

# Where are we with noncommunicable diseases health promotion in South Africa, where should we be, and how can we get to where we need to be?

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*“A healthy nation  
is a successful nation.”*

*– President Cyril Ramaphosa,  
July 2019<sup>1</sup>*

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# 1) INTRODUCTION

The necessity to have healthy individuals and populations, and for countries to take concerted actions to optimise health, is largely self-evident and also strongly reinforced by a robust international evidence base. In South Africa, this need is urgent due to a growing disease prevalence and burden, especially from non-communicable diseases (NCDs)<sup>2</sup>. This report outlines three vital reasons to promote good health: individuals themselves desire to be healthy; good population health is essential for economic and social development and unhealthy people place unnecessary burden on health services. It then sketches three broad areas that require rigorous actions to achieve good health outcomes: political and economic interventions; combatting the behavioural determinants of ill health; and quality and accessible health care, treatment and rehabilitation. The critical question of whether everything that promotes health can or should fall within the discipline/domain of health promotion is then posed. If it should, what are the implications of this, and if not, where should the boundaries be drawn, and why? The paper then examines and assesses where South Africa currently is with health promotion (particularly in relation to NCDs); where it should be and what is needed to get from where we are currently to where we need to be. This paper is informed by interviews with key health promotion experts. There is a special focus on health promotion research to be conducted by the SAMRC in order for the SAMRC to be able to assist the country to move to where it needs to be in this area.



## 2) KEY REASONS TO PROMOTE GOOD HEALTH

1. **Individuals themselves desire to be healthy.** Essential to the question of why to improve population health, is the fundamental and even inherent wish of people to live lives devoid of disease and to experience physical, mental and social well-being for themselves and for those around them. As Amartya Sen, the renowned Indian economist and philosopher, has aptly stated, health is a core 'capability' required for human flourishing<sup>3</sup>.
2. **Good population health is essential for economic and social development**<sup>4, 5, 6</sup>. High mortality and morbidity from NCDs (especially in people younger than 60 years) reduces productivity and income for households<sup>7</sup>. Enduring development requires healthy and vibrant individuals to start, run and participate in activities that promote growth and sustainability, while absent workforces, illness at work and health related early retirement hinder productivity and creativity. Social and community cohesion is deeply obstructed by financial, care and relationship pressures caused by mental and physical ill-health. A financial burden is also put on families where a member has a chronic disease. Poverty drives people into poor health, while poor health drives people into poverty<sup>8</sup>.

Estimates on the accumulated losses to South Africa's gross domestic product between 2006 and 2015 from diabetes, stroke and coronary heart disease suggest a cost to the country of around R26 billion<sup>9</sup>. It has similarly been estimated that the economic cost due to productivity losses arising from absenteeism, an absence of presenteeism and early retirement due to ill health in South Africa, largely from NCDs, equated to a total of 6.7% of GDP in 2015 and is expected to increase to 7.0% of GDP by 2030<sup>10</sup>. It is estimated that for diabetes alone, in 2018, the public sector costs of diagnosed patients was approximately R2.7 bn and would be R21.8 bn if both diagnosed and undiagnosed patients are considered. In real terms, it is estimated that the 2030 cost of all Type Two Diabetes Mellitus (T2DM) cases will increase to R35.1 bn<sup>11</sup>.

On the other hand, the World Health Organization's (WHO) global business case for NCDs shows that if low and low-middle income countries put in place the most cost-effective interventions for NCDs, most of which are promotive/preventive, by 2030, they will see a return of \$7 per person for every dollar invested<sup>12</sup>. In addition, evidence shows that treatment for depression would yield USD \$5 for every one dollar spent<sup>13</sup>. Similar high returns on outlay would certainly be expected in South Africa.

Critically too, accessing health care puts additional financial, personal time and social pressures on people, especially poor and vulnerable people adding extra burden on them and seriously restricting opportunities for sustainable development<sup>14</sup>. In a World Bank qualitative survey of 60 000 poor women and men in 60 countries, sickness was the most frequent trigger for downward mobility<sup>15</sup>. At the household level, unhealthy behaviours, poor physical status, and the high cost of NCD-related health care, lead to loss of household income. People often become trapped in a dangerous cycle where poverty and NCDs continually reinforce one another<sup>4</sup>.

3. **Unhealthy people place an unnecessary burden on health services.** Unhealthy people add substantial pressures and costs to health services. For example, moderate obesity is associated with an 11% increase in healthcare costs and severe obesity with a 23% increase<sup>16</sup>. Having less people requiring health care would enable those in need to receive far better quality of care from the same financial and human resource pool<sup>1</sup>. For the future National Health Insurance (NHI) Fund in South Africa, the fewer the number of people drawing from the NHI Fund due to fewer clinic and hospital visits, the less medication, surgery and other medical interventions needed; the less laboratory tests that have to be done and the fewer other health and support interventions that are required, the greater the likelihood of a successful NHI. The time and human resource (and hence quality of care) that can be spent per patient will increase or decrease relative to the numbers of people that need to be seen. A healthier population can justifiably be said to be a sine qua non for an efficacious NHI<sup>17, 18</sup>.

<sup>1</sup> With increasing numbers predicted to develop NCDs in the coming decades, it will be necessary for health planners to constantly add resources (human and financial) to meet the ongoing growing need in addition to that which must be added to meet population growth.

### 3) GROWING PREVALENCE OF NCD RISK FACTORS

A comprehensive depiction of the extent and growth of disease in South Africa falls outside the scope of this manuscript. Nonetheless, it is important to briefly illustrate the high prevalence, and in some instances very rapid growth of key risk factors for NCDs through a few important examples, as this clearly demonstrates why it is so important for South Africa to urgently promote better health for all. There is global recognition that for countries to meet the SDG Goal 3.4 of reducing premature mortality by one third by 2030, and for NCD reduction to positively impact on other SDGs, reducing NCD risk factors is essential<sup>19</sup>.

*Raised blood pressure* is an important risk for cardiovascular diseases and chronic kidney disease and has high comorbidity with diabetes. The global age-standardised prevalence of raised blood pressure in 2015 was 24.1% in men and 20.1% in women<sup>20</sup>. In South Africa however, according to the 2016 South African Demographic and Health Survey, 46% of women and 44% of men aged 15 years and older have hypertension (Figure 1)<sup>21</sup>. This is almost double the world average. While hypertension rates in South Africa peak in people over 65 with raised blood pressure in 84% of both men and women, levels of raised blood pressure in youth aged 15-24 is extremely high and growing. Hypertension rates are 17% for women in this age group and 20% for men (Figure 1).

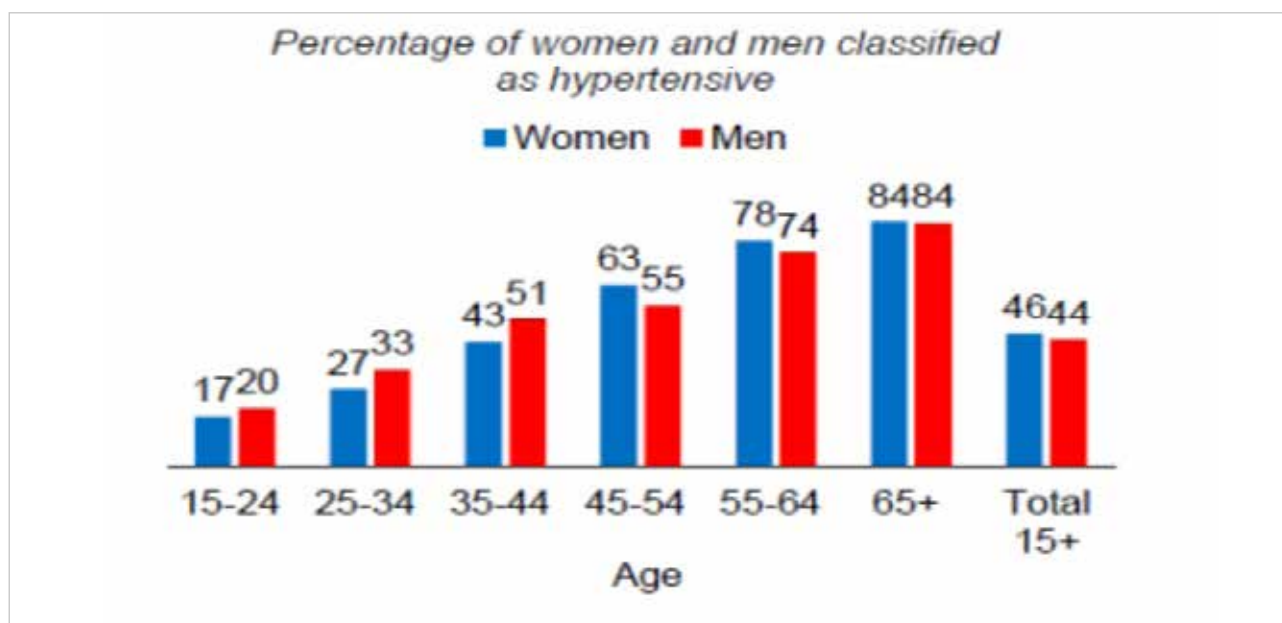
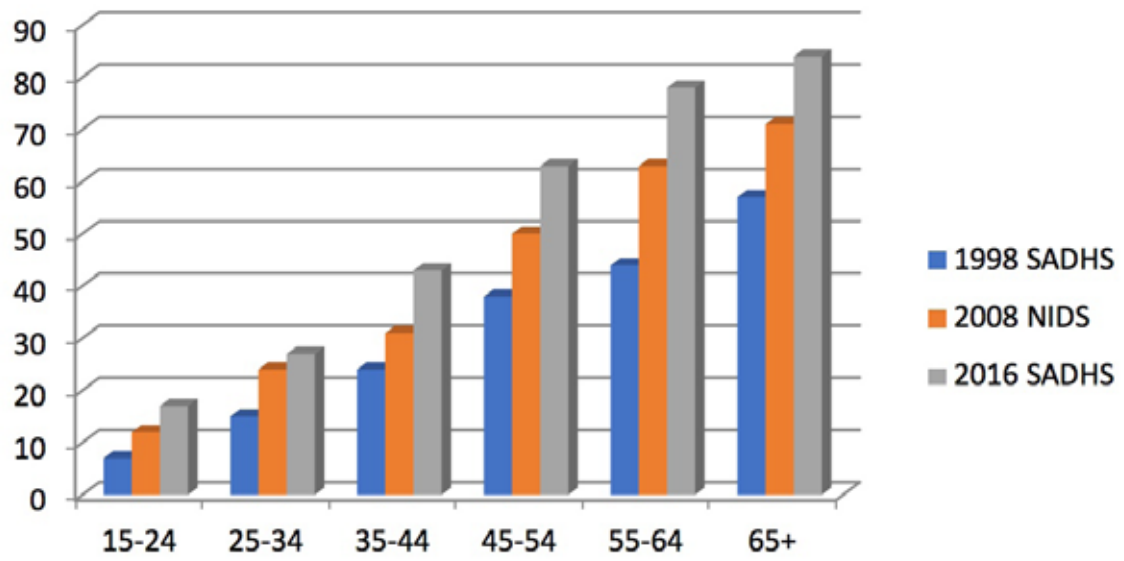


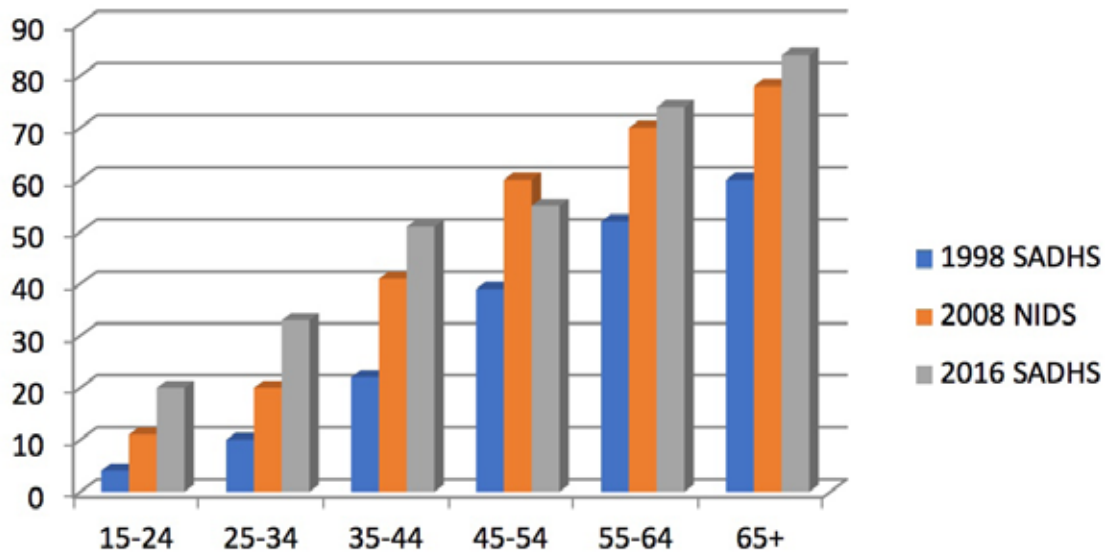
Figure 1 Prevalence of hypertension by age<sup>21</sup>

The growth in the numbers of people with hypertension between the 1998 SADHS and the 2016 survey (with figures for the 2008 National Income Dynamic Study (NIDS) in between) is large, with rates also growing substantially in younger age groups. Since 1998 the prevalence of hypertension has nearly doubled, from 25% to 46% among women and from 23% to 44% among men<sup>21, ii</sup> (Figure 2).

