Healthcare workers’ perspectives of the barriers and enablers in health promotion human resources

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Dissertation accepted in fulfilment of the requirements for the degree Master of Health Science in Transdisciplinary Health Promotion at the North-West University

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PREFACE

This dissertation is presented in article format. This format is approved by the North-West University. The dissertation consists of an introduction, motivation and methodology, literature overview, a manuscript to be submitted to a peer-reviewed journal, namely *Health Promotion International*, and a concluding chapter in which the research is evaluated and recommendations are made.

This dissertation is outlined as follows:

**Chapter 1:** Overview of the research comprising a background and a brief literature study, research question(s), aim and objectives, methodology, trustworthiness and ethical considerations.

**Chapter 2:** This article comprises author guidelines for the journal *Health Promotion International*, an abstract, introduction, methods, results, discussion, conclusion.

**Chapter 3:** An evaluation, limitations and recommendations.

The references cited in each chapter are presented at the end of the chapter. Chapters 1 and 3 follow the NWU Harvard referencing style, while Chapter 2 is presented according to the guidelines of *Health Promotion International*. 
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACHA</td>
<td>American College Health Association</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency syndrome</td>
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<tr>
<td>AUTHeR</td>
<td>Africa Unit for Transdisciplinary Health Research</td>
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<tr>
<td>CSDH</td>
<td>Commission on the Social Determinants of Health</td>
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<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
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<tr>
<td>DKK</td>
<td>Dr Kenneth Kaunda</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<td>DPSA</td>
<td>Department of Public Administration</td>
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<tr>
<td>ECDC</td>
<td>Early Childhood Development Centres</td>
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<tr>
<td>HCP</td>
<td>Healthcare professional</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>HP</td>
<td>Health promotion</td>
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<td>HR</td>
<td>Health promotion</td>
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<tr>
<td>HREC</td>
<td>Health Research Ethics Committee</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<td>ISHP</td>
<td>Integrated School Health Programme</td>
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<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
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<tr>
<td>NHI</td>
<td>National Health Insurance</td>
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<tr>
<td>NHP</td>
<td>National Health Plan</td>
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<tr>
<td>NHPPS</td>
<td>National Health Promotion Policy and Strategy</td>
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<tr>
<td>NHREC</td>
<td>National Health Research Ethics Council</td>
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<tr>
<td>NW</td>
<td>North West</td>
</tr>
<tr>
<td>NWPDoH</td>
<td>North West Provincial Department of Health</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>SA</td>
<td>South Africa</td>
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<tr>
<td>SAHRC</td>
<td>South Africa’s Human Rights Commission</td>
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<tr>
<td>SDH</td>
<td>Social determinants of health</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>Stats SA</td>
<td>Statistics South Africa</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UL</td>
<td>University of Limpopo</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>UTI</td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td>UWC</td>
<td>University of the Western Cape</td>
</tr>
<tr>
<td>VHWs</td>
<td>Village health workers</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>Wits</td>
<td>University of the Witwatersrand</td>
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</tbody>
</table>
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CHAPTER 1: INTRODUCTION AND OVERVIEW

1.1 INTRODUCTION

Human health, development and growth are threatened by the emerging rise of non-communicable diseases (NCDs) causing more deaths than all other causes combined (World Health Organization [WHO], 2014:28). Global NCD-related deaths, mainly due to cardiovascular diseases (CVDs) (such as heart attacks and strokes), cancers, diabetes, and chronic respiratory diseases (such as asthma and chronic obstructive pulmonary disease), are estimated to increase from 38 million in 2012 to 52 million by 2030 (WHO, 2014:28). According to Statistics South Africa (Stats SA), a group of the above-mentioned NCDs contributed to more than half (55.5%) of the mortality rates, followed by communicable diseases and injuries at 33.4% and 11.1% respectively (Stats SA, 2015:52). In South Africa, NCDs accounted for six of the top 10 underlying causes of natural death, while four underlying causes of natural death were attributed to communicable diseases (Stats SA, 2015:52).

Based upon several population studies conducted in Sub-Saharan Africa between 2008 and 2011, Sampson, Amuyunzu-Nyamongo and Mensah (2013:345) predicted an increase in the prevalence of NCDs, with hypertension increasing by 68% between the years 2008 and 2025 (Sampson et al., 2013:345). South Africa experienced an epidemiological shift in the main causes of death and diseases, transitioning from communicable diseases to NCDs between 2010 and 2015 (Stats SA, 2015:27). This increase could be attributed to the rapidly ageing population, prevalence of multiple chronic conditions, and high prevalence of risk factors (Goodman et al., 2013:1). High prevalence of risk factors includes, among others, changes in lifestyle (that is, physical inactivity), access to unhealthy food (due to urbanisation), globalisation and other common risk factors such as tobacco and alcohol use (Mayosi et al., 2009:934-936). Health promotion is therefore significant in addressing the escalation of NCDs and other public health concerns (Kumar & Preetha, 2012:1).

