

## ORIGINAL ARTICLES

# Health care professionals' perceptions of health promotion with preschool children

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## ABSTRACT

**Background:** The growing burden of non-communicable diseases (NCDs) all over the world calls for a change in peoples' lifestyles. One way to prevent NCDs is to work with health promotion. The burden of communicable diseases (CDs), however, is still high and resources are limited. Studies suggest that promotion of health should start early in life and in cooperation between preschool teachers and parents. Also health care workers should be included in such work. The aim of the present study was to explore health care professionals' experiences and their reflections on health promotion in relation to children's health in two different Western Cape settings, South Africa.

**Methods:** Data was collected in two focus group discussions (FGDs) with twelve health care professionals from health clinics situated in two different settings; one upper-middle income urban suburb and one peri-urban township. Data was analysed with latent content analysis.

**Results:** The findings are presented in four categories and twelve subcategories. The focus group (FG) participants had a holistic view on health and they talked about children's health from a health promotion perspective where they saw children's health as affected by an interplay between family, societal and structural factors. Further they saw several possibilities and expressed ideas about how to work from a health promotion perspective. They had a positive attitude to working intersectorally and interdisciplinary and believed that they could contribute to such a work. However, the cooperation with doctors and social service must be improved in order to succeed.

**Conclusions:** The organizers of the health care sector should see to that health professionals have the possibility to work according to health promotion principles. Also the health care workers themselves must engage more actively in the work by considering the attitudes of the staff, the parents and grandparents and develop cultural awareness and sensibility.

**Key Words:** Child health, Determinants of health, Focus group discussions, Health promotion, Health care professionals, Intersectoral work, Interdisciplinary work

## 1. INTRODUCTION

The growing burden of non-communicable diseases (NCDs) all over the world calls for a change in peoples' lifestyles.<sup>[1-4]</sup>

Lifestyle changes should be brought about early in life, ideally during the pre-school years<sup>[1-10]</sup> or earlier<sup>[11]</sup> and in cooperation between the parents and pre-school teachers. Sev-

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eral authors state that health promotion activities with parents and teachers would be most effective if they took into consideration the parents' and teachers' opinions as well as their contexts.<sup>[5,12]</sup> This indicates that an interdisciplinary way of working with the promotion of children's health would be preferable. Interdisciplinary and intersectional ways of working are in line with one of the seven guiding principles for health promotion according to the Ottawa Charter.<sup>[13]</sup>

The increase of NCDs calls for a health promotion action from health care professionals. Therefore, health care professionals, particularly in primary health care (PHC), should be included in this work as they play an important role in promoting children's health. Studies from Sweden<sup>[14]</sup> and Spain<sup>[15]</sup> indicate that health care professionals at PHC level agree that they should work both with prevention and promotion, but that they feel constrained in their ability to engage in health promotion when they have limited time, resources and tools, and when their load of curative care is high.

Many low- and middle-income countries face the double burden of simultaneously struggling with communicable diseases (CDs) while battling the increased burden of NCDs.<sup>[16,17]</sup> In South Africa (SA), it has been argued that there is a "quadruple disease burden" including CDs, NCDs, perinatal and maternal, and injury-related disorders.<sup>[18]</sup> However, the resources to address this burden are limited.<sup>[19,20]</sup>

In SA there are constant strides to improve the health of children.<sup>[21]</sup> Much of this effort of health service delivery is, however, directed towards the huge burden of infectious diseases.<sup>[19,21-23]</sup> Nevertheless the place of health promotion and disease prevention in the context of health care professionals' role in facilitating healthy lifestyles must be considered. A study by Parker, Steyn, Levitt *et al.*<sup>[24]</sup> showed that nurses working in the same province as those included in the present study understood the value of health promotion for NCDs, but their knowledge of how to do this in practice was limited. Children in SA are visiting a PHC facility on average 4.6 times a year.<sup>[21]</sup> Children under five years age are primarily treated in PHC facilities run by nurses (in the public sector) and often by pharmacists (in the private sector). Thus these are the ones who have the first opportunity to promote health during a child's early years. The health professionals are likely to teach what they themselves understand and therefore it is important to further explore how PHC professionals, see their role and how they understand their task of promoting a healthy lifestyle in children.