<sup>ii</sup> It should be noted, however, that different instruments were used to measure blood pressure in the two surveys.



**WOMEN**



**MEN**

Figure 2 Prevalence of hypertension comparisons between 1998 SADHS, 2008 NIDS and 2016 SADHS. Women and Men<sup>21</sup>

Overweight and obesity is another NCD risk factor that is extremely high in South Africa (Figure 3)<sup>21</sup>. In 2016 only one-third (30%) of women had a BMI in the normal range and 3% were underweight. Twenty seven percent (27%) are overweight (BMI of 25.0-29.9), and 41% are obese (BMI of 30 or above). Twenty percent of women are severely obese (BMI of 35 or above). The majority of men (59%) have a BMI in the normal range; 10% are underweight, 20% are overweight (BMI of 25.0-29.9), and 11% are obese (BMI of 30 or above). Three percent of men are severely obese (BMI of 35 or above)<sup>21</sup>.



Figure 3 Men and Women Overweight and Obesity and comparisons over time<sup>21</sup>



The association between weight and diabetes is well depicted in Figure 4 where far more women that are overweight (BMI over 25) suffer from diabetes<sup>21</sup>.

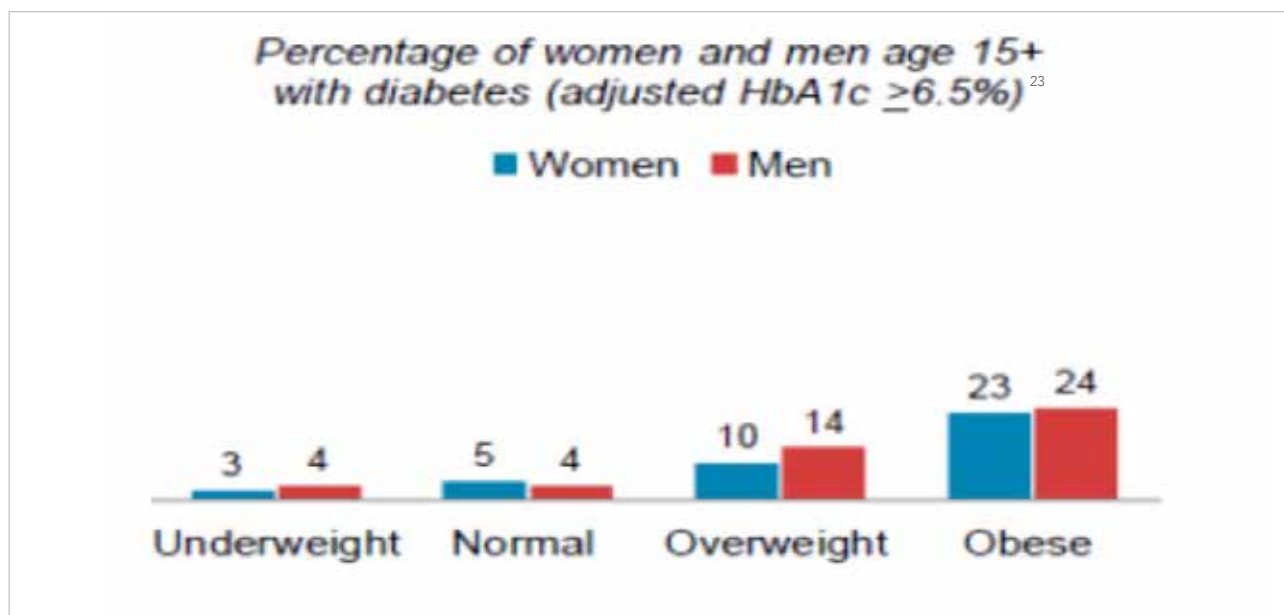


Figure 4 Diabetes by nutritional status<sup>21</sup>

Data on other risk factors such as *tobacco and alcohol* use do not specifically reflect increases over the past decade and in fact there have been decreases in tobacco use<sup>iii</sup> (Figure 5)<sup>22</sup>, and a possible stabilisation in alcohol consumption (Figure 6)<sup>23</sup>. However, given the very high impact of these risk factors on health, current rates are still far too high and must still be reduced very substantially to promote health. Heavy episodic drinking in South Africa in particular is currently extremely high.

Nearly a third of men in South Africa are daily smokers (Figure 5)<sup>22</sup>. This puts pressure on risk for lung and other cancers, chronic obstructive pulmonary diseases (COPD), heart diseases and stroke and diabetes. Tobacco is also known to worsen mental health and alcohol use.

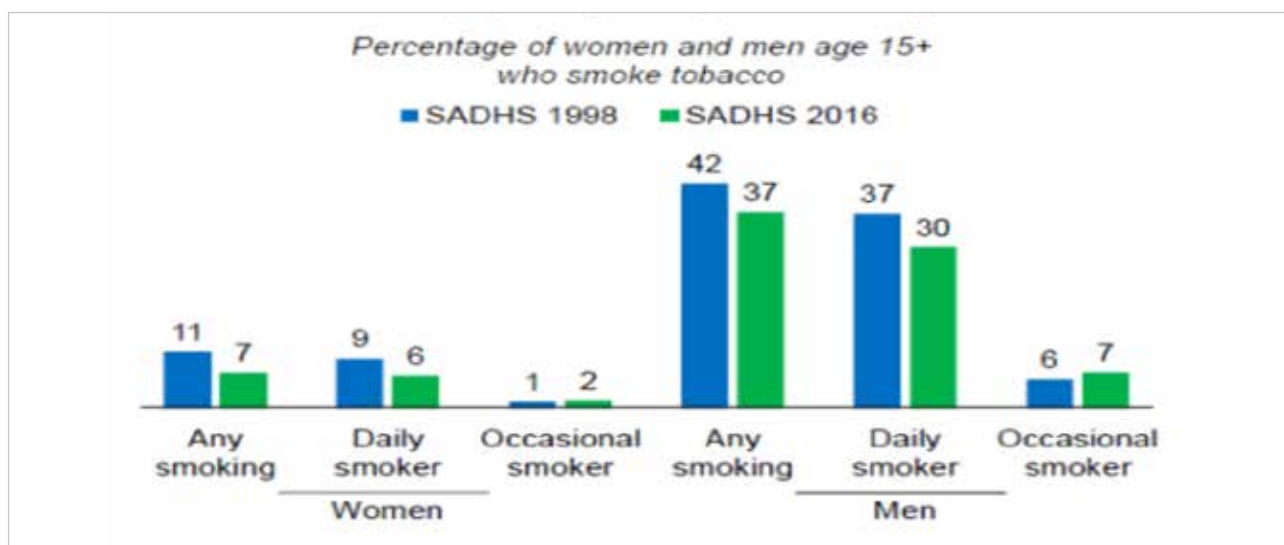


Figure 5 Comparison of tobacco smoking in 1998 and 2016, by frequency of smoking<sup>22</sup>

<sup>iii</sup> This decrease is in all likelihood due to health promotion activities taken, including fiscal and legislative interventions.

Sales of alcohol between 2012 and 2018 reflect a somewhat flat level of consumption (Figure 6)<sup>23</sup>. However, according to the 2016 SADHS, rates of risky drinking are particularly high with over 20% of young men (15-20) and around 36% of men in the 25-34 age group drinking to risky levels<sup>22</sup>. In 2018 the WHO estimated an average annual per capita consumption of alcohol for South Africa (persons over 15 years of age) as 9,3 litres (16,2% of men and 2.7% of women); and the proportion of heavy episodic drinkers as 18.2%<sup>23</sup>. However, 59% of drinkers engaged in heavy episodic drinking. The numbers of people abstaining from alcohol consumption in the past 12 months was estimated at 56.8% of males and 80.6% of females<sup>24</sup>.



Figure 6 Volume of alcohol in 000's of litres<sup>28</sup>

Rates of *physical inactivity* are also very high in South Africa. Twenty eight percent (28%) of men and 47% of women are doing insufficient physical activity<sup>25</sup>.

## 4) KEY REQUIREMENTS FOR GOOD HEALTH

As apparent as the need is to have healthy people, there are fundamental requirements to achieve healthy individuals and populations. Three broad areas stand out<sup>iv</sup>: the role of social, political and economic forces in healthy outcomes; combatting the direct behavioural determinants of ill health to improve health and the need for excellent quality and accessible health care, treatment and rehabilitation at all levels of the health system across the life course for better health.

- 1. Health is dependent on social, political and economic forces.** Health status of populations between countries, and even between people in countries is caused “by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities” (Commission on the Social Determinants of Health (CSDH)<sup>5</sup>). Similarly, related issues of unemployment, quality of education and housing, nutrition, safe water and sanitation and many other social determinants are critically important to health, but have little to do with health services and health systems per se. As the then General Secretary of the United Nations Kofi Annan put it in 2001, “Poverty is the biggest enemy of Health in the Developing World”<sup>26</sup> and there is little that has altered since then to suggest that this situation has changed. Poverty, together with a number of other profound social ills such as gender inequality, maldistribution of land, violence and other power, economic and educational differentials are without doubt central to health and will require major changes to enable global health to thrive. Figure 7, from the Lancet NCD Action Group shows how NCDs are impacted on by at least 9 of the other SDGs<sup>27</sup>.

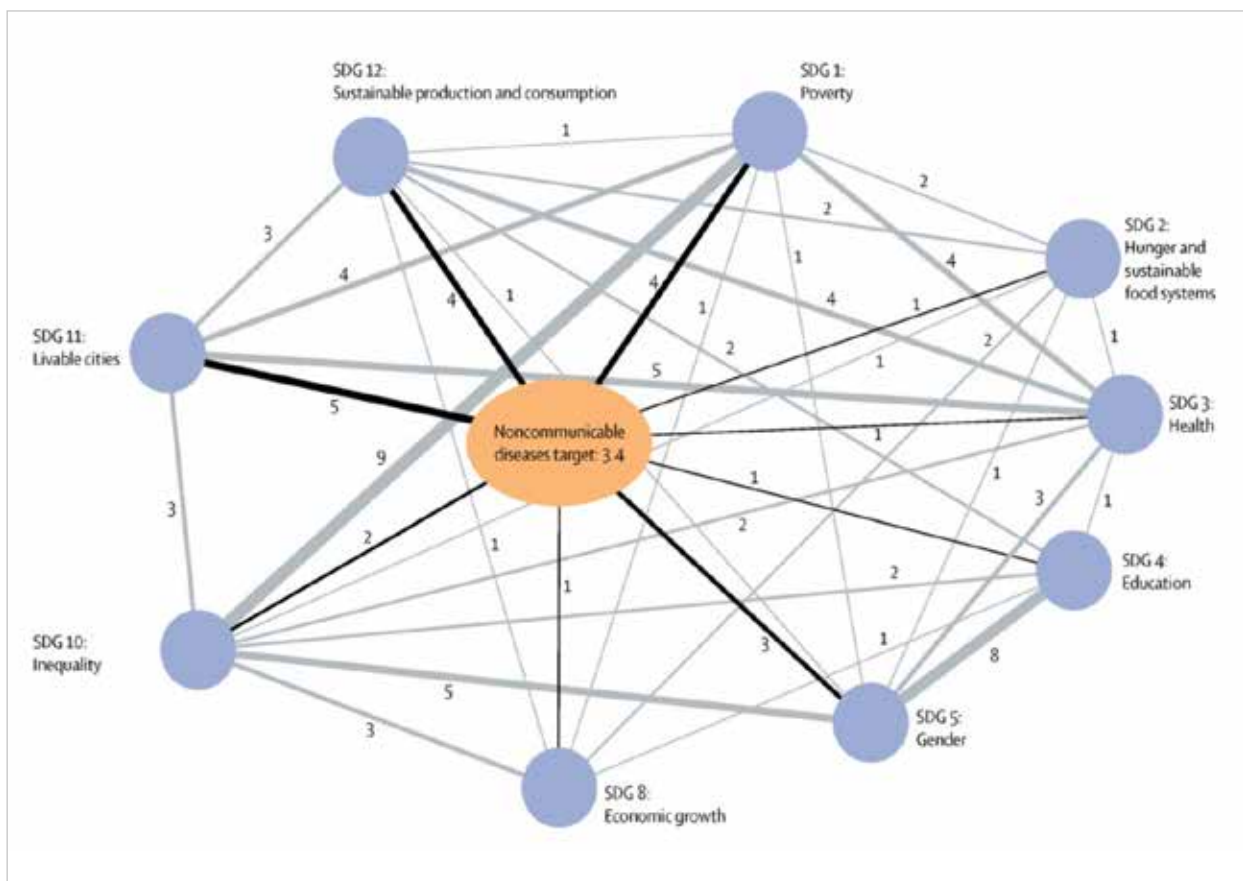


Figure 7 Links between nine SDGs and NCD target 3.4<sup>27</sup>

<sup>iv</sup> It is important to note that the below are not mutually exclusive. For example in poor countries, not only are people prejudiced by the health impacts of living in poverty such as living in a house without water and sanitation and breathing air from a coal stove, but access to healthy foods and gyms to do exercises is highly limited by their economic positions. Moreover, the health services in poorer areas are usually worse and the transport costs to get there are proportionately much higher.