1.2 BACKGROUND

1.2.1 From health to health promotion

Health promotion within a global perspective is best described from a chronological and historical order. The development of health promotion is illustrated in Figure 1.1. In 1948, the WHO defined health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1986). Thus, to maintain optimal health, an individual requires living a healthy lifestyle, which comprises regular physical activity, correct eating habits, moderation in alcohol consumption, self-actualisation and reducing stress levels (Vasuthevan & Mthembu, 2016:4). Almost four decades after the WHO had coined the definition of health, the WHO
declared in 1986 that health promotion is essential to obtain and maintain health as captured in the Ottawa Charter. The Ottawa Charter defines health promotion as “a process of enabling people to increase control over, and to improve, their health” (WHO, 1986). Improving and increasing control of peoples’ own health, requires community empowerment, shared decision-making and advocacy for equity and justice to reduce health inequalities, leading to the management of one’s own health (Coulter et al., 2008:1-4).

In the 19th century, the biomedical model of health was an approach to diagnose and treat conditions: this approach was used by healthcare professionals and focused mainly on biological factors and did not take environmental and social influences into consideration (Kokko, Green & Kannas, 2014:496). It was an approach to address infectious diseases through prevention programmes, for example, immunisation (Wilson & Mabhala, 2009:5). The biomedical model was challenged by sociologists and health professionals in the early 1970s, arguing that removing the symptom does not solve the problem as there might be underlying illness (Russell, 2014:13). The bio-psychosocial model was recognised as an approach to address biological, psychological and social factors, and this led to health promotion as a point of focus in modern public health (Wilson & Mabhala, 2009:145). Health promotion resulted from the Lalonde Report in 1974, titled A new perspective on the health of Canadians. This report facilitated a shift from the medical/curative approach to recognise environmental and behavioural factors as major causes of ill health (Kokko et al., 2014:496). The Lalonde Report (Lalonde, 1974) referred to the concept of “health field”, which implied four interdependent fields that impact on an individual’s health, namely: biology (physical, mental health, human body development and its genetic composition); environment (physical and social environments that are health-related to matters outside the human body that one has no or little control over); lifestyle (the accumulation of personal resolutions under one’s control that can contribute to and/or cause illness or death); and healthcare organisation (public health services, emergency medical services, medical practices, hospitals, medical drugs, clinics, etc.).

The Lalonde Report also distinguished between two main health-related aims, namely: the prevention of health problems and the promotion of good health; and the healthcare system. Following the Lalonde Report, health promotion gained momentum by means of the Alma-Ata Declaration in 1978, stating that it was critical to achieve economic sustainability and social development; to improve quality of life; to promote and protect health; and equal opportunities to health (Gelb, Pederson & Greaves, 2012).
A progressive transition from health as a curative phenomenon to health as everybody’s responsibility to maintain, promote, cure and rehabilitate.

1900
- Early public health movement was disease-focused, aimed at preventing and managing disease.
- Advocacy for improved living conditions to improve health.

1948
- WHO defined health, post-World War II era, with a strong transition from military health systems towards improved control over communicable diseases.

1974
- Lalonde Report shifted from curative approach to environmental and behavioural factors in health.
- Two main health-related arms prevent health problems and promote good health, and healthcare system.

1978
- Declaration of Alma-Ata raised urgent action by all to protect and promote health of all people.
- Altered the unacceptable socio-economic and political inequality to health.
- Commitment to achieve the goal of "Health For All" by 2000, started first in developing countries.
- Primary health care incorporated into all health systems.

1986-1997
- First international health promotion conferences (1986).
- Ottawa Charter listed five health promotion action areas:
  - Build healthy public policy.
  - Create supportive environments.
  - Strengthen community action.
  - Develop personal skills.
  - Reorient healthcare services towards promotion of health and prevention of illness.

Health promotion conferences evaluate, strengthen, monitor health promotion key action areas
- Adelaide 1988 focused on health policymaking.
- Sundsvall 1991 focused on creating supportive environments.
- Jakarta 1997 and Mexico 2000 focused on capacity building for health promotion and health promotion to address the social determinants of health.
- Bangkok 2005 focused on health promotion within context of globalisation.
- Nairobi 2009 focused on health promotion to close the gap between evidence and policy and the appropriate application of health development.
- Helsinki 2013 focused on experiences from the Health in All Policies approach.
- Rotorua 2019 focused on health promotion and planetary health.