### **Aim**

The aim of the present study was to explore the experiences of health care professionals and their reflections on health promotion in relation to children's health in two different settings in the Western Cape Province, South Africa.

## **2. MATERIAL AND METHODS**

### **2.1 Method**

As we wanted to capture the perceptions of the health care professionals, a qualitative approach was chosen. Data was collected during two focus group discussions (FGDs). Participants from one focus group (FG) comprised of health professionals working at various in-private PHC facilities in the same upper middle income suburb (I), and the other FG comprised of nurses working at a government-run PHC clinic in a peri-urban township (II). We chose these two different settings as we wanted to capture various perceptions of the phenomenon as well as the impact of the social determinants of health.<sup>[25]</sup>

### **2.2 Description of the settings**

#### **2.2.1 Setting I**

Participants for the FGDs were recruited from a private PHC clinic. They included pharmacists, registered nurses and a speech therapist. The pharmacies employ a number of pharmacists and registered professional nurses. The main task of the pharmacists is to distribute medication whereas the registered professional nurses, both at the pharmacy and the clinic, offer advice on health matters, and render a clinical service. These clinical services include immunizations (mainly children), breastfeeding support, monitoring blood pressure and cholesterol levels, as well as calculating body mass index.

#### **2.2.2 Setting II**

The health clinic is situated in a peri-urban, sub-economic township, outside of a small industrial town. It is a nurse-driven clinic which means that the nurses are running the clinic and doctors come there three times a week, for half a day. The most common diseases are AIDS/HIV, TB, diabetes, high blood-pressure and stroke. The clinic is visited by 6,000 - 7,000 individuals every month; of these about 3,000 are children. The residents use the clinic as a primary health care provider from where they are referred to the hospital if further care needs to be provided. Health care is free of charge.

### **2.3 Participants**

All health care professionals concerned were invited to participate, resulting in 12 informants; three nurses and two pharmacists from setting I (Md age 39 years [34-70 years]) and seven nurses from setting II (Md age 61 years [26-66 years]). All were females.

### **2.4 Data collection**

The FGDs were conducted in October 2012 and lasted for about one and a half hours each. The FGDs took place in English, and were facilitated by author 2, author 3 and author

4. A thematic question guide was used to elicit perceptions and an understanding of the following key areas related to children’s health: health and a healthy lifestyle; challenges to a healthy lifestyle; what might be helpful in order to create and maintain health and a healthy lifestyle; one’s own responsibility and the responsibility of others who care for children in enabling a healthy lifestyle for those children. These key areas were explored through probing questions.

The discussions were digitally recorded and transcribed verbatim.

**2.5 Analysis**

The data was analysed using latent qualitative content analysis.<sup>[26]</sup> Initially, two of the authors (author 1, author 4) read through the interviews repeatedly with an open mind, to gain a sense of the whole, and then analysed the material independently. Quotations were extracted and brought together with reference to the domains of the interviews. Further, the data was condensed into meaning units and then abstracted into subcategories and categories (see Table 1). When the analyses differed, a discussion of how to categorise the findings was held until there was a consensus that the categories derived from the data. Thereafter, the findings were discussed

with author 2 who is more knowledgeable with the SA context. Finally, the whole manuscript was discussed between all authors. The findings are illustrated with quotations. Each setting is indicated in the text with a number: (I) refers to the 1st FGD with private health care providers, and (II) refers to the 2nd FGD, held with public sector health care providers.

**2.6 Trustworthiness**

The findings and the writing of the manuscript were discussed continuously between all the authors to ensure trustworthiness. Special attention was paid to cultural, national and geographic differences between the researchers. A strength of the study is that the researchers have different cultural and national backgrounds and perspectives: social science (author 1, author 4), health policy and systems research (author 2), nursing (author 3), and education and public health (author 4). The researchers are living in SA and Sweden, so different perspectives were brought into the analysis. Two of the researchers (author 3 and author 4) attended both FGDs. The quotations given in the study are intended to facilitate the reader’s evaluation of the credibility of the findings. To increase the possibility of transferability, the study context and the participants are carefully described.<sup>[26]</sup>