- 2. Better health can be achieved through combatting the direct behavioural determinants of ill health.** There are key direct and modifiable risk factors for health. For non-communicable diseases, the main behavioural determinants of ill health have been identified by the WHO and the United Nations General Assembly as tobacco use, unhealthy diet, abuse of alcohol, physical inactivity and air pollution. Reducing these risk factors would significantly reduce morbidity and mortality. Social and behavioural change communication (SBCC) is central to this approach. While behaviours are practiced by individuals, these are usually themselves driven by forces that lie outside their direct control. Behaviour change thus involves a complex set of interventions that go well beyond the individual and involve cultural, social, economic and commercial factors – many of which overlap with determinants mentioned in 1 above.
- 3. Better health outcomes will be attained through excellent quality and accessible health care, treatment and rehabilitation at all levels of the health system across the life course.** Health systems and services must achieve universal health coverage (UHC) within a highly functional health system that comprises optimal coverage of each of the WHO health systems building blocks i.e. (i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/governance<sup>28</sup>. Within the South African context, improving health services requires fully addressing the 9 pillars for health agreed to in the Presidential Social Compact, many of which overlap with the health systems building blocks<sup>29</sup>. These pillars are: 1) Human resources (health workforce); 2) Supply chain management, medical products, equipment and machinery; 3) Infrastructure plan; 4) Private sector engagement; 5) Health service provision (delivery); 6) Public sector financial management; 7) Leadership and governance; 8) Community engagement; and 9) Information systems.

In addition to the structural and process requirements from the health system, gaining best health outcomes necessitates optimal clinical interventions, including the discovery and cost-effective use of medicines, surgery, nursing care, laboratory services, palliative care and other care related interventions. *In essence, health is critical to personal, social and economic well-being, while itself being dependent on a range of social, economic and commercial determinants, behavioural factors (that have complex causes) and accessible and quality health systems and services.*

## 5) IS EVERYTHING THAT PROMOTES HEALTH THE DOMAIN OF HEALTH PROMOTION?

Health promotion currently suffers from a “crisis of boundary”. This begs the question “Is anything (and everything) that promotes, or can potentially promote health, health promotion?” If affirmative, then at the very least, fully addressing all the social, economic and commercial determinants of health, improving health systems and services, changing health behaviours and their causes, health systems and even clinical interventions fall within the realm of health promotion as health is indisputably promoted through each of these.

The position taken here is that while curative health care, including clinical interventions, health systems development and related research unquestionably promote health, they are seldom, if ever, seen as health promotion or included in health promotion practice or literature<sup>v</sup> and, in fact health promotion is often portrayed as the alternative to curative care and treatment<sup>30</sup>. We therefore will not set up a “straw man” debate in this regard. What is highly relevant though is the extent to which addressing broader social, economic and commercial determinants that can and should be included as part of health promotion and whether there should also be limitations or boundaries drawn on these determinants of health. In the following sections we examine the narrow perspective of health promotion and its limitations, examine broader conceptualizations and definitions and then consider how far health promotion should go in attempting to address broad health determinants.

### 5.1) The narrow perspective on health promotion

“Health promotion programmes aim to engage and empower individuals and communities to choose healthy behaviours, and make changes that reduce the risk of developing chronic diseases and other morbidities. Wellness is related to health promotion and disease prevention. Wellness is described as the attitudes and active decisions made by an individual that contribute to positive health behaviours and outcomes”<sup>31</sup>.

This perspective of health promotion puts the main focus and responsibility for health and related behaviours on individuals themselves and sometimes also on communities. Once empowered with the correct information and knowledge, it becomes the individual’s responsibility to make informed decisions about their own health. There is an assumption that when people know what is good for their health, they will act in accordance with this knowledge. Paired with this though, is the ideological proposition that it is a person’s own choice whether to act towards their own better health or not, and hence “forced” interventions, even those proven to promote health, are unacceptable. The primary role of health promotion is therefore to ensure that people have the correct and most up to date information available, but not to enforce this. Going beyond education and information is seen as interfering with a person’s individual rights to choose and hence their personal freedoms. This model, which was dominant prior to the 1970s, but still persists currently and is strongly promoted in South Africa through groups such as the Free Market Foundation<sup>32</sup>, is based on the biomedical model of health and a liberal social and economic ideology.

This approach has been criticized largely because it treats people in isolation from their context and the many influences that impact behaviour<sup>33</sup>. It has been largely discredited as it fails to take environmental, economic, political, commercial and other social factors or determinants into account. It also fails to adequately address the well-studied gap between knowledge and behaviour<sup>34</sup> and how to bridge this. It is still however widely practiced, including by people trained as health promoters. This approach is particularly limited in lower and middle income countries (LMICs) where health decisions and behaviours seldom de facto rest with the individual. However, even in higher income countries there are very strong forces, including very strong commercial forces, that determine health related behaviours and true individual choice is usually a misnomer.

This is not to say that working with individuals and communities is in itself either wrong or that it cannot effectively impact health, but that this must be done within a context of understanding the drivers of ill health in a particular situation. More is needed to address behaviour change, including working in familial spaces and across communities, to advocate and mobilise for opportunities to make and sustain healthy changes. Empowering individuals so that they

<sup>v</sup> This does not imply that health behaviours linked to curative care such as promoting adherence to care or health seeking behaviours should not be included as health promotion.

are not only encouraged to change their personal behaviours towards healthier lifestyles, but also act to challenge and change the underlying causes of their unhealthy lifestyles, is indeed practicing progressive health promotion.

## 5.2) Global initiatives to broaden the scope of health promotion

### The Ottawa Charter on Health Promotion

The Ottawa Charter on Health Promotion is generally credited with being the beginning of a more comprehensive approach to health promotion. In this Charter, the understanding of health promotion shifts away from health as the responsibility of individuals alone towards an emphasis on creating an enabling environment that would support individuals to make healthy choices. It focuses on strengthening community action, building healthy public policy, developing personal skills and reorienting health services as ways of ensuring this<sup>35</sup>.

Five key action steps towards health promotion were identified and adopted by the congress that adopted the Charter: build healthy public policy; create supportive environment for health; strengthen community actions; develop personal skills and reorient health services moving into the future. Three basic strategies were highlighted: to enable, to mediate and to advocate. Figure 8 graphically represents this position whereby the outer circle represents the goal of “Building Healthy Public Policies” and the need for policies to “hold things together”. This circle has three wings inside it which symbolise the need to address all five key action areas of health promotion in an integrated and complementary manner. The small circle stands for the three basic strategies for health promotion: “enabling, mediating, and advocacy”. The three wings represent and contain the words of the five key action areas for health promotion – reorient health services, create supportive environment, develop personal skills and strengthen community action<sup>36</sup>.

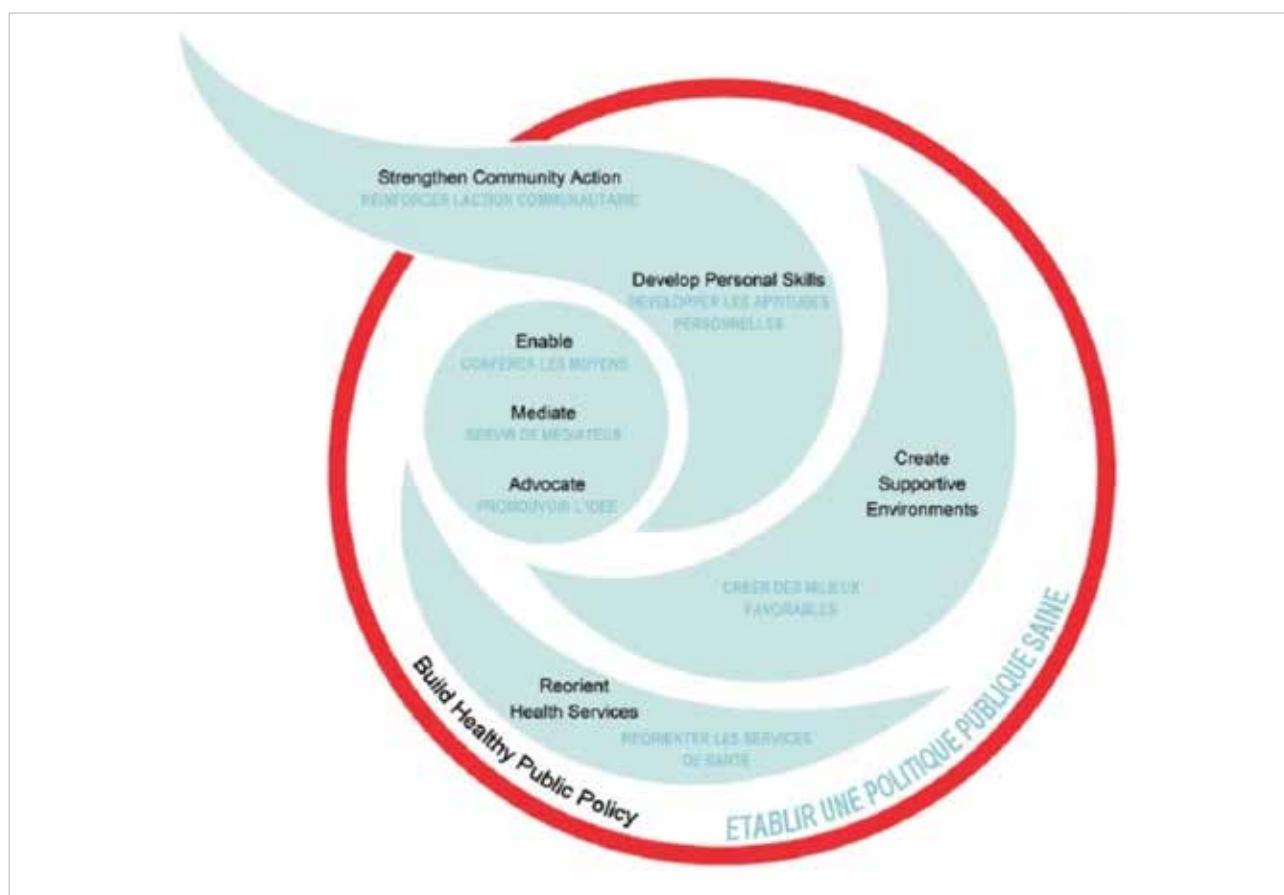


Figure 8 Model of Health promotion from Ottawa Charter<sup>36</sup>

The principles of the Ottawa Charter have been built upon at a number of UN conferences on Health Promotion between 1986 and 2016 (Adelaide 1988; Sundsvall 1991; Jakarta 1997; Mexico 2000; Bangkok 2005; Nairobi 2009; Helsinki 2013) and culminated in 2016 in the Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development<sup>37</sup>.

## Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development

Four action areas were identified in the Shanghai Declaration as critical to promoting health (Figure 9)<sup>37</sup>.