Figure 1.1: The development of health promotion
The first health promotion conference, which marked the birth of the Ottawa Charter, was held in Canada in 1986, and it highlighted the need for a new global, public health movement, intersectoral collaboration and social values related to health so as to ensure the reality of good health for all (WHO, 1986).

At the heart of the Ottawa Charter lies the key words *advocate, enable and mediate* – this describes the core activities in what became the new Public Health Movement in 1986 (Saan & Wise, 2011). Advocacy (advocate) means to influence the factors to be changed in order to encourage health as an essential resource for development and social means. Enabling is the action to help individuals towards health equity by empowering people to have control over the determinants that affect their health to reach quality of life. To mediate implies that health promotion is intersectoral between all sectors of government with the health sector and independent organisations such as industry (WHO, 1986). The Ottawa Charter for health promotion further stipulates five key action areas to mitigate the social determinants of health (SDH), namely: building healthy public policies; creating supportive environments; strengthening community participation; reorientation of health services; and personal skills development (WHO, 1986). The Ottawa Charter came as a response to the requisite of taking action on the SDH and pursues to empower communities (McPhail-Bell, Fredericks & Brough, 2013).

### 1.2.2 Social determinants of health

Health promotion addresses the fundamental prerequisites for health, namely peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity (WHO, 1986). Health is not only about individuals’ genes and their lifestyles but is also influenced by other external dynamics such as households, environmental and educational factors, economic and political forces and other cultural and behavioural factors that can affect one’s health, positively or negatively (WHO, 1986), referred to as the SDH. Health promotion is necessary to address critical behavioural, social and structural determinants of health (National Department of Health [DoH], 2014:11) and is universally organised according to the theory-based framework of the socio-ecological model. The socio-ecological model is a multilevel approach to health promotion and refers to factors impacting on and causing health at individual-, household-, community- and societal levels. For the purpose of this research, the SDH and examples of health promotion action areas applied to the quadruple disease burden of South Africa are illustrated in Figure 1.2.
Figure 1.2: The social determinants of health (SDH) applied to the interdependent and multilevel factors influencing a person’s health (left) and applied health promotion action areas (right)
1.2.3 Health promotion in South Africa

The South African healthcare system was transformed to a primary health care (PHC) approach and implemented through a district health system post-apartheid (1994) in order to deliver comprehensive, community-based healthcare services accessible to all South Africans (Dookie & Singh, 2012:1-4). The approach is contained in the National Health Plan (NHP) framed by the Alma-Ata Declaration and designed with experts from the WHO (Kautzky & Tollman, 2008:18). The NHP was developed by taking into consideration the strides made by the Pholela Health Centre model, which started in KwaZulu-Natal in the early 1940s, which advocated for community-oriented primary care (Kautzky & Tollman, 2008:18). Health promotion in South Africa is also directed by the National Health Promotion Policy and Strategy 2015–2019 (NHPPS). This policy focuses on six (6) target audiences across the full human lifecycle (DoH, 2014:4), listed as follows: promoting better health for children under five years; create awareness on services that are available to women of child-bearing age; promote changes in gender norms and value through broader involvement of men in health issues; address risky behaviour and promote healthier lifestyle practices amongst the youth; support groups and community-based programmes to promote self-management of chronic conditions and promote regular health amongst older people; and the specific health needs of marginalised populations.

Health promotion is an intersectoral collaboration in order for the following five (5) action areas to be addressed within South Africa (DoH, 2014:19-21):

- **1st action area: Advocate for healthy public policies** – promote intersectoral actions shared between individuals, health workers, clinics, health facilities, communities, civil society and government to build a holistic system that prioritises preventative services.

- **2nd action area: Empower local communities on health promotion approaches** – effective and concrete community action through community empowering; self-help to take responsibility for own health; social support and flexible systems.

- **3rd action area: Create enabling environments that promote healthy behaviour** – advocacy to impact on social, economic, policy and physical factors to maintain and improve health, especially in households, schools, higher education institutions, PHC facilities, hospitals, communities, taxi ranks, shopping centres, workplaces and places of worship.

- **4th action area: Strengthen human resources capacity to deliver health promotion services** – provide adequate resources based on redress and equity; dedicate resources for health promotion programmes at all levels; and define roles and responsibilities at different levels.
• 5th action area: Strengthen systems to monitor and evaluate health promotion interventions – activate monitoring and evaluation systems so that all health promotion decisions can be evidence-based through formative assessments prior to health promotion interventions, acknowledging that health promotion programmes are multifaceted and have direct and direct impact on health outcomes.