**Table 1.** Example of the data analysis

Meaning unit	Condensed meaning unit	Subcategory	Category
“There’s such an emphasis laid on starches and the vitamins and the minerals and the rest just fly out of the window, and they come here and they want medicine. But medicine is not going to cure the diet”(II)	Too much emphasis on vitamins instead of healthy food	Medicalization	Structural aspects
“I also want to say that if the boyfriend wants a baby, they get the girl pregnant ----She wants a baby because her boyfriend wants a baby”	The boyfriend decided that the girlfriend should have a baby	Gender roles	Family

**Table 2.** Categories and subcategories

Categories	Subcategories
Health	Holistic view on health
	Promoting health
Family	Parenting
	Generations
	Gender roles
Knowledge and education	Education
	Culture
Structural aspects	Chrèche a challenging resource
	School
	Maternity care
	Collaboration
	Medicalization
	Money/poverty

**2.7 Ethical approval**

The study received approval from the Health Research Ethics Committee at the University of Stellenbosch, SA (#:N12/06/038). All the participants were informed about the project orally and in writing (English), whereafter they signed a consent form. They were all informed that partic-

ipation was voluntary and that they could withdraw at any time. Personal identifiers have been removed or disguised to maintain anonymity.

**3. RESULTS**

The participants of the two focus groups started to discuss health and health promotion on a general level. Thereafter the discussion in both groups quickly focused on various aspects of how to promote children’s health. They emphasized various factors related to the individual (parents and professionals) as important for the promotion of children’s health. Perceptions of these factors emanated from their own experiences from working in different contexts/settings. They also described and discussed structural factors influencing families’ and children’s health as well as factors related to the work with health promotion in practice.

The findings are presented in four categories and ten subcategories (see Table 2).

### 3.1 Health

#### 3.1.1 Holistic view on health

Initially the participants were asked about what thoughts came into their minds regarding the concept of health. Both FGs established that health is something beyond just physical well-being; that health is a holistic concept including physical well-being, emotional well-being and social, economic and environmental factors.

*Health is more than just the physical. It's the emotional, it's the mental, so it's a much bigger picture than just physical health of the person (I).*

The participants further stated that health is about how you perceive things and whether you approach life positively. There is also a relational aspect to health in terms of considering individual relationships as well as society at large. In other words, what is my contribution? One participant said:

*... not being a parasite but in symbiosis with others (II).*

#### 3.1.2 Promoting health

There was agreement among the participants that health promotion should be emphasized as a key to maintaining good health and avoiding serious health consequences. They stated that it is costly for society to have an unhealthy population, and that it therefore is important to implement actions in a way that prevents serious health consequences.

*"It is much easier to start with a healthy lifestyle rather than to treat an obese child at four, five or six years or teeth problems and things like that. So prevention is better than cure" (II).*

Participants of FG II said that they meet parents daily who bring children to the clinic, who are presented with symptoms associated with malnutrition. The symptoms have a wide range, from a running nose to cognitive impairment.

### 3.2 Family

The participants of the FGs focused on family as a key factor that affects children's health.

#### 3.2.1 Parenting

Both groups expressed that parenting has a significant effect on a child's well-being. Participants of FG II stated that the family's capacity to provide the child with a healthy environment as well as love and care was of vital importance. They further said that the child should be treated with respect and encouragement and that it is important to dedicate time to children, and not "brush them off". Moreover, they stated that a child should be seen as an individual, and not be compared with others.

*The non-physical things are almost more important for a*

*child's development at certain stages, that even if there are not all foods that they need, or all the physical things they need, if there is a good family dynamic and love and care to the parents best abilities, I think that is more important than actually providing all the physical things for the child (II).*

In addition, FG I stressed that the likelihood of a child having a healthy life starts right at the very beginning. Breastfeeding was mentioned by one participant as the lifestyle factor that affects child health most. There was a discussion in the group about the middle-class lifestyle in Western Cape that has become hectic, with both parents working. The participants felt that parents are looking for "an easy way out", and this can also influence attitudes towards breast feeding, infant nutrition and care.

*... we are working long hours, we're coming home tired because we are forced into the position we don't have time for our children (I).*

#### 3.2.2 Generations

Participants of FG II stressed that healthcare professionals need to acknowledge the generational structure of the family. It might not be of any use teaching the mother how to cook healthy food, if the grandmother does the cooking. Instead, one should find out who prepares the food in the family and equip them with cooking skills.