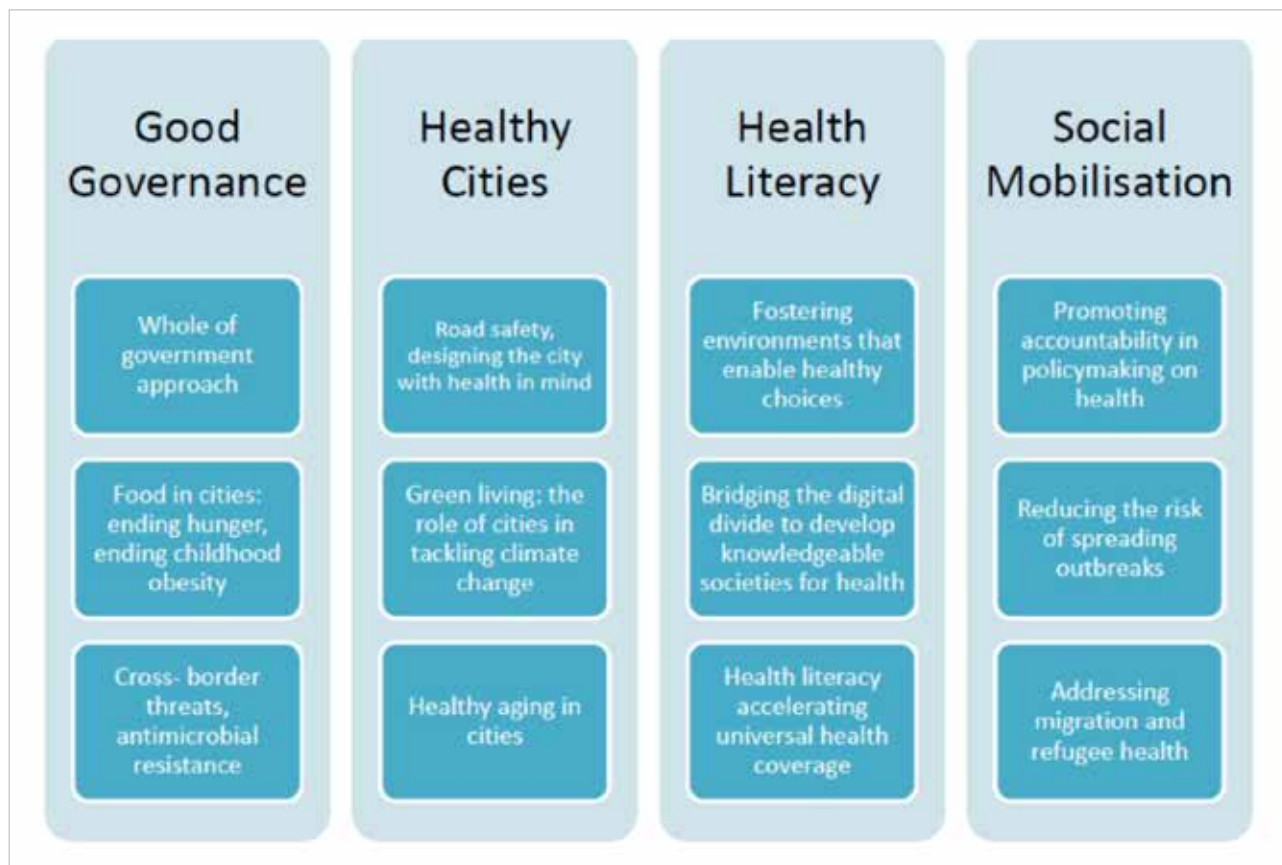


Figure 9 Model of Health promotion from Shanghai Declaration<sup>37</sup>

This model recognizes the importance of integrated/cross sectoral planning to promote health as well as the importance of “top-down” as well as “bottom-up” organisation. Health promotion as a discipline cannot survive without drawing on the involvement of a range of sectors that impact on health, and on the collaborations that will enable more healthy outcomes. There is also strong recognition that while country level initiatives are very important through, for example, legislative or regulatory mechanisms, or engaging in policies that ensure that healthy foods are available, the city/urban conglomeration needs to organise across sectors at this level too.

There is also significant acknowledgment given to the fact that without involvement of people who believe, and in reality have, firstly a chance to participate in their own better health, and secondly to influence environments towards those in which they can be healthy, that health promotion is likely to fail.

## WHO definition of health promotion

The World Health Organization has attempted to find middle ground between the broad and narrow approaches of health promotion by defining health promotion as “The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.”<sup>38</sup>

The first part of the definition veers strongly to the side of individual responsibility, but then attempts to shift from this individualistic position by suggesting that social and environmental interventions are also needed. However, it is not clear from this definition whether the social and environmental interventions are directly linked to enabling people to increase control and improve their health (i.e. all changes are aimed specifically at assisting people to change their behaviours), whether these are additional (unrelated) interventions in the social and environmental spheres, or perhaps both. Whichever this is, this definition emphasises both the importance of people taking more control of their health and of the environment as an important factor that needs to be modified in order to optimally promote health.

### 5.3) Promoting health through addressing distal health determinants

The evidence showing that the health impacts of social, economic and commercial determinants is persuasive and the argument that, of the three broad areas that impact on health described previously, it is the broad determinants of health that most significantly determine population health status, is compelling. The Commission on the Social Determinants of Health (CSDH), supported by in-depth research, states that “Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health”<sup>5</sup>.

The Commission proposes three main areas for intervention to redress the core problems identified:

- a. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
- b. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
- c. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

The CSDH is in all likelihood correct in concluding that health will be most effectively promoted through changes in the most basic and fundamental social determinants and implementing the above recommendations. Moreover, the need to tackle a broad range of SDGs in order to redress NCD prevalence, as illustrated in Figure 7, is convincing.

This type of broad approach was well exemplified during Apartheid in South Africa, when health workers and writers recognised that far more would be achieved for health by ridding the country of the “Disease of Apartheid” and the political cause of ill health than any number of narrower health interventions<sup>39,40,41</sup>. Political activism contributing to the downfall of Apartheid was thus perceived as more pertinent to achieving improved health outcomes than any number of more conventional health interventions would ever have been. Political actions were hence inspired by the need for better health without any direct health interventions being implemented.

It would appear that the main recommendations from the CSDH are following a similar path that improved global health will be best achieved through tackling the root social and economic problems of the planet and within countries, even if these are distal or “causes of causes”. However, it is not clear whether this would be the role of health promotion to instigate and how far health promotion would be expected to implement the necessary interventions. The underlying principle, that for better health, the broad social determinants should be identified and addressed, holds sway even outside of such obvious determinant as Apartheid. South Africa still has poverty, unemployment, lack of housing, gender inequality and violence against women, landlessness and many other social challenges that impact negatively on health. Perez et. al., in a motivation for developing a Health Promotion Development Foundation (HPDF) in South Africa, say



that the “emphasis would be on reducing the effects of poverty, inequity and unequal development on disease rates and wellbeing”<sup>42</sup>. It is not clear however *how* they would do this, and whether, as a Foundation, the intention would be to get involved in poverty alleviation projects or dealing with issues of inequity, or to merely identify these relations with health and propose that others implement the changes. While one may agree that redressing the broad social and economic challenges may well be more important to the country’s health outcomes than any additional health services that may be provided, or indeed from what may be achieved through attempting to deal with more direct NCD risk factor determinants, this does not necessarily mean that these broad determinants **should become the main focus of health promotion, or indeed of a Health Promotion Foundation or equivalent?**<sup>vi</sup>. It may well be argued that fundamental social problems should be addressed because their alleviation or reversing of them are worthy of striving for in and of themselves – rather than for the sake of achieving positive health outcomes. Putting a health lens as the prime priority for development and for tackling the core social and economic problems of the country potentially undermines the intrinsic importance of these essential values and goals. In South Africa poverty, unemployment and inequality are stated priority objectives of the government and they must be dealt with not because doing so is good for health, but because of their own undoubted and essential importance. If effectively addressed, meeting these objectives would **of course** have massive positive health implications, but the main driving force need not be, and many would argue should not be, health. Similarly building houses for indigent people will undoubtedly bring positive health outcomes, but the necessity to build houses doesn’t need a rationale in health, and nor does education, transport, water supply or any other number of social services that are rights and expectations in and of themselves. However, the impact on health of addressing housing, education, transport, water and other social needs has the potential to be significant.

A variation of this broad model that focuses on the importance of social, economic and commercial determinants, but does not involve people concerned with health promotion and attempting themselves to take on and redress the broad determinants themselves, is a “whole of government”, “whole of society” and “health in all policies” approach. The WHO defines Health in All Policies as referring to “taking health implications of decisions systemically into account in public policies across sectors, seeking synergies, and avoiding harmful health impacts, in order to improve population health and health equity through assessing consequences of public policies on determinants of health and well-being and on health systems.”<sup>43</sup>

Poor health status of indigent and rural people can for instance be utilised as *added motivation* for poverty alleviation and rural development programmes, with health becoming an *additional* reason to reduce poverty or develop rural areas without making it *the* reason. Information collected on health can be employed to better understand poverty drivers, and the Department of Health can use this to apprise other governments departments such as agriculture, transport, trade, environment and others of what may be required from them in order to impact more positively on both development and health. This is likely to involve providing analysis and information, including information on the interactions between health outcomes and social determinants and possibly organising communities to make health demands that require redress in sections other than health.

The *shaping* of interventions by other sectors can and should be informed by health needs. For example, if promotion of jobs through energy generation is adopted as part of a poverty alleviation strategy, health advocates should argue that this should be in the renewable sector rather than in coal production, as the latter would result in more illness in the longer term. Similarly, in building human settlements, health experts could contribute by informing the lead department of the health benefits of open spaces and parks, bicycle lanes, disability requirements and ventilation in houses, so that the lead department can promote health in undertaking its core responsibilities. Where the primary capacity for making concrete changes falls outside of the direct line function of health, the responsibility and accountability for making the changes needed would be with the relevant sector – though now armed with more information and (hopefully) more motivation. In effect, the health concerns would be identified and integrated as part of the rationale for changes in other sectors and even possibly as an indicator of their successes, without health or a health focus attempting to take over the rationale, responsibility and accountability of these changes.

## 5.4) Putting health or well-being at the centre of development

Given that health is not only a product of social policies and a driver of development<sup>26</sup>, but also a good indicator of how well a country is doing in terms of its social and economic development and its well-being, there is a rational base

<sup>vi</sup> It is relevant that this motivation was for a Health Promotion and Development Foundation, whereas most other countries have set up only a Health Promotion Foundation.

for a country putting health at the centre of its development agenda, including its budgetary agenda. As Ban Ki Moon, the previous Secretary general of the United Nations put it “Health and well-being are at the centre of the Sustainable Development Goals. They are a precondition, an outcome and an indicator of progress. That is why we must promote health through all 17 global Goals with innovation and commitment”<sup>44</sup>. All else could then ultimately be measured in terms of how well it has contributed to the health status of the country.

While it would be highly contentious to make health outcomes the main rationale for country outcomes, as explained above, there are similar approaches emerging. The closest modern<sup>vii</sup> example is the country budget passed by New Zealand in 2019<sup>45</sup>. This wellbeing approach<sup>viii</sup> required that any new spending must advance one of five government priorities:

1. Improving mental health;
2. Reducing child poverty;
3. Addressing the inequalities faced by indigenous Māori and Pacific island people;
4. Thriving in a digital age; and
5. Transitioning to a low-emission, sustainable economy.

Within this approach it is well understood that for people to thrive, objectives that might usually be at the forefront of government strategic planning such as economic growth, while still essential, are the means towards human well-being, rather than ends in themselves. For example, a growing economy, while necessary, is no guarantee of well-being as not everyone may benefit from it. But by putting well-being as the primary goal, growth is deemed important *if and only if* the most vulnerable are prioritised to benefit from it.

While this debate is significant, putting health at the centre of government prioritisation is not imminent in South Africa and hence (currently at least) not helpful in assisting to define the parameters of the discipline of health promotion. Instead, the current South African priorities that all departments and agencies are required to work toward that were outlined by the President in his 2019 State of the Nation Address<sup>46</sup>, and which health needs to align with, are:

1. Economic transformation and job creation;
2. Education, skills and health;
3. Consolidating the social wage through reliable and quality basic services;
4. Spatial integration, human settlements and local government;
5. Social cohesion and safe communities;
6. A capable, ethical and developmental state and
7. A better Africa and World.