In Table 1.1, the health promotion target audiences and key action areas according to South Africa’s Health Promotion Policy and Strategy (2015–2019), are summarised and aligned accordingly with one or more of the appropriate action areas of health promotion (Ottawa Charter). From this summary, it came to light that two action areas are under-represented within the South African Health Promotion Policy and Strategy (2015–2019), namely action areas four (4) and five (5).

Table 1.1: A summary of the South African Health Promotion Policy and Strategy (2015–2019) according to target audiences

<table>
<thead>
<tr>
<th>Target audiences for health promotion in South Africa</th>
<th>Proposed action areas for health promotion in South Africa</th>
<th>Action areas of health promotion</th>
</tr>
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<tbody>
<tr>
<td>Children under five</td>
<td>Health promotion programmes that focus on promotion of physical and mental wellbeing of children under five years. The Integrated Management of Childhood Illness (IMCI), household community component, key family practices form basis of all health promotion programmes. Focus on promoting better health for children through collaboration with Early Childhood Development Centres (ECDCs), parents, caregivers and health services.</td>
<td>1st action area: Advocate for healthy public policies. 2nd action area: Empower local communities on health promotion approaches. 3rd action area: Create enabling environments that promote healthy behaviour.</td>
</tr>
<tr>
<td>Women of child-bearing age</td>
<td>Make women aware of available reproductive health services and choices. Stress importance of early antenatal bookings, pre- and post-natal care services. Encourage to live a healthy life.</td>
<td>1st action area: Advocate for healthy public policies. 2nd action area: Empower local communities on health promotion approaches. 3rd action area: Create enabling environments that promote healthy behaviour.</td>
</tr>
<tr>
<td>Target audiences for health promotion in South Africa</td>
<td>Proposed action areas for health promotion in South Africa</td>
<td>Action areas of health promotion</td>
</tr>
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<td>---------------------------------------------------</td>
<td>---------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td>Targeted campaigns to increase awareness towards changes in gender norms and values. Encourage broader involvement in maternal health and family planning. Screen for NCDs such as prostate cancer, hypertension and diabetes. Prevent gender-based violence. A comprehensive health promotion intervention regarding awareness of substance abuse and HIV prevention.</td>
<td>1st action area: Advocate for healthy public policies. 2nd action area: Empower local communities on health promotion approaches. 3rd action area: Create enabling environments that promote healthy behaviour.</td>
</tr>
<tr>
<td><strong>Youth</strong></td>
<td>Address risky sexual behaviour, such as multiple sexual partners, sex without a condom, consequences of unwanted pregnancies. Promote healthy lifestyle practices, such as nutrition and physical activity to prevent obesity and abstinence from substance abuse, tobacco and alcohol. Integrated School Health Programme (ISHP) to screen early for health conditions and illnesses, such as poor eyesight and cognitive challenges.</td>
<td>1st action area: Advocate for healthy public policies 2nd action area: Empower local communities on health promotion approaches 3rd action area: Create enabling environments that promote healthy behaviour</td>
</tr>
<tr>
<td><strong>Older people</strong></td>
<td>Improve longevity through lifestyle changes. Create supportive environments and develop personal skills for self-management of chronic conditions. Establish and facilitate community-based programmes and support groups to promote regular health- and self-management of chronic health conditions, including mental health wellbeing.</td>
<td>1st action area: Advocate for healthy public policies. 2nd action area: Empower local communities on health promotion approaches. 3rd action area: Create enabling environments that promote healthy behaviour.</td>
</tr>
<tr>
<td><strong>Marginalised populations and vulnerable groups with specific health needs</strong></td>
<td>Design specific interventions to meet the needs of refugees or migrant workers; homeless people; key populations at high risk for HIV infection; people with disabilities (physical, intellectual, sensory, emotional); adult and juvenile offenders; lesbian, gay, transgender, bisexual and intersex people, and mentally-challenged people.</td>
<td>1st action area: Advocate for healthy public policies. 2nd action area: Empower local communities on health promotion approaches. 3rd action area: Create enabling environments that promote healthy behaviour.</td>
</tr>
</tbody>
</table>
Insufficient evidence in health promotion action areas makes it difficult to assess progress made with regard to public policies, capacity building and other areas of success (Potvin & Jones, 2011:247). Consequently, health promotion services require a well-structured, standardised monitoring and evaluation system for research, civil society, non-governmental organisations and other sectors contributing to health promotion (Onya, 2007:235). In order to address the determinants of health in a globalised world, as highlighted in the Bangkok Charter, South Africa is obliged to deploy sustainable health promotion action areas (WHO, 2005). The structure for health promotion in South Africa comprises a health promotion directorate at the national office working closely with health promotion coordinators in each of the nine provincial offices (Wills & Rudolph, 2010). The table below highlights discrepancies in at least three (3) provinces and highlights that need to dedicate human resources to health promotion, considering that health promoters in South Africa are employees of the DoH.