Furthermore, they commented that the older generation may have a negative impact, in that they may not know how to cook a nourishing meal. They often encourage mothers to give the baby the bottle, instead of breastfeeding. The opinion was expressed that it is commonplace for a child to live with his/her grandparents for months, and then to come back to the parental home malnourished.

*80% of the kids that come back from Eastern Cape have got skin problems and immunizations are not done and they're underweight (II).*

However, the presence of grandparents was also seen in a more positive light. It was mentioned in the discussions that many young families do not have any grandparents living close by, and that there is an ensuing lack of a support system.

*I would like to "have a punt" [authors' remark: something positive to say] for grandparents. I think they are grand buffers against the world. I think young people need grandparents, tremendously. I think it's very sad if they've got no grandparents anywhere close, because in the olden days you had this large family, now we've got this tiny nuclear family, and a lot of them have no support at all (I).*

#### 3.2.3 Gender roles

The participants stated that fathers generally need to be more involved in parenting. Single mother households constitute a

high proportion of the total number of family units. In those families the mothers often have the responsibility for both the upbringing of the children and the household work.

*Also two parents are needed, both parents, the mother and the father and not a single parent. The ideal would be to have both parents present (II).*

Given that, they continued the discussion, there is less time for cooking. Therefore parents often either buy junk food, or make a meal from whatever they already have at home not considering the nutritional value. It was mentioned that even in two parent families the burden of cooking often falls on the woman, although both parties are working.

Despite the above comments, the participants also had other experiences and believed that gender roles are changing in the new generation.

*I think men were isolated in the old days. They were kept away from their children . . . Now, I mean good men are hands on. I really like young men. If they are both in the same situation, both working, men have to help, and if you just encourage them they are supportive (I).*

### 3.3 Knowledge and education

#### 3.3.1 Education

Through the discussions, education was repeatedly mentioned by both groups as a key factor in promoting health.

Participants felt that the combination of hectic lifestyles and lack of social networks has resulted in previous knowledge being lost.

*So kind of back to basics and just give her the basic information; you must eat breakfast, you must eat lunch, you must eat dinner, the dad should be there because he needs to get that information as well so that you've got the supportive teamwork (I).*

In FG II the participants explained that education should start from the very basics, such as teaching children how to wash their hands, what food to eat, and about behaviours that will prevent them from becoming ill. They emphasized that children should be educated from junior school, and it is also important how children are taught. Children should be given reasons to follow certain behaviours, rather than just being told what to do. It is desirable that children become involved in their own health.

*Kids are like sponges. They just suck up everything that you feed to them. You sort of lay the basis of knowledge right then, about what's good and what not good and what's good to eat and what is not good to eat, and what will assist you in your life ahead. But as you say, don't treat them as like*

*they are dof [authors' comment: stupid]. You must give the children reasons and then they go home and they say to their mother that the teacher at the school said we must eat this because it does this, and I want to be like that (II).*

The discussions in the same group also revealed that fathers and grandparents could benefit from education if they are to play a more effective role in child rearing. In particular, in order to get men on board, it is necessary to target fathers and educate them about child health issues.

Further, the participants mentioned that lack of reading skills and difficulty in understanding the language are two other obstacles to get through to people with information about health. They said that all mothers receive a booklet at the maternity ward providing useful information about how to give your child a healthy life. Concern was however expressed that since it is written in English, the information may not be understood by parents who do not have English as a first language.

The participants emphasized that literacy skills need to be improved among the younger age groups. In order to achieve this, children should be read to (for example bedtime stories), an activity, which, according to the participants, has gone down tremendously.

It was widely agreed in both groups that education about health issues ought to be based on dialogue between the persons involved. In other words, simply telling people what to do would not be effective. "Empowerment" was a concept frequently mentioned in the discussions, but lack of time and language barriers were seen as obstacles for building such a dialog.

