu/Natal 지방에는 traditional healer의 면허를 갖고 있기 때문에 traditional healer들에게 전통적인 약초를 이용하는 치료요법의 훈련 프로그램을 개발시켜 에이즈, 정신건강, rehydration programm, 암치료, 폐결핵과 모자보건의료 등의 양상을 다룬다. 여성을 위한 보건정책은 1995년 9월에 UN에 의해 열린 Beijing Women's Conference에서 제시하고 있는 방법들을 수용하고 있다. 인구정책은 남아공의 삶의 질을 추구하는 것을 기초로 하며, 인구, 경제성장의 유지와 개발과 환경이 집단이나 개인들의 기본적인 결정권이 자유롭고 책임있게 이루어지는 서로의 상관관계로 이어져야 한다는 인식하에 추진하고 있다. 새로운 국가적인 약물정책은 1996년 2월에 주민들에게 약을 처방자나 분배자, 소비자들이 합리적으로 사용하고 안전하고 충분하게 공급되어지고 비용절감을 위할 수 있도록 수립되었다.

결 론

건강증진에 대한 오타와 헌장의 개요처럼 WHO 의 견해도 남아공 주민들의 상태와 연관되어 지고 있다. 남아공에서 1차 보건의료의 수행을 위한 전략이 1992년에 시작 되었고, 1994년에 수립된 Reconstruction and Development Programme and National Health Plan에 의해 수행 되고 있다. 남아공의 전 국가적인 보건제도는 1차 보건의료접근에 의하여 제공되고 있다. 보건교육은 건강증진의 중심적인 도구로서 사용되고 있고, 더욱 건강하게 되는 것을 추구하는 사람들에게 더욱 쉽게 선택할 수 있는 도구가 되며, 건강을 결정하고 건강을 증진시키는데 중요한 역할을 한다.

(요약: 남아공 포쳅스트룸대학원 보건교육학과 박사과정 강혜숙)