## Health in all policies and whole of government approach to health risk behaviours

Slotting between the position that each and every broad social and economic policy that impacts on health is/should be the subject matter and target of health promotion interventions, and the narrow approach that concentrates on changing individual health and lifestyle behaviours, is a view whereby key modifiable risk factors for disease are identified, highlighted and become the focus of health promotion programmes. Within NCD health promotion these areas, as identified by the WHO, are poor diet, tobacco use, alcohol, insufficient physical activity and air pollution. The exact extent to which modifiable risk factors could prevent NCDs in South Africa has not been calculated, however the WHO in the region of the Americas (PAHO) estimated that 80% of all heart disease, stroke, and Type 2 diabetes and over 40% of cancer is preventable through multi-sectoral action<sup>47</sup>. Given that many of the countries in the PAHO region share socio-economic similarities with South Africa, analogous figures are probable in South Africa too.

Critical to this position is that the identified risk factors are firstly not isolated from their context, and secondly that the changes required are multi-sectoral and cannot be achieved from within the health sector alone. This approach

<sup>vii</sup> An earlier though somewhat different example was in Finland when as early as the 1970s it recognised health as a basic contributor to the welfare of the country. The health of the population in Finland became a political priority with the recognition that health outcomes depended less on the provision of health care services than on social factors. In 1985 the Finnish parliament approved targets and policies for health, even for sectors outside of health care.

<sup>viii</sup> If health, rather than a broader notion of well-being, was at the centre of the country budget, it would probably have resulted in slightly different priorities, however the approach would be the same and the outcomes would, in all likelihood, be fairly similar too.

potentially leads into the establishment of structures such as a National Health Commission or a Health Promotion Foundation (See pgs. 39-43). This approach also draws heavily from the WHO definition of health promotion and more particularly on the Ottawa Charter on Health Promotion<sup>35</sup> and the Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development.<sup>37</sup>

## 6) WHERE ARE WE WITH HEALTH PROMOTION IN SOUTH AFRICA?

In 2007 Hans Onya conducted a review and assessment of health promotion in South Africa<sup>48</sup>. He pointed out that the first significant statement on health promotion appeared in the African National Congress (ANC) health policy document in 1994, suggesting that the intention of the first democratic government was to give adequate attention to the promotion of health and the prevention of illness. This commitment translated into a Directorate in the National Department of Health in its first organogram. However, Onya points out that while this section continues to exist, it has not lived up to the expectation created in the ANC policy document that health promotion would be prioritised. The directorate operates with a very small budget and inadequate staff to make any real impact.

Onya's review further notes that health promotion:

- Is spread to all levels of the health system but without sufficient depth and understanding to make a positive difference to population health;
- Funding for health promotion activities comes from the Department of Health budget allocation by the National Treasury but this is insufficient;
- Infrastructure is a problem;
- Research and evaluation is limited;
- Lacks trained health promotion specialists either capable or in the position to inform politicians and opinion leaders about the relationship between health and social determinants;
- Shows minimal evidence of effectiveness of health promotion action;
- Lacks occupational standards for health promotion education and training are needed<sup>48</sup>.

### 6.1) Department of Health Promotion Policy and Strategy 2015-2019

In 2015, the National Department of Health, in consultation with a number of health promotion stakeholders, adopted a 5-year Health Promotion Policy and Plan<sup>49</sup>. This policy and strategy recognises that "health promotion is not only focussed on impacting on individual behavioural outcomes, but also upon social networks, community norms and attitudes. It also aims to create an enabling environment by incorporating health promotion into all policies, strategies and programmes in order to foster a culture for people to improve and maintain their health by placing health at the centre of the development agenda" (pg. 7). The document further states that "Health promotion in South Africa has... evolved from health education to become a comprehensive programme, which includes education, training, research, legislation, policy coordination and community development". The document utilises a social ecological framework, that recognises the interconnected influences of family, peers, community and society on health seeking behaviours. It further states that health issues can be addressed by focusing on the structural factors that undermine effective health outcomes such as income, gender and social equality and that "promoting the health and well-being of the population is central to the activities of all government departments, and each has some responsibility that relates directly to the health of the people, ranging from actual threats to health to circumstances that inhibit healthy living in work, school and home settings" (pg. 12).

The policy describes roles and responsibilities of health promoters at national, provincial and district and or sub-district levels and within certain contexts like the Ward-Based PHC Outreach Team. Five specific goals are outlined, with activities and outputs to be achieved under each of these. They are 1) Advocate For Healthy Public Policies To Achieve Health Outcomes 2) Empower Local Communities On Health Promotion Approaches That Facilitate Strengthened Community Action And Ownership 3) Create An Enabling Environment That Promotes Healthy Behaviour Practices 4) Strengthen Human Resources Capacity To Deliver Health Promotion Services 5) Strengthen Systems To Monitor And Evaluate Health Promotion Intervention.

As yet no formal evaluation has been done on the Policy and Strategy to establish the extent to which it has been implemented and its impact on health in South Africa. However, in order to assess the current position of health promotion in South Africa and to gauge where the country should be going in this regard, interviews were conducted by the first author of this report with 13 health promotion experts from government, academia, NGOs and the MRC itself during the first half of 2019.

## 6.2) Findings of expert interviews

There was an overwhelming sense from interviewees that despite the Department of Health Policy and Strategy and commitments made to promoting health, health promotion as a discipline is underperforming relative to its potential to contribute to health. Some comments were that health promotion is “fragmented and vertical”, “underfunded”, “culturally out of touch”, “not enabling”, “is not attended to”, “fails to change social norms”. On the other hand, the potential for health promotion to be a game changer for better health in the country was unanimous<sup>ix</sup>.

Most respondents felt strongly that funding for health promotion was “laughable” and consequently the discipline was largely unable to show what it was worthy of achieving if it were to have the resources to do more. One of the problems is that for health promotion, especially for NCDs, the results are not immediate, and there is an impatience, especially within government, to see outcomes within a very short space of time. As one interviewee put it there is a near obsession with “low hanging fruit”, and quick results are almost impossible to achieve with NCDs. Experts also bemoaned the fact that whatever money is available for health promotion gets sucked up into relatively superficial and untested information and education campaigns, that were generally thought to have little impact.

Some respondents expressed the view that with the advent of National Health Insurance, there was real potential to get health promotion moving in a positive direction and for far more activity to take place in this area than has ever been the case previously. (This relates to point 3 on page 6 above where it is stated that NHI could well collapse unless drastic steps are taken to keep more people healthy). However, respondents stated that unless this was backed by thorough research and resources for implementation from the NHI fund, this opportunity could well be missed.

The importance of a life-course approach to health promotion was emphasized by a number of the experts. They asserted that promoting health must start in the foetus, continue through birth and infancy and endure right through the life course to old age and palliative care. It was however expressed that the more that is done early in life to promote health, the better adult health will be, the more health care costs could be saved, the more the economy will thrive and the better the well-being of the populous will be. The importance of people making decisions that are health promoting; creating environments that facilitate healthy decision making and also fashioning environments where health is promoted without even involving individuals were all seen as important. As an example, a pregnant women should be fully aware that she should not drink alcohol as this might endanger her foetus; she should have the support from her partner, family, friends and community (who for example may decide themselves not to drink to support her during this period); and the cost of alcohol and its accessibility should be structured so that this woman is discouraged and disincentivised from consuming alcohol. However, if Foetal Alcohol Spectrum Disorders (FASD) cannot be avoided, the child and the mother/family of the FASD child will need special health promotion support throughout the child’s life. Health promotion is hence not doing one thing, but involves a series of interventions at different levels ranging from health knowledge and support through to legislation and regulation and social (including educational, transport, labour) and health support.

A second example is that South Africa has a serious challenge with the twin epidemics of under and overnutrition<sup>x</sup>. Health promotion has a very important role in combatting both of these. Importantly, the main problem is not of mothers deliberately depriving or starving their children or purposely feeding them unhealthy foods that make them obese, but issues such as breastfeeding that may be restricted because the mother has to go to work and hence has to stop feeding, and limited access to healthy foods due to their (un)availability and cost. It is also a problem of general education rather than health education per se. Improved general education for the mother and improved life outcomes is more likely to lead to better health literacy and the ability to feed a child than giving health education to an indigent woman that is restricted from doing things differently due to their life circumstances. Hence to conceptualise health

<sup>ix</sup> Given that most of these interviews were done with experts in health promotion it was perhaps inevitable that they all saw the critical importance of their own discipline, however each interviewee was able to back up why they thought this to be the case and how health promotion may change the health landscape in South Africa.

<sup>x</sup> Overnutrition is usually defined as a BMI of over 25.

promotion without reference to poverty, education, transport, labour and gender is to do an injustice to the child, the mother, the family and the community and may easily result in victim blaming.

At present, the health promotion “workforce” in SA are mostly health promoters<sup>xi</sup>. Interviewees largely felt that this cadre has an important role, but they were not trained to work independently in areas where they could have most impact and hence tend to be mostly involved in narrow health education approach rather than a broader health promotion approach and have minimal impact on population health. Most respondents felt that health promotion without research and without skilled researchers and epidemiologists severely limits the impact of what health promoters can achieve. One of the biggest roles of health promotion is to analyse and understand why ill-health trends are occurring and to identify the root or the source of the problem and to intervene appropriately. Most interviewees did not feel that most health promoters were able to conduct the necessary research to do this, due to their education and training levels and lack of support. However, they felt that health promoters could be excellent fieldworkers in such studies, and together with the researchers and community, identify both the problems and possible solutions to them. Their proximity to the local community and understanding of local culture would make most current health promoters outstanding holistic health promoters. They would, however, need to work as part of a team, possibly with the researchers and other experienced health promoters, to devise a strategy of how to feedback the results and to use evidence-based behaviour change techniques to shift local health patterns. It was also felt that they needed more training to do the public health work they are expected to do.

Some experts felt that health workers in clinical care excluded any health promotion and health information from their consultations, as they felt they could more easily refer to the health promoters to do this. This was felt to be an abdication of their responsibilities and an incorrect understanding of what health promoters can do to effectively impact health.

Most respondents suggested that events commemorating annual health days in all likelihood played little or no role in changing behaviour. However, as there was little or no local research into this, no concrete evidence existed either way.

Certain key respondents spoke at length about the lack of attention to the cultural aspects of health promotion and behaviour change. One interviewee went as far as to say that this was probably the main reason why the country was not winning the war against overweight and obesity. She opined that we often tell people what to do, without understanding why they do it – which obviously runs against all health promotion principles. Obesity and how it is perceived in some local cultures and how health messages countering it were formulated, was cited as a good example of this challenge<sup>xii</sup>.

The use and the potential use of Community Health Workers (CHW) to do health promotion was discussed with respondents. It was generally felt that the depth of knowledge of CHW in health promotion was insufficient. If they were to hand out pamphlets for example (which many do), their knowledge is inadequate to reinforce the messages and they could in fact potentially contradict the given information. If CHW were to effectively play the role of health promoters, they needed to be properly trained in healthy behaviours as well as in understanding the larger drivers of health choices and behaviour and social determinants of health to avoid victim blaming should the recipients of health messaging not be able to make changes. Experts felt that South Africa’s tendency towards encouraging an individualist culture results in the majority of people acting as individuals within a community rather than as a collective. It was suggested that health promotion activities would be more successful if, for example, health promoters were not encouraging individuals to make decisions to diet or to exercise which were usually very difficult for them to do in their circumstances, but facilitating whole communities to grow vegetables together or requesting a park gym and securing its safety, within an accountable structure. It was noted that health promotion works well in settings such as schools or cities/villages. However, this doesn’t work when the health promoter arrives with their own “big idea” of what they will be doing and neglects to find out where people are at and what they might want to do. Community participation was seen as central to the work of health promotion

While not being the panacea of health promotion, nor is it sufficient, most experts felt that health literacy is important as without information people would not be able to make healthy choices, even if they wanted to (though many still cannot). It was also felt that “behaviour literacy” and expectations of what is acceptable and suitable behaviour for people is largely determined by those selling (mostly unhealthy) products, rather than by those “selling” health. Therefore, countering perceptions was seen as critical – if the first prize of banning messaging promoting unhealthy lifestyles was not possible.

<sup>xi</sup> The proposed role of health promoters in South Africa are described in The National Health Promotion Policy And Strategy 2015-2019. Department of Health pages 23-25.

<sup>xii</sup> For example that a substantial body implies prosperity or that a lean body means that a person has HIV.

Importantly, it was felt that if done well, media communication and education can be highly effective; and if combined with other community-based interventions, could shift attitudes and actions. For example, well researched edutainment followed up with community-based interventions such as done by Soul City and Soul Buddies can be highly successful in promoting healthier behaviour<sup>50</sup>.