**Table 1.2: Comparison of the health promotion human resource structure in three provinces of South Africa (Van den Broucke et al., 2010; Wills & Rudolph, 2010)**

<table>
<thead>
<tr>
<th>Province</th>
<th>Human resources on provincial level</th>
<th>Human resources on district level</th>
<th>Human resources on sub-district level</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>1 Deputy director</td>
<td>No staff</td>
<td>Community liaison officers (also called HP coordinators) in five (5) out of 19 sub-districts</td>
<td>At provincial level, all have diplomas in health-related fields. At sub-district only 10% have post-matric qualifications.</td>
</tr>
<tr>
<td></td>
<td>2 Assistant directors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gauteng</td>
<td>2 Deputy directors</td>
<td>Assistant director at each district</td>
<td>Community liaison officers in each sub-district</td>
<td>At provincial level, all have diplomas in health-related fields. All other levels have been trained through the University of the Witwatersrand and hold a certificate in health promotion.</td>
</tr>
<tr>
<td></td>
<td>2 Assistant directors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1 Deputy director</td>
<td>No staff</td>
<td>Assistant director in each sub-district</td>
<td>At provincial level, all have diplomas in health-related fields. All assistant directors have diplomas in health promotion.</td>
</tr>
</tbody>
</table>
1.3 PROBLEM STATEMENT

Eighteen years after the implementation of the PHC approach in South Africa, Dookie and Singh (2012:2) argued that implementation at district level has been slow and poorly coordinated, but they also acknowledged the progress made in some areas, such as more people being reached with preventive health services when compared to the past. Poorly-coordinated PHC delivery can be attributed to inherent inequities in resource allocation and the quadruple burden of disease that places a severe strain on scarce resources (Dookie & Singh, 2012:2). The ultimate goal for PHC is “better health for all”, therefore integration of health services into the processes of community development requires political commitment, intersectoral collaboration and multidisciplinary involvement (Vasuthuthevan & Mthembu, 2016:43).

Kautzkyi and Tollman (2008:18) suggested a need to refocus effective healthcare services through the district health system, prioritising health promotion initiatives, implementing screening programmes and by controlling key risk factors as well as addressing the SDH. To renew and have a successful PHC system in South Africa, there is a great need to undertake enormous actions to promote health and prevent disease through empowering communities and ensuring their participation (Dookie & Singh, 2012:2). Considering health inequalities due to the South African apartheid history, health promotion came as a decisive shift of power from professionals (Marcia & Simon, 2009:753) to the patients as empowered team members in their own health. The shift places emphasis on the right of individuals to participate as members of the healthcare team, gaining information that enable informed decisions contributing to their own health (Vasuthuthevan & Mthembu, 2016:61).

Health promotion has been adopted in South Africa by the Health Promotion Policy and Strategy (DoH, 2014). However, there are still challenges in the implementation thereof in South Africa (Sampson et al., 2013:346). The underlying determinants of health, which are mainly economic, environmental, political and social changes, have an enormous effect on health and ill health, thus a need to consider these influences is critical in the upscaling and strengthening of the PHC system and health promotion (Dookie & Singh, 2012:3). Scaling up of health promotion action areas amidst current challenges require also private–public partnerships and intersectoral collaboration to yield evidence-based action areas (Sampson et al., 2013:353).

The lack of collaboration and integration of health promotion services are further related to the fact that the health promoters are rendering health education to communities instead of applying the five key actions areas as characterised in the Ottawa Charter (Wills & Rudolph, 2010:30-34). A report tabled to the North West Provincial Human Resource Unit by the North West Health Promotion Unit in 2015 highlighted aspects that impede service delivery in terms of health promotion action areas, namely: disparities in health promotion structure within the sub-districts; health promoters being expected to support the PHC system, including PHC re-engineering with
limited skills; non-replacement of resigned health promoters; lack of capacity building or skills development programmes; and insufficient health promotion monitoring and evaluation. Furthermore, within the North West Province, the profile of the 102 health promoters was as follows: 50% were older than 50 years of age; 29 did not have a grade 12 certificate; 58 had only a matric certificate; nine (9) had office administration certificates; and six (6) had a Health Promotion Diploma from the University of Limpopo (UL) between the years 2009 and 2011. There are also discrepancies in districts and facilities in all nine provinces in relation to human resource systems.