*The biggest challenge for us is that working here; this is a very busy clinic. So the time you spend with a client is not sufficient because they are accumulating, because there is always a queue in the waiting room. . . . time is so limited and then we also don't speak the language. That is the challenge; we have to do it via somebody else, via an interpreter (II).*

One pharmacist expressed her role as health educator:

*It is also there for us to give information, even if the patient doesn't buy anything, they can go out and will know. Say someone poor come and the child has got diarrhoea, they can't afford to buy medication or something but you can tell them "listen take a litre of water, mix salt and sugar and they can go home" (I).*

#### 3.3.2 Culture

FG II repeatedly mentioned "the culture" as a barrier to health promotion. In this study we interpreted "Culture"

broadly to mean cultural differences between generations, between Western and traditional culture as well as ethnicity. The professionals in FG II stated that they were white, and the local residents were black. The staff perceived themselves as “coming from a different planet” compared to the clients, the parents. The solution they saw to this barrier was to recruit staff from the clients’ culture.

*If you can get somebody who has seen the “light”, as it were, to talk to their people, they accept it with bigger grace. It is not somebody talking down to them. It’s their own level, and they accept it better, especially if a person can produce an example of what happened because he took heed of advice he was given (II).*

The FG participants in FG II had positive experiences from working with a black doctor who spoke the language of the local area and who achieved much better results than the previous white doctors.

They mentioned that giving up the traditional culture for modern culture could also lead to a loss of better nutrition as the substitution of the traditional staple food (maize porridge) with rice has been reported by the township participants.

### 3.4 Structural aspects

#### 3.4.1 Crèche – a challenging resource

Most parents leave their child at a preschool (crèche) when the child is 4 months old, since the mothers have to return to work after maternity leave. According to the participants in both groups, there are preschools especially in the townships that are not always professionally run. The participants stated that there are no guarantees that the child will receive either a balanced diet or stimulation there. As a consequence, which was especially stressed in FG II, tired parents do not bother to make a proper meal at home, thinking that the child has been properly fed at the preschool.

*In the district I just approve of 5 out of 25 crèches. They have a balanced meal, they are educated, the staff working there are trained ... the rest of them are just places where the children are put down to sit and wait for the day to pass (II).*

The participants of FG II agreed that the preschool could be an important resource, but they stressed that the requirements for setting up and running a preschool must be much stricter. The staff should have relevant qualifications and the preschools ought to be inspected. There is often a lack of facilities in general in the preschools in the townships.

#### 3.4.2 School

Both FG groups suggested different actions for the Government to take, in order to improve health among children.

School nurses were mentioned as a conduit for reaching children as well as parents. The nurses should be involved from an early stage at all school levels. Teachers in particular catch issues in families and a nurse at hand would make it easy to intervene. In this way a dialogue with the parents who collect the child could easily be initiated and problems solved earlier.

*You can pick up problems right at the root and sort them out before they become an issue. Maybe we wouldn’t have so many kids on Ritalin and stuff like that. Problems are often to do with things like not eating properly or watching too much television for example (I).*

Some of the participants had positive experiences of projects which serve high quality food in schools.

#### 3.4.3 Maternity care

The participants engaged in promoting breastfeeding and hoped that this was going to increase its uptake. Breastfeeding, they believed, is not as established as it should be and not supported legally at work or in the preschool. As many mothers go back to work or start seeking new employment within four months of giving birth, participants believed that most of them stop breastfeeding at that time. They meant that this could mark the start of malnutrition for many children.

#### 3.4.4 Collaboration

Being health care professionals the participants saw themselves as playing an important role in guiding with health education. Inter-professionally they also felt that they have an important role to play. They stressed that it would be several benefits if they could work as a team with other professions. FG I emphasized that they meet a great deal of people from the community as these visit the pharmacy instead of the doctors because of both costs and accessibility.

Some participants stated that in SA the medical system is hierarchically organized and that the doctor’s word is given high value. They also stressed that there is too little collaboration across professional levels (each working in their own silo).

*There is a hierarchical system in this country, and that’s what needs to change. We are all professional in our own right. Yes, I’m not a nursing sister, I’m not paediatrician [authors’ comment: she is a pharmacist], but I have studied so I believe that we all have got something to add and we’ve got to respect one another on the same level (I).*

Participants in FG II said that there are structures with a health and welfare committee for collaboration between different professionals in the welfare system. However it does not work the way it was anticipated as people do not prioritise

“that kind of work”.