Assisting individuals with personal barriers towards health behaviour change has many facets. This includes behaviours to prevent ill-health, seeking health care when needed and adhering to health recommendations (including both lifestyle and medicine adherence). This is best facilitated through a person-centred approach. However, experts pointed out how social and personal factors map out into a complex web and that working with an individual alone often results in frustration. One expert spoke about how it is necessary to get individuals to engage with the structural barriers, and how at times it is necessary for people to do this in unison with others in similar positions, as individual impacts are often minimal. This approach fits well with the health promotion principle of mobilising communities towards positive health ends.

Current models of behaviour change have mainly been developed in high resource settings and have not generally included steps of how to engage with structural barriers to health. Behaviour change models look more at overcoming individual (internal) barriers, but this requires different skills and resources from how to deal with the obstacles of social (dis)organisation. Notwithstanding, any behaviour change programme can be complex, and most health promoters do not have the capacities required for addressing this, and certainly not for assisting with intractable problems that many people have, such as substance abuse.

Respondents also pointed to the fact that without a people-centred approach, health promotion would be ineffectual. Most health practitioners such as nurses and doctors have been trained to tell people what to do and this is antithetical to people taking more control over their lives, as is essential to behaviour change. As importantly though, health practitioners often give messages that are not possible for the recipient to implement. For example, telling an individual to eat five fruit and vegetables a day when they can either not afford it or there are no fruit and veg in the vicinity, results in victim blaming. The intervention can thus not only be seen as useless, but worse than useless.

Experts felt strongly that cost-benefit and cost-effectiveness analysis was very important for health promotion. This is important not only because health promotion is a “soft” discipline where health authorities need to be convinced that it works, and is not merely wasting money, but because in the current fiscal climate the Treasury will not release any (additional) funding until it has been shown that the benefits outweigh the costs. One respondent suggested that a similar study of ascertaining the WHO “Best Buys” should be done in South Africa as a study had shown that the research to come to these conclusions and recommendations had been mainly done in developed countries<sup>51</sup>. Only South African data that showed real cost savings through health promotion interventions was likely to stimulate action by any government department.

How much of a country health budget should be spent on health promotion and health research was debated. No specific amount was proposed other than “a lot more than currently”. It was proposed though that an analysis should be done on what other countries invest in health promotion, especially of countries that could show benefits of such programmes, and benchmark against this.

Highly common themes that ran through all the interviews were that we don’t know enough about:

- *what* can be achieved through health promotion because not nearly enough has been tried,
- *how* to do effective health promotion within our SA context and cultural complexity and
- *what* works and *why* as few comprehensive evaluations on NCD health promotion have been conducted<sup>xiii</sup>.

Despite this, experts felt that there is sufficient global and local knowledge about the causes of ill-health and a range of well-conceived, theoretically sound, and in some cases well tested (albeit not all local) health promotion strategies, many structural or regulatory in nature, that are highly likely to have positive impacts on health. Furthermore, it is not required to wait for more research to be done before introducing comprehensive health promotion interventions. Once employed though, these interventions should be thoroughly evaluated. This will inform their continuation and expansion or not. Simultaneously, additional evidence for innovative health promotion interventions should be generated.

<sup>xiii</sup> It is interesting to note that as part of the interviews, interviewees were requested to send any articles, documents of health promotion activities and evaluations that had been done in South Africa to assist this review. Interviewees were aware that my main focus was on NCDs. Of the 24 articles received 18 were focussed on HIV

Importantly, health promotion experts pointed to the need for links between various branches of health and health sciences and not just across different government departments. Experts pointed to the need to better understand the genetic and biological mechanisms of African populations as this relates to health promotion. For instance, what implications does the fact that most African woman have large buttocks have for measurement of BMI – and therefore weight loss recommendations and attempts? Is the tolerance for salt in African populations any different from European populations, and if so, what are the health promotion implications of this? In addition, it was felt that disciplines such as psychology, sociology and anthropology are all critical for understanding behaviour and for finding health promotion alternatives that fit local conditions, people and culture.

The area of health promotion research, especially in relation to NCDs, appears very scant.

## 6.2) Fiscal and financial interventions

An important area of health promotion in South Africa, and an area that has shown proven effectiveness, is fiscal and financial interventions. In their review in 2017, PRICELESS South Africa found preliminary evidence that fiscal measures – including taxes and subsidies – can improve health in the short term without relying either on additional budgetary allocations to Ministries of Health, or on public health systems to work more efficiently<sup>52</sup>. At the same time, they could raise revenue. They argue that fiscal measures could significantly help to reduce inequalities in health and contribute to progress towards meeting numerous Sustainable Development Goal (SDG) targets. Having identified major drivers of poor health outcomes as being alcohol, tobacco, high body mass index, and poor diet, they argue that this makes non-communicable diseases highly modifiable through fiscal measures as they drive market behaviour. The available tools considered include excise taxes, subsidies and income transfers. Taxes on products such as alcohol, tobacco and sugar present opportunities to reduce the occurrence of behaviours responsible for lifestyle and NCDs. It is anticipated for example, that the levy on Sugar Sweetened Beverages (SSB tax) that has recently been introduced will avert an estimated 8000 premature deaths related to T2DM over 20 years. Government would save R2 billion in subsidised health care, and raise ZAR6 billion in tax revenues per annum. An estimated 32 000 T2DM-related cases of catastrophic expenditures and 12 000 cases of poverty will be averted<sup>53</sup>. The deaths averted would be concentrated in the third and fourth income quintiles, while the bottom two income quintiles would bear the lowest burden of taxes.

In addition, The PRICELESS review proposes that reductions in the economic burden of transportation on pregnant women and incentives for chronic disease treatment adherence, may also be possible and cost saving in the longer term<sup>52</sup>.

## 6.3) Current limits on health promotion

The actions required to promote health seldom matches tangible interventions. While there are numerous reasons for this, three stand out:

1. The **intersectoral nature of health** is often not recognised or adequately acknowledged, and where it is, it is rarely translated into concrete actions.
2. The health sector and government in particular, is often caught in a **double bind vis-a-vis investing its resources**. On the one hand it is meant to care and treat people with good quality health care from early detection right through to rehabilitation and palliative care and throughout the life course. At the same time though, the health sector must promote health in all people, including both those that do not (yet) have a health condition as well as those that do, and prevent diseases/disorders from happening in the first place. Authorities may well know that investment in promoting health or preventing disease is not only a good thing in itself but is very often cost effective in the longer term, but there are ill people that need direct and immediate care and that require the available resources to be spent on them. When such choices need to be made, and pressures are coming from the ill person, their family and their community for treatment, then it is quite understandable that decisions are made in favour of providing curative care and hence by default against health promotion. It is also often a political decision where votes will be won and lost due to the availability and quality of health services rather than how well or badly a government has kept people healthy.

Importantly, decisions around investment of resources take place in a context of finite resources and hence the need to intervene in areas of highest impact. Answers must also be found in a context where health is not only a prerequisite for a range of development outcomes, but is also the outcome of multiple social and economic determinants. Hence, purely from a health perspective, a careful balancing of the resource pool is needed, such that optimal health outcomes are reached through a combination of investments directly into health and into the social and economic determinants of health.

3. Thirdly, the **knowledge base for health promotion is poor**. While there is a general sense amongst health planners that promoting health is a “good idea”, the evidence to shift this to become a budgetary “non-negotiable” item is inadequate. To get to such a point research is needed on:
  - What health promotion works globally and can this be extrapolated to South Africa? If not, why not and what would work instead?
  - What health promotion innovations could be introduced in South Africa that have not been tried elsewhere in the world?
  - What are the “best buys” for health promotion in South Africa? The World Health Organization “best buys” for prevention of NCDs are not based on studies that have been done in LMICS<sup>51</sup>. Other studies have pointed to the poor evidence available even for what are commonly considered to be good health promotion interventions<sup>54</sup>.
  - Demonstration projects are needed with thorough evaluation of what works and why.



## 7) WHERE SHOULD SOUTH AFRICA BE GOING WITH HEALTH PROMOTION?

There are many pointers in Section VI around where South Africa needs to go with health promotion with respect to NCDs. However, the strongest message is that the country is in serious need of a multi-sectoral approach and action.

### 7.1) Multi-sectoral action for better health

The need to comprehensively address the social determinants of health and to make sure that formal coordination takes place across sectors is contained in a number of important policy documents both globally and in South Africa. For example, the National Development Plan 2030<sup>55</sup>, the White Paper on National Health Insurance for South Africa<sup>56</sup> and the United Nations Political Declaration on the Prevention and Control of Non-communicable Diseases<sup>57</sup> all emphasise the importance of multi-sectoral collaboration and the need for a formal intersectoral structure/process to achieve their objectives. The ruling ANC at their party conference in 2007 committed to the establishment of a National Health Commission<sup>58</sup>. This has, however, never formally adopted into Department of Health plans, budget or organogram.

While no document has been formally made public by the Department of Health on how a National Health Commission would be comprised and how it would function, the previous Minister of Health stated on numerous occasions that such a structure would be established and that it would be chaired by the Deputy President of the country. Moreover in 2017, the government released a document, "NHI Implementation: Institutions, bodies and commissions that must be established" for public comment<sup>59</sup>. This document stated that 'promoting health and preventing illness is central to NHI as well as to social and economic growth and development in South Africa' and that this structure would deal with determinants of health, including its social determinants, and be part of NHI. It was proposed that a National Health Commission (NHCom) would be set up with the primary objective and purpose being to 'address the social determinants of health through a multi-sectoral and development approach involving key government departments and non-state actors'. This commission would 'co-ordinate key sectors in implementing "a health in all policies" and an all-inclusive approach to the prevention and control of Non-Communicable Diseases, including mental health".

A possible structure that has been considered by the Department of Health is that in addition to the Chair, there would be two Deputy Chairs who would be specialists/experts in NCDs. The members would consist of Ministers of relevant Departments inclusive of but not restricted to Ministers of Agriculture; Forestry and Fisheries; Basic Education; Communications; Co-operative Governance and Traditional Affairs; Economic Development; Energy; Environmental Affairs; Finance; Health; Higher Education and Training; Labour; Public works; Rural Development and Land reform; Science and Technology; Small Business Development; Social Development; Sport and Recreation; Trade and Industry; Transport; Water and Sanitation<sup>xiv</sup>. It would also have Civil Society stakeholders (NGOs and NPOs); academics/experts; organised labour; CEOs of Water Boards and in all likelihood also members of the private sector (though their involvement and role was still to be finalised and it would be essential to ensure there is no conflict of interest). Nominations (for non-Ministerial members) will be done through a public process and members would be appointed by the Deputy President.

<sup>xiv</sup> These Ministries were proposed prior to the slimming down of Cabinet by President Ramaphosa after taking office as President of South Africa and the amalgamation of some departments and changing of names of some Departments.