The South African Health Promotion Policy and Strategy is aligned with the global movement of health promotion and initiated within South Africa’s overburdened PHC services amidst a quadruple disease burden. The Health Promotion Policy and Strategy presents the five key areas of which, key area 4, namely that of strengthening human resources capacity to delivery health promotion services, seems inadequate within the North West Province and incongruent between the nine provinces in South Africa. There is insufficient evidence of health promotion human resources related to redress and equity, dedicated resources for health promotion programmes at all the levels in the public health system and unclear roles and responsibilities of human resources at different levels. In order to inform the North West Provincial Department of Health (NWPDoH), at present impacted by overburdened and under-resourced facilities, on mechanisms to strengthen human resources capacity to deliver health promotion services, the researcher asked the primary research question as: “What are healthcare workers’ perspectives of the barriers and enablers in health promotion human resources within the North West Province?” The following sub-questions were presented:

Research Question 1: What are healthcare workers’ perspectives of the barriers in health promotion human resources in the North West Province?

Research Question 2: What are the healthcare workers’ perspectives of the enablers in health promotion human resources in the North West Province?

Research Question 3: What recommendations can be made to strengthen health promotion human resources in the North West Province at PHC-, sub-district-, district- and provincial levels?

1.4 RESEARCH AIM AND OBJECTIVES

The main aim of the research was to inform the North West Department of Health on health promotion human resources within the current public health system. The research objectives were to:

Objective 1: explore and describe healthcare workers’ perspectives of the barriers in health promotion human resources in the North West Province;
Objective 2: explore and describe healthcare workers’ perspectives of the enablers in health promotion human resources in the North West Province;

Objective 3: make recommendations to strengthen health promotion human resources in the North West Province health system at PHC-, sub-district-, district- and provincial levels.

1.5 CENTRAL THEORETICAL ARGUMENT

Health promotion replaced the biomedical approach to health over the global course stretching longer than a century. As countries worldwide adopted health promotion as an essential approach to empowering people to obtain more control over their own health and to maintain their health, it was also adopted by South Africa. The NHPPS of South Africa is aligned to the Ottawa Charter for health promotion. In this policy and strategy, the five key action areas are acknowledged, although key area 4, namely human resource capacity, is insufficiently represented throughout the policy. In addition, there is incongruence regarding health promotion human resources between provinces in South Africa, and the human resource profile within the North West Province is aged and insufficiently qualified. Insight into healthcare workers’ perspectives of the health promotion human resources barriers and enablers can assist the researcher to formulate recommendations for the NWPDoH, applied to the public health system.

1.6 BRIEF LITERATURE OVERVIEW

To understand the research problem, it is essential to view health promotion in the global context. The emergence of the Ottawa Charter (1986) resulted in definitions, concepts, declarations and strategies aimed at replacing the public health approach to disease control with an approach focusing on inequalities to address the SDH (Jackson et al., 2013; WHO, 2005:48). The current global health issues, ranging from historical and cultural factors, socio-economic factors, climate change, political will and human resource, have become a threat to population health development, although it varies in magnitude (Ziglio, Simpson & Tsouros, 2011:219).

Under the current constrained economic challenges, investment in curative clinical services may not be sustainable in many countries (especially on the African continent) (Ziglio et al., 2011:219). The increasing medical technological costs and medicalisation of problems, which result in a high demand for drugs and other remedies, add to the economic burden (Bandura, 2005:45) and therefore reorientation of health services and investment in other health promotion strategies may be the vehicle required for an effective and sustainable healthcare system. Transformation is required in managing health problems from the perspective of health specialists whose focus still revolves around curative public health models (Nyamwaya, 2003:86). This approach disadvantages the programme and, as a result, the health promotion Ottawa Charter principle does not find clear expression in ensuring effective interventions (Nyamwaya, 2003:86).
1.6.1 The Ottawa Charter’s definition of health promotion

The Ottawa Charter defines health promotion as “the process of enabling people to increase control over, and to improve their health” (WHO, 1986). To enhance broader changes in the socio-economic and political environments, the Ottawa Charter set out three principles, namely advocacy, enablement and mediation through relevant health policies (Saan & Wise, 2011:187). Amongst the range of health promotion actions that have been implemented, is the settings approach which entails collaboration of stakeholders within different sectors or social contexts to address health inequities and wellbeing through policy enforcement (Jackson et al., 2013:476). Settings could range from healthy cities or communities, healthy schools and healthy workplaces (Whitelaw et al., 2001:431).