*The problems are addressed, so these forums and all those people represent this committee. But then, only two members arrive and we don't have the participation of the social service or environmental officers, or they will come to one meeting and the rest of the time you won't see them (II).*

#### 3.4.5 Medicalization

The issue of medicalization was mentioned by the participants in both FGs as a barrier to health promotion. According to them, medicalization starts right from the beginning of a child's life, in that mothers are often offered a caesarean section. Furthermore, according to the participants, the information given to mothers at the maternity ward has a medical focus.

*There's such an emphasis laid on starches and the vitamins and the minerals and the rest just fly out of the window, and they come here and they want medicine. But medicine is not going to cure the diet (II).*

According to the participants of FG II, parents visiting the clinic generally do not ask for health advice, but for medicine. The parents are not open for issues such as a healthy life style, nutrition and exercises regimes. They do not want to only hear that their children look healthy and nice, but they come to the clinic because they want medication.

*You are going to find it hard to believe, but mothers who come here are not happy to be told that the child is fine. They want to take a bottle of medicine home with them or else you're not a good nurse. They don't want to be told the baby doesn't need medicine (II).*

Participants also mentioned that they had observed an over-consumption of a regularly prescribed ADHD medication amongst children. They thought however that the children's unruly behaviour was more likely due to a lack of exercise and poor nutrition than to an underlying medical condition. They further said that they accepted that there is a place for this drug, but not to the extent that is now prescribed for hyperactive children.

*People think video games are exercise, but it is not exercise and that also has an impact on the health of the kid. Their muscles aren't developed, they sit with children on Ritalin. . . They just walk in taking a coke and a chocolate bar just because mom put it on the account while they should be eating an apple instead and having a drink of water (I).*

#### 3.4.6 Money/poverty

The question of finances and poverty was of great concern for all the participants in both FGs.

They discussed the dilemma that on the one hand it is a good

investment both for the individual and society to maintain good health by having a healthy lifestyle. On the other hand, it can be costly for the individuals. Even if nutrition could be seen as a key factor to health, nutrition depends on finances and affordability. The FGDs participants perceived an interplay between poverty, education and healthy lifestyle.

*What I am saying is, poverty plays a big role. If they do not have (money), the child is malnourished. So maybe you can give them education and stuff like that, but it flies out the door because they don't have anything to give the child (II).*

The child support welfare grant for children (birth to 18 years) of indigent parents, was discussed especially in FG II. Participants explained that while the grant is meant for the child, in reality it is often used by the whole extended family. The participants thought that parents and boyfriends encourage the young girls to have babies in order to receive money from the grants.

*We get girls in here whose mothers have told them to get pregnant so that they can get another grant. It's true. Basically they got pregnant to get the money (II).*

The FG participants highlighted that SA has become a society of disparity; living conditions are very different across the population. Although the middle class parents can afford to give their children healthier food than the poor parents, it should not be taken for granted that they do so, as their lifestyle has become very hectic. People spend very little time with their children and tend to compensate the guilt they feel with fast food and electronic games.

*We won't talk about the more wealthy parents where the children are sort of hooked onto electronics and they forget about everything else, even physical activities (I).*

## 4. DISCUSSION

In this study, we explored health care professionals' experiences and reflections on health promotion in relation to children's health. Data was collected in focus group discussions with participants originating from two different settings; one upper-middle income urban suburb and one peri-urban township in the Western Cape Province in SA.

The participants' holistic view on health and a healthy life style is well in line with WHO's definition of health and health promotion.<sup>[13,27]</sup> They further described in the FG discussions that they viewed health as an interplay between society and the individual as is also clearly elucidated in the Ottawa Charter.<sup>[13]</sup> Thus the participants' perceptions were congruent with the understanding of health promotion as espoused by the Ottawa Charter.

In their discussions the participants also showed knowledge about the determinants of health.<sup>[25,28–30]</sup> In a social-ecology model Dahlgren and Whitehead<sup>[31]</sup> have described the main determinants that have an impact on people's health from three layers. The first layer includes factors related to the individual such as behavior, friendship patterns and the norms of the community. The next layer is about social and community influences and the third level includes structural factors. The participants in the present study discussed factors related to all the three layers. The discussion below is structured accordingly.