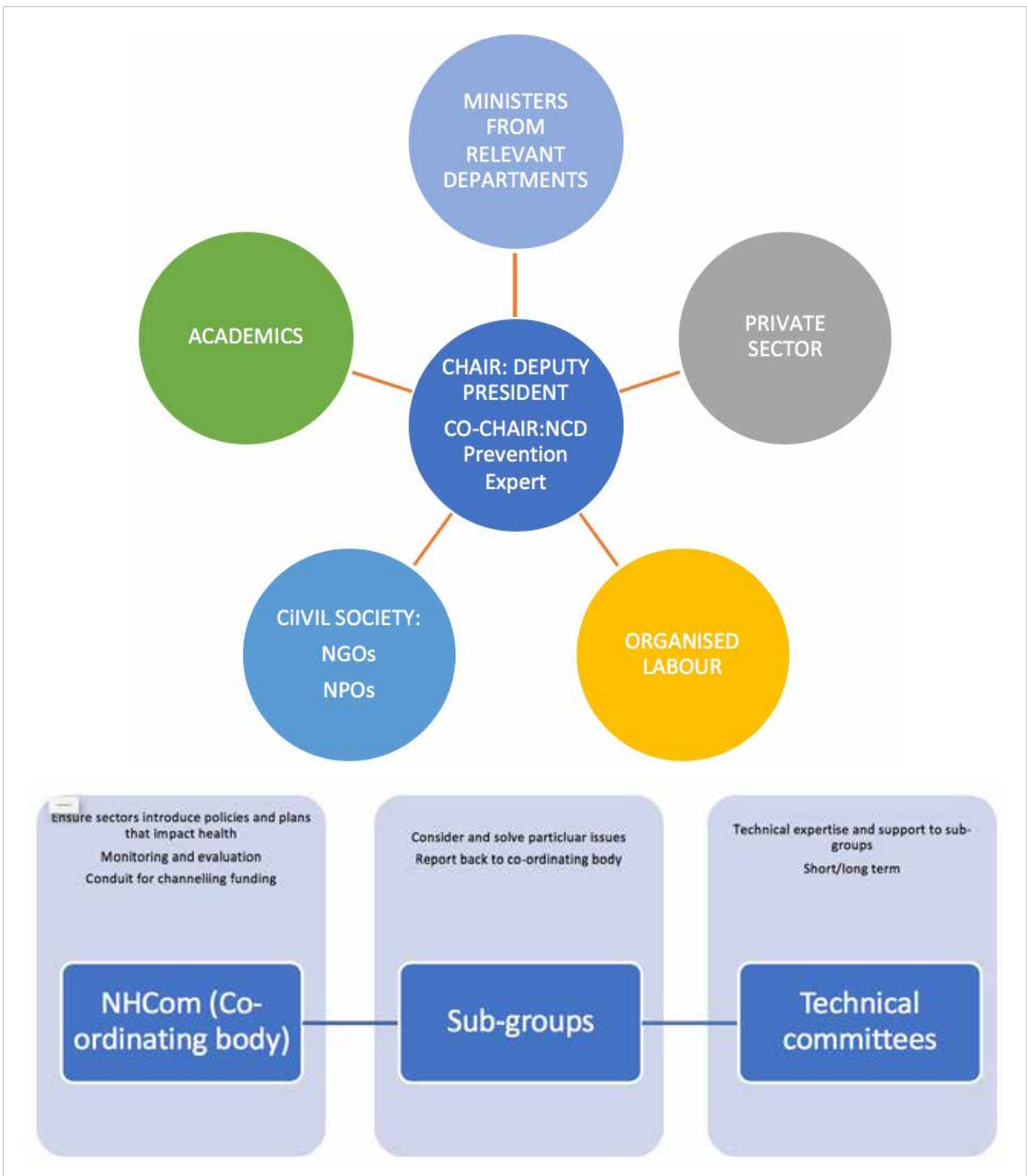


Figure 10 Proposal for a National Health Commission

Either complementary to (and possibly even nestled in) the NHCom, or independent from it, a Health Promotion Development Foundation (HPDF) has been proposed. The idea of a health promotion implementation structure within the NHCom as proposed above, though excellent for encouraging all sectors to engage in activities that promote health, would not itself have the capacity to implement health promoting projects or to provide resources to assist any sector to implement such projects. A HPDF would hence need to be funded to fill this gap. Freeman et al.(2020) have proposed that these should be from a direct allocation from the National Health Insurance Fund<sup>17</sup>.

An independent HPDF has been strongly proposed by Perez et al.<sup>42</sup>, based largely on the successes of similar independent foundations elsewhere in the world. They say that that HPFs generally operate independently of government, but

support government priorities and contribute to the development of evidence-based public policy. They point out that international best practice shows that effective HPFs need to be able to make autonomous decisions about policies, programmes and funding, while their policies should remain within government parameters. They suggest that this bypasses bureaucratic deficiencies and its autonomy provides greater freedom to advocate for a wider range of health and development interventions. They propose that a HPDF can also provide a research platform for policy development, advocacy, intersectoral planning and policy. They say that in the medium to long term, an HPDF reduces the costs associated with curative care, while promoting broader social and development goals<sup>42</sup>.

Probably the most famous and possibly most successful health promotion foundation is that established in Thailand in 2001<sup>60</sup>. The Foundation is set up as follows:

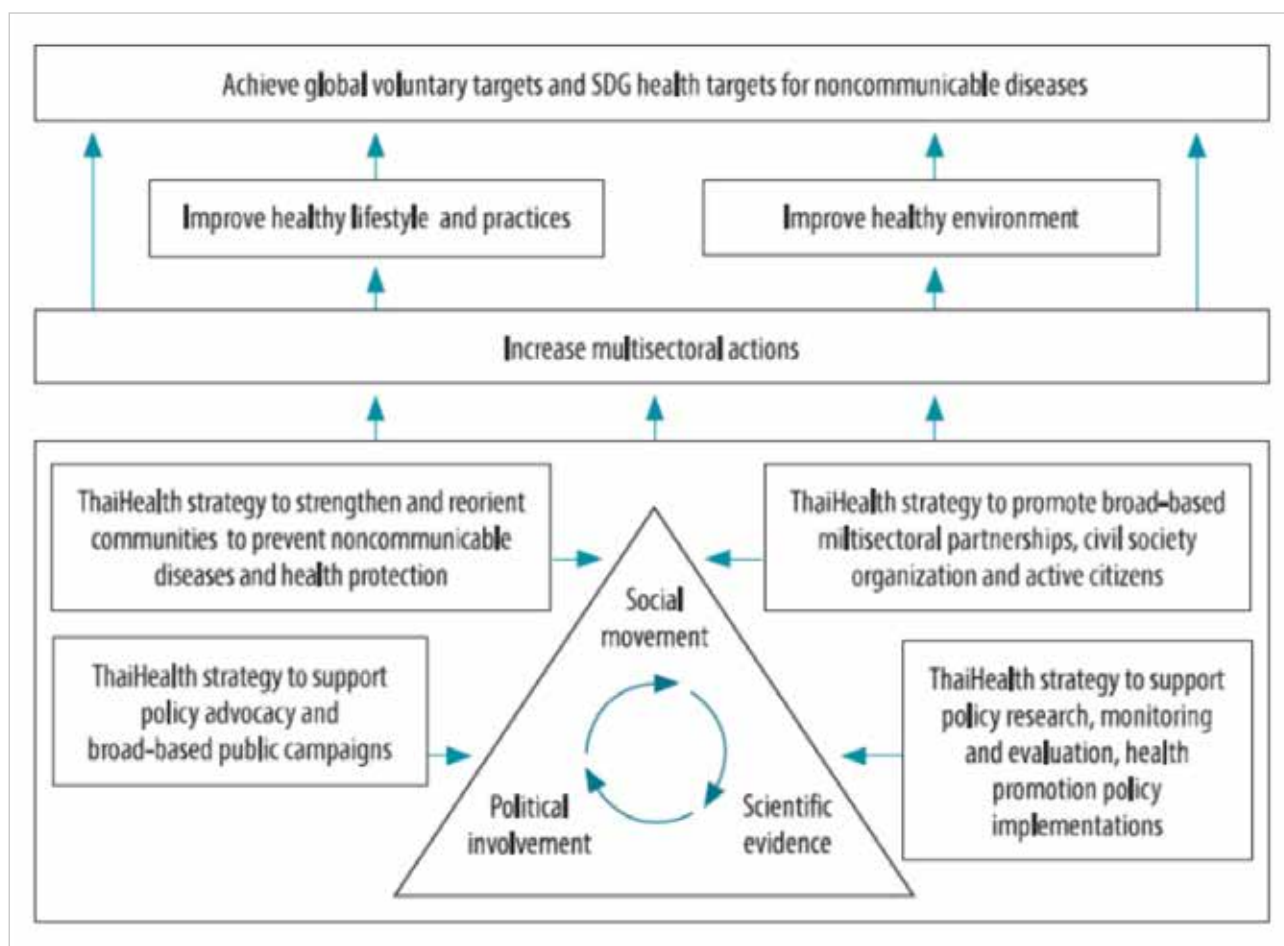


Figure 11 Thai Health configuration<sup>60</sup>

Critically the Thai Health Foundation develops its policies and plans based on a triad of scientific evidence, social movement and political involvement. They also carefully monitor their impact. Importantly the focus of the Foundation is on the major NCD risk factors, i.e. tobacco, alcohol, physical activity and diet. However, where for example poverty might be impeding people’s ability to eat healthy foods, the structure allows then to involve Ministries that can assist, for example the Treasury, Agriculture and Trade and Industry.

## 7.2) Resources for health promotion activities

Promoting health requires resources. While there is often an excellent return on investment from health promotion interventions as has been outlined in this report, in order to get the return, it is nonetheless necessary to make the investment(s) in the first instance. This applies to investments that are part of a whole of government/society approach, including adapting policies so that they incorporate health outcomes (health in all policies) and specific health driven prevention/promotion programmes.

The proportion of health spending that currently goes towards prevention/promotion is highly variable globally and the percentage spent in South Africa is unknown. But even in more developed countries, the percentage spent on prevention/promotion varies significantly. In the OECD (Organisation for Economic Co-operation and Development) countries it ranges from just over 1% in the Slovak Republic to over 6% in Canada with a mode of 3%<sup>61</sup>. It is not clear exactly how these figures have been calculated and whether, or to what extent, social determinants of health have been included. It is also unsure whether even at the higher levels this is adequate, but certainly a lot more can be done with 6% of the percentage of health spending than with 1%.

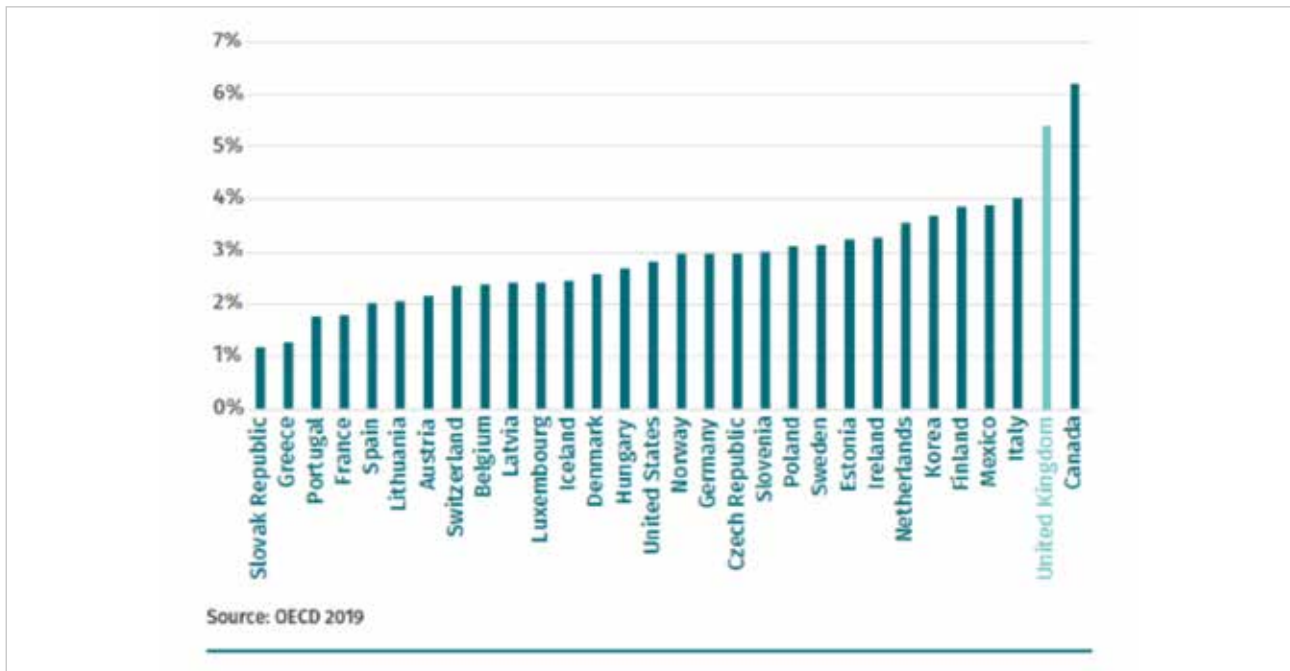


Figure 12 OECD countries spending on preventive services<sup>61</sup>

The Thai Health Promotion Foundation receives a 2% surcharge on all tobacco and alcohol taxes<sup>60</sup>. With this it funds evidence generation, campaigns and social mobilisation to address NCD risk factors, including tobacco use, harmful use of alcohol and sedentary behaviour. For a population of around 69 million, the amount allocated to the Thai Health Promotion Foundation was around US\$120million or around ZAR1,8 billion<sup>xv</sup>. Using this resource, they managed to reduce tobacco smoking from 22.5% of the population in 2001 to 18.2% in 2014; the annual per capita alcohol consumption from 8.1 litres in 2005 to 6.9 litres in 2014 and increased the percentage of the adult population doing at least 150 minutes of moderate intensity or 75 minute intensive exercise per week from 66.3% in 2012 to 72.9% in 2017<sup>60</sup>.