In advocating for communities, political, economic, social, cultural, environmental, behavioural and biological factors must be taken into consideration due to the negative or positive impact they have on health outcomes (Saan & Wise, 2011:188). Saan and Wise (2011) argue that professionals and politicians tend to be more reactive than proactive when attending to community needs and suggest a more robust advocacy strategy where advocates can be developed within communities with limited public voice. Improving and maintaining health requires dynamic and justifiable advocacy strategies that compete with the current technological advancements. Developing personal skills is one of the key strategies of health promotion that enables communities to take control of the determinants of health. Empowered communities are confident and more demanding and as such can exert power on the authorities to secure supportive environments that would enhance healthy choices (Saan & Wise, 2011:189). Pursuing healthy choices and better health outcomes requires different sectors to mediate for community interests through a multidisciplinary approach by government departments, non-governmental organisations, social groups, individuals and health professionals (Saan & Wise, 2011:189).

To enhance intersectoral collaboration, the Ottawa Charter set out five (5) key action areas as a framework to implement integrated health promotion interventions, leading to increased life expectancy, namely building healthy public policy at all sectors, personal skills and reorienting of health services (Coe & De Beyer, 2014;WHO, 1986:18).

1.6.2 Social determinants of health

The Ottawa Charter and its renewal in Bangkok in 2005 embraced the significance of the SDH approach in public health; this played a critical role in reconfiguration of the healthcare system through reorientation of health services (WHO, 2005). Focus on individuals’ behaviours, community participation, stakeholder engagement and health policies form the basis of health promotion and the SDH principles and strategies (Jackson et al., 2013:488). The Commission on the Social Determinants of Health (CSDH) (WHO, 2008) endorsed PHC as a fundamental
principle in addressing the determinants of health at local level. This action was further reinforced by the WHO in reaffirming its position in the 2008 World Health Report (WHO, 2008). In addressing the SDH, health promotion should be approached from a socio-ecological, intersectoral model that will encourage responsibility and participation of the community to take control of owns health and for efficient management of government resources (Berenguera et al., 2017:908).

The health sector alone will not prevent NCDs; choosing a healthy lifestyle and the ability to modify risks depends on living conditions and access to resources (Rasanathan & Krech, 2011). Ataguba et al. (2016:8) assessed the contribution of the SDH to health inequalities and identified knowledge and education, social protection and employment, and housing and infrastructure as domains accounting for good health disparities in South Africa. To address these domains, appropriate policy review and rapid response by all government entities and intersectoral collaboration are required, complemented by an in-depth analysis of the fiscal policy.

Adopting an SDH approach may address social inequalities and the conditions in which people are born, grow, live, work and age, coupled with measures strengthening the health systems that would work better for all population groups (Rasanathan & Krech, 2011) – thus, the need for collaboration with different sectors, including, but not limited to, trade, agriculture, education, environment, finance, civil society to address conditions giving rise to NCDs and implementing policies to minimise their exposure to risk.

1.6.3 Health promotion models and theories

Seedhouse (1997:27) described health promotion as a “magpie profession”, meaning health promotion is built through the accumulation of numerous features from other disciplines through different categories involved in health promotion, which includes health promotion practitioners and theorists. Social scientists, education professionals’ voluntary associations, funding agencies and community groups tried to appropriate health promotion to their field by designing their own model on health promotion (Scriven & Orme, 2001). Thus, health promotion is founded on adopted techniques, models and goals influencing interventions (Seedhouse, 1997:21). Some of the adopted techniques include behaviour change techniques derived from psychology; legislative change derived from law and politics; and surveys of people’s beliefs about health, illness, morbidity and mortality derived from sociology, psychology, epidemiology and statistics (Seedhouse, 1997:21).

In his social cognitive approach, Bandura describes individuals as having the power to change their own attitudes towards a healthy lifestyle in his social cognitive approach (Bandura, 2005:245), using the primacy of self-regulation, which is a self-management model. He describes motivation and self-regulatory skills to be enhanced by three generic sub-functions: self-
monitoring of health-related behaviour and the social and cognitive conditions under which one engages therein; adoption of goals to guide one’s efforts and strategies for realising them; and self-reactive influences that include enlistment of self-motivating incentives and social supports to sustain healthful practices (Bandura, 2005). The self-management model is cost-effective and covers a wider population through the support of one facilitator. This makes it more credible as its fits well into the Ottawa Charter principles and strategies of skills development and empowerment. A self-management system was used to promote lifestyle changes in patients suffering from coronary artery disease and showed greater success amongst those aided in self-management than those receiving the usual medical care by their physicians (Haskell et al., 1994). In consideration of this self-behaviour management system, which focuses on individuals, it might have limitations in societal behaviour change as behaviour might be influenced by the society in which people live.