#### 4.1 Individual-, social- and community level

Both FGs mentioned the family as the most important union for children for achieving health. They assented that it is important to see the individual in the context of the family. There was an agreement that the children's wellbeing depended on their parents' social and psychological situation. This has also been stressed in earlier studies.<sup>[32,33]</sup>

The participants expressed a clear child perspective. They explained that they viewed the child as an individual person and stressed that it is important to reach the child directly. Further, they saw the child as an active person with resources of his/her own and who should be addressed as an individual in line with modern childhood sociology.<sup>[34]</sup> In FG I it was suggested that the presence of nurses in schools could be a tool for reaching the child directly in order to empower them. This is in line with WHO's definition of empowerment: "In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health."<sup>[35]</sup> Similar ideas are espoused by Grandes *et al.*<sup>[36]</sup> They suggest that health promotion work should be extended to arenas such as schools, leisure time activities, sports and a variety of health care settings and town halls.

Both FGs expressed the need for health professionals to acknowledge the impact of the generational structure of the family as well as how the gender roles are manifested in the family. This would facilitate an understanding of how to work with the child's health. Lake and Reynolds<sup>[37]</sup> stress that the health care staff must play a more active role in the promotion of children's health.

Medicalization was mentioned by the participants as a barrier to working from a health promotion perspective. They described the barriers as being both at the individual- and the structural layer. The participants discussed that the parents (individual layer) seem to have adapted the medical way of thinking (structural layer) by asking for medication and not being open to advice about nutrition and life style changes. According to Conrad<sup>[38]</sup> there is a strong medicalization tak-

ing place in many parts of the world as a result of redefining the patient to become a consumer. One explanation could be that many parents for economic reasons visit the (often private) pharmacies for some medical advice as well as medical prescriptions instead of visiting the doctors. Visiting just the pharmacy might lead to an increased use of drugs. This has been seen for example in India<sup>[39]</sup> and Vietnam.<sup>[40]</sup>

The ethnicity diversity of SA was mentioned as another challenge by the participants. They stressed the importance of cultural awareness and sensibility in the professionals in order to build trust between the different groups. As a way to reach that, FG II suggested to have racially mixed professional work teams. In a study by Parker *et al.*<sup>[24]</sup> it was discussed that one reason for not working with health promotion was the lack of adherence in the patients but also language difficulties. FG II exemplified this when they talked about the booklet "Road to Health" which is given to all mothers and new born children. However, the participants had the experience that not all parents read this book. They thought that language problems could be one reason for that, as it is only provided in English.

#### 4.2 Structural level

The participants expressed worries about poverty, the dangerous environment, the unequal access to the medical and health system as well as preschools and schools of good quality.

One of the guiding and central principles for health promotion is equity in health.<sup>[13]</sup> WHO,<sup>[41,42]</sup> the United Nations<sup>[43–45]</sup> and several authors<sup>[23,25,28–31,37]</sup> all underline the importance of bridging the inequalities in health. Lake and Reynolds<sup>[37]</sup> suggest that structural changes must be made, but they also stress, as mentioned above, that the health care staff must play a more active role in the promotion of children's health.

According to Coetzee,<sup>[20]</sup> Children's Act in SA in 2005<sup>[46]</sup> is a step forward in providing legislation supporting the United Nation's Convention on the Rights of the Child (CRC).<sup>[47]</sup> Coetzee mentions two examples of best practices in SA: "The Child Nurse Practice Development Initiative" at the Red Cross Memorial Children's hospital in Cape Town at the "Philia Impilo project". In these projects, child and family-friendly services have been implemented. It is also stressed that the children's voices should be listened to.

The participants of the present study clearly stated willingness to work intersectorally and interprofessionally. Interprofessionally they felt that they have an important role to play. They thought that this mode of working could be a sustainable way for improving children's health. However,



they mentioned that it is difficult to do so in practice due to different barriers such as extreme workload, time-pressure, shortage of staff, the focus on curing diseases and disease prevention, the hierarchical organization of the medical system and individuals not prioritizing this way of working. The situation of having knowledge about health promotion and understanding the value of it, but not being able to practice it, has been seen in other studies both from Europe<sup>[15]</sup> and South Africa.<sup>[20,36]</sup>

Grandes *et al.*<sup>[36]</sup> recommend intersectional work, using a socio-ecological approach, and they believe that the health care staff is well suited to lead this work. They stress that there is also a need for re-orientation in the health-care service towards prevention of illness and promotion of health. A prerequisite for working with health promotion, they state, is that the managers support this mode of working.