### 7.3) Research for health promotion

The potential for a wide range of interventions to positively impact on health status is severely inhibited by inadequate evidence for actions/interventions. This is a world-wide concern as health promotion research is scant everywhere relative to more medical/clinical/biological research, but it is a particularly worrying situation in low and middle income countries. There is in fact considerable disease, including from many of the expert group interviewed, that even the interventions most commonly recommended to reduce NCDs, are based on research done in more developed countries and simply extrapolated and generalised to less resourced countries. As cultural, economic, social and other variables play a central role in health promotion, and because the challenges encountered in doing health promotion interventions in different countries and regions vary considerably, the need for local research to inform health promotion policy and interventions is especially critical.

<sup>xv</sup> This translates to a per capita expenditure of around \$1.7 per annum. For South Africa's population the equivalent allocation would be around US\$97 or around R1.5 billion.

As mentioned above, the WHO have published a number of highly cost-effective non-communicable disease (NCD) policy options – dubbed ‘best buys’ – that are included in the Global Action Plan for the Prevention and Control of NCDs<sup>62</sup> which represent the de facto global strategy to control NCDs. Although the reasoning behind the ‘best buys’ is considered to be relatively uncontroversial<sup>51</sup> it is highly possible that context-specific factors may influence their effectiveness. In order to assess what evidence for these recommendations comes from low and low-middle income countries, Allen et. al. conducted a systematic analysis of the relevant research from these countries<sup>51</sup>. Their main findings were that there is a general lack of published evidence for the ‘best buy’ interventions in low income countries, and a number of the interventions have not been evaluated at all in these settings; only five studies were found from the African region and more than half of the identified studies evaluated tobacco-related interventions – there were only two on physical activity and diet, four on cardiovascular disease and 11 on cancer. There were no studies evaluating tobacco taxation or marketing restrictions, and no studies evaluated polypharmacy for ischaemic heart disease or aspirin for myocardial infarction. There were no studies on any of the trans fat, salt or alcohol ‘best buys’<sup>51</sup>.

The main recommendations coming from this review are firstly that there is a strong need for prioritising NCD ‘best buys’ in the national research agenda as this would contribute to the generation of more ‘context specific’ evidence for NCD prevention and improve the implementation of those policies. Secondly, it is recommended that countries that introduce ‘best buys’ should evaluate these interventions and publish findings in the public domain.

South Africa was not included in this study as it is categorised by the World Bank as an upper middle-income country. Certainly, had South Africa been included, the numbers of studies included would have increased quite considerably – for example quite a number of studies have been done in South Africa on the impacts of tobacco taxation (and to a lesser extent alcohol taxation). Nonetheless the recommendations above apply similarly to South Africa<sup>xvi</sup>. The fact that few studies that result in global recommendations come from low and even middle income countries is further well illustrated by Siegfried and Parry when they conducted an overview of systematic reviews on alcohol control policies and interventions<sup>54, xvii</sup>. They found only two primary studies were identified from the upper-middle income countries of China and Brazil respectively, and a single primary study from each of the upper-middle-income countries of Colombia, South Africa, Thailand and Mexico. No studies were identified from low or lower-middle income countries. The overwhelming majority of evidence for global alcohol policy directions came from studies in high income countries.

Importantly for South Africa, the WHO best buys (despite the reservations expressed above) are very likely to be prioritised in the National Strategic Plan for the Prevention and Control of NCDs 2020-2025 that is currently being discussed by a reference group – as they were in the National Strategic Plan for the Prevention and Control of NCDs 2013-2017. These are being adopted with cognisance of the above reservations, but in the absence of better local data are regarding as “as good as we have”. It is concerning though that without adequate local research to inform the interventions based on resident culture and conditions, the interventions may not be successful or at least are less likely to be efficacious than if local knowledge was known and used for the Plan. Once introduced, it will be critical that the implementation and the health impacts of the Strategic Plan are scientifically measured and evaluated. This can assist in making adjustments where they are needed or even abandoning interventions where they are ineffective – especially where these also have costs.

However, health promotion cannot be reduced only to “best-buys” and there are numerous other research areas within the field of health promotion that also need to be looked at. Taking examples from the Draft NSP on NCDs, the following is being proposed:

- Conduct research on prevention of alcohol harm;
- Conduct research to decrease physical inactivity;
- Conduct research to lower salt intake;
- Conduct research to lower tobacco use;
- Research more effective interventions to prevent hypertension;
- Research more effective interventions to prevent diabetes and obesity;
- Prevent heart attacks and strokes through research;
- Ensure availability of basic technology and medicines through monitoring and research;
- Undertake technological innovations in e-health and m-health, including the use of social media to prevent NCDs and improve management and control.

<sup>xvi</sup> Though systematic reviews have not been conducted for this paper, from what was said by the experts interviewed for this paper, support for almost all of the 24 best buys is in all likelihood still low or non-existent in South Africa.

<sup>xvii</sup> Alcohol is one of the five main risk factors for NCDs and is in all likelihood fairly representative of research done in different countries on NCD risk factors.

## 8) HOW CAN SOUTH AFRICA GET TO WHERE WE NEED TO BE WITH HEALTH PROMOTION?

Health promotion has great potential to contribute to improving the lives and health of people, to economic and social development, and to keeping health services from becoming overwhelmed with people that could potentially be prevented from needing such services. To make this contribution though, a number of changes are needed. Some of the more important ones are:

- Greater consensus needs to be achieved within the health promotion community as to exactly what health promotion is, what it can achieve and how to work collaboratively to achieve it.
- Health authorities need to be(come) convinced that health promotion is not a “soft” discipline that can be jettisoned when shortages occur elsewhere in the health system or health services.
- Fiscal measures must be further employed to promote health. A set proportion of the NHI Fund must be dedicated for health promotion and this should not be able to be moved or tampered with. Alternatively a percentage of taxes/levies from tobacco, alcohol and or sugar should be dedicated for health promotion.
- Universal Health Coverage, including National Health Insurance, must include coverage of health promotion programmes and not just curative care and medical prevention.
- A National Health Commission must be set up urgently and this must promote a “whole of government/society” and “health in all policies” approaches.
- Serious consideration must be given to the establishment of an independent Health Promotion (and Development) Foundation that is well funded and appropriately administered. Should this be rejected, the NHCom should be equipped to oversee and undertake health promotion activities.
- Recognition must be given to the fact that health outcomes resulting from even good health promotion activities are usually long term. Time must be afforded to reap the outcomes.
- Health promotion must be done from a life-course perspective starting even before birth and stretching to old age. Health promotion is necessary both during infirmity and in maintaining health while well.
- The importance of culture and environment must be carefully considered, and local and distinct interventions must be developed for health promotion activities.
- The distinct genetic makeup of the local population, in addition to the cultural, economic and social contexts, must be understood and integrated into health promotion choices and programmes
- The roles of health promoters and community health workers in health promotion must be reconfigured.
- Highly skilled professionals that work with communities to promote health must be employed/deployed.
- Health literacy must be encouraged, however the context and the vehicle for delivery of information and education must be carefully researched and carefully utilised.
- Legislative and regulatory measures must be further utilised to promote health.
- Health promotion must be practiced at all levels of health interventions from primary level through to palliative care.
- Obstacles to behaviour change must be confronted and wherever possible changed rather than blaming the individual.
- More research, and more research resources, must go towards health promotion. It will only become known which interventions are needed to promote health and how well they are working in the local context once appropriate and sufficient research is being done and evidence generated through this.

# ADDENDUM I

## Implications for the South African Medical Research Council (SAMRC) arising from this Technical Report.

This Technical Report reviewed the current situation with regards to health promotion in South Africa and identified challenges in moving from the current situation, where health promotion plays a largely insignificant role in impacting on population health, to one in which it can potentially make a substantial contribution to reduced morbidity and mortality, economic and social development and a successful National Health Insurance.

A key area recognised in this report as requiring extensive enhancement if health promotion is to indeed play a major role in improved population health in South Africa is **research**.

The SAMRC is uniquely and strategically placed to be at the core of such research and to thereby play a critical role in fulfilling its own mandate, which is "To improve the health of the country's population, through research, development and technology transfer, so that people can enjoy a better quality of life."

### Why the need for additional Health Promotion research?

Some of the main reasons for further research recognised in the Report include:

- Research, particularly research within the SAMRC, is showing increasing morbidity and mortality from NCDs. Many of the reasons for this are avoidable and are due to preventable risk factors.
- While health promotion can play a far greater role in keeping people healthy in South Africa, South Africa lacks sufficient knowledge of:
  - *what* can be achieved through health promotion, because not nearly enough has been tried,
  - *how* to do effective health promotion within our SA context and cultural complexity and
  - *what* works and *why* as few comprehensive evaluations on NCD health promotion have been conducted
- Health promotion is potentially a far more cost-effective approach than treatment, but this requires far more and better understanding of what can be cost-effectively achieved and how.
- Health promotion is profoundly linked to culture, economics and local conditions. While this is true for all health issues, this is particularly pertinent for health promotion.
- Research done recently on the WHO "best buys" for NCDs, which is essentially the global recommended recipe book for what countries should be doing to prevent the growth of NCDs, found that these recommendations were derived almost exclusively from research done outside of low and low-middle income countries. This is a problem.

Without properly researched interventions that take local and cultural factors into account and that consider the social and economic determinants of health, interventions may be wasteful. (In the same way that one wouldn't give medical interventions that were not evidence based, one should not provide health promotion without evidence of its effectiveness, including its cost effectiveness).

In addition to the wide gaps in empirical knowledge of local health challenges and what interventions work and which interventions would be effective in the local context, there are serious weaknesses in the ability to translate the broad health promotion goals into comprehensive strategies and programmes that advance health and bridge the equity gap. There are further gaps in getting research into policy, and practice although there have been some critical advances such as the sugar sweetened beverages tax and legislation controlling where tobacco products may be consumed.

### Possible role of South African Medical Research Council

The South African Medical Research Council (SAMRC) has the experience and capacity to take responsibility as a health promotion research hub through the setting up of a Health Promotion Research Office (HPRO) along the same lines as it does for HIV, TB and malaria. Functions may include:

- a. Identify the social and economic factors that drive premature illness and death from noncommunicable diseases.

- b. Interrogate the means and mechanisms through which these determinants can be addressed, including the interventions required from different government departments and non-state actors.
- c. Utilise scientific evidence on the causes of non-communicable diseases and how to prevent these. Based on this information draw up feasible and implementable plans to promote health and prevent diseases through interventions by the relevant stakeholders.
- d. Research and utilise international best practice on health promotion and disease prevention interventions across sectors, analyse these for their feasibility and relevance to South Africa and make recommendations on implementation through the South African National Health Council (SANHC)<sup>xviii</sup> to member government departments and non-state actors.
- e. Periodically analyse surveillance data on non-communicable diseases and adapt strategies to changing patterns.
- f. Analyse cost-effectiveness and cost benefit of interventions to reduce non-communicable diseases and ensure the most effective and efficient use of resources across sectors.
- g. Assist government departments and non-state actors to draw up strategic and operational plans that will positively impact on the social determinants of health.
- h. Consider and provide input into strategic and operational plans drawn up by government departments and other non-state actors vis-à-vis objectives and activities aimed at promoting health and preventing disease.
- i. Monitor the implementation of the plans and activities of all sectors with regards to the plans submitted to redress the social determinants of health.
- j. Evaluate existing interventions aimed at the promotion of health and the prevention of illness as well as programmes and projects that derive from the SANHC and make applicable recommendations to the relevant department or non-state actors.

Should a National Health Commission or a Health Promotion and Development Foundation be set up as part of National Health Insurance, or even independent of this as is proposed in the Report, then the Health Promotion Research Office (HPRO) could act as its research arm.

It is envisaged that the Health Promotion Research Office (HPRO) at the SAMRC would operate a research and monitoring and evaluation role within the SAMRC with a particular focus on research translation. By scoping health promotion research already being done in the SAMRC; by identifying what health promotion research has found and by raising funds for cross unit research and self-initiated research projects by researchers at universities across the country through filling out specific Requests for Applications (RFA), the HPRO can motivate for intramural and extramural research and interventions with a health promotion focus and promote healthy behaviour, choices and activities with the SAMRC and its staff and be a role model to other institutions (see diagram below). In addition, by hopefully accessing funds from NDoH and Treasury and other funders, the SAMRC can support the NDoH and the successful implementation of the NHI Fund.



<sup>xviii</sup> The South African National Health Council is the highest decision making body for health in South Africa, chaired by the Minister of Health.



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