According to the participants some attempts for improving health by working with health promotion on a structural level and working in an interdisciplinary manner already exist in SA. It was mentioned that there is a structure for collaboration labelled Health and Welfare Committees. These committees, using an interdisciplinary approach seem to be a sustainable way to work well in line with the principles of the Ottawa charter.<sup>[13]</sup> However, according to the participants of our study, it does not work in practice, as the work in the committees is not prioritized by the members.

Grandes *et al.*<sup>[36]</sup> describe that health promotion should be integrated in health care, especially in PHC. However, they stress that the most useful models to work with health promotion (the Health Belief Theory, Theory of Planned Action, the Social Learning Theory, “stages of change” and integrative models) must be redesigned and adjusted to the context in which they are going to be used.

Coetzee<sup>[20]</sup> stresses that in order to work with health promotion programmes in practice, it is important that society enables the health care workers to do so. Mostly the staff are overloaded with work due to staff shortages, resulting in curative care becoming the highest priority. Further, Coetzee underlines that it is important that the staff are educated in health promotion and if they are going to work with children’s health they must be interested in doing so.

According to the FG participants of the present study a re-orientation of the health care service towards prevention of illness and promotion of health is to be preferred. They indicated that not all professions are willing to or have the knowledge to work in that way. Westwood *et al.*<sup>[23]</sup> define basic health care services for children in SA and suggest that it should address the key health challenges for children,

cover the full continuum of care from promotive to palliative services, and be supported by an efficient health system that delivers essential child health services. This means that basic health care has a large span, and health traverses all levels of care from primary through to tertiary services and that all levels must cooperate.

According to Marmot *et al.*<sup>[48]</sup> a long term agenda is needed, involving action and changes in social politics, economic arrangements and political actions. Health promotion is not just an issue for the health sector but for the whole society with changes required on all levels.

### 4.3 Strengths and limitations of the study

There are principally three strengths of this study. Firstly the FGDs were lively and resulted in rich and deep material. Secondly data was collected in two different settings. Thirdly the researchers involved in the study came from different disciplines and from different parts of the world. One limitation of the study is that there were only twelve informants. All health care professionals concerned were invited to participate and the majority did so. This study should be regarded as a pilot study and in a future study it is desirable to include more participants and from other settings. The participants suggested a better co-operation between medical doctors and social workers. As these two groups of professionals not are involved in the immediate health care of young children they were not included in this study. However, in a future study it would be of interest to also explore their views of working with health promotion. Several measurements have been taken in order to secure trustworthiness, described in the method section. As the discussions were on a higher abstract level, we believe that the findings from this study can be transferred to similar contexts and not only to SA.

## 5. CONCLUSIONS

There was an agreement among the participants that children’s health must be seen from a holistic perspective and for a large span of time.

Contrary to an earlier study in SA<sup>[24]</sup> the health care professionals in this study had deep knowledge about health promotion. These conflicting findings suggest that the knowledge is inconsistent and that there is a need for a continuous teaching of health care professionals in general, in health promotion, before practicing it.

Working with health promotion is very complex. It includes several sectors and a multi-strategy approach. The participants of the present study were willing to work in that way and they also believed that they could contribute. They saw a great deal of possibilities and expressed several ideas about

how to work from a health promotion perspective. However, they did not do so in practice due to several barriers. In order to succeed, they stressed that society must enable for the health care staff by addressing the structural challenges, as well as enable an improved collaboration between the staff working within the medical sector and those working within the social service. They also emphasized that the health care workers themselves must engage more actively in the work by considering the attitudes of the staff, the parents and grandparents and develop cultural awareness and sensibility.

In a future study, it would be interesting to explore perceptions of health and how to promote a healthy lifestyle in children from the perspective of preschool children's parents

and staff caring for children attending preschools.

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## CONFLICTS OF INTEREST DISCLOSURE

The authors declare no conflicts of interest.

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