According to social norms theories pointed out by Bartholomew et al. (2015:172), “health promoting behaviour can result in health promoting social norms”, as portrayed by members of certain social groups. Individuals’ norms are influenced by how they are socialised through different stages of their upbringing; however, these norms can be influenced through different methods, which includes mass media, entertainment education, mobilisation of social networks and behavioural journalism (Bartholomew et al., 2015:172). These methods have greater impact by increasing visibility of positive health behaviours by opinion leaders, risk populations, health workers and popular characters, leading to the adoption of health promoting social norms (Reininger et al., 2010:350). Social and ecological factors remain core influencers to health behaviours; strategies moving towards addressing these influencers are critical in resolving disparities within health promotion as a programme and a profession (Terry, 2018:261). Baum (2014:220) argues that behavioural theories have limited outcomes to communities with lower socio-economic status. However, if coupled with health policies addressing unhealthy environments, the potential to yield positive health outcomes increases (Baum & Fisher, 2014:220).

1.6.4 Challenges in health promotion

Health promotion has become more dynamic and the knowledge on factors protecting the health of people and those adding health risk, emerges over time and therefore requires new designs and actions (St Leger, 2005:318). PHC offers an ideal context in which integrated and person-centred services to implement health promotion actions encourage behaviour change. Workload, lack of time, skills, and uncertainty about programme effectiveness present as barriers to the incorporation of health promotion interventions into daily practice (Berenguera et al., 2017:897).
1.6.4.1 Human resources

A hierarchical framework of a disease-oriented healthcare system, coupled with the absence of occupational standards for health promoters in South Africa, confines health promotion to a narrow behaviour change approach rather than the enabling role within communities (Wills & Rudolph, 2010; Onya, 2009). Although the number of professionals described as health promotion practitioners in South Africa is steadily growing, professionalization of health promotion remains a challenge (Van den Broucke et al., 2010).

The sustainability of health promotion action and future growth is dependent on building capacity of the workforce with the necessary knowledge, skills and abilities to translate policy and current research into effective action (Barry et al., 2009:5). Many countries lack clarity about roles, lines of accountability and gaps in competency and skills in health promotion (Wills & Rudolph, 2010). To address health inequities and social determinants of health, health promotion core competencies for both health promotion specialists and the wider health promotion workforce need to be constantly reviewed (Barry et al., 2009:6).

In June 2008, the Galway Consensus Conference convened and hosted in Galway, Ireland, identified eight broader domains of core competencies that serve as a guide in the advancement and strengthening of health promotion practice globally (Allegrante et al., 2009:479). According to Onya (2009), the consensus statement would give impetus to African countries, like South Africa, Botswana, and Nigeria, which progressed in developing health promotion policies but experience “constraints of strengthening health promotion systems and professionalization of health promotion” (Onya, 2009:48). Health promotion programmes need to be designed by people with the appropriate skills and competencies who can incorporate the Ottawa Charter framework for effectiveness (Fry & Zask, 2017:910). Linking the competencies to the South African Health Promotion Policy and Strategy presents prospects of notable progress that have been achieved in policy development and desired future milestones to support capacity and resources for health promotion. Table 1.3 illustrates the linkages.

Table 1.3: Galway Consensus competencies linked to the South African policy and strategy

<table>
<thead>
<tr>
<th>Galway Consensus Statement: eight broader domains of core competencies</th>
<th>The South African health promotion policy and strategy (DoH, 2014:19-21)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Catalise change</strong>: Enabling change and empowering individuals and communities to improve their health.</td>
<td>Empower local communities on health promotion approaches.</td>
</tr>
<tr>
<td><strong>Leadership</strong>: Providing strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion and building capacity.</td>
<td>Advocate for healthy public policies. Strengthen human resources capacity to deliver health promotion services.</td>
</tr>
<tr>
<td><strong>Assessment</strong>: Conducting assessments of needs and assets in communities and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental and organisational determinants that promote or compromise health.</td>
<td>Empower local communities on health promotion approaches.</td>
</tr>
<tr>
<td><strong>Planning</strong>: Developing measurable goals and objectives in response to assessment of needs and assets and identifying strategies that are based on knowledge derived from theory, evidence and practice.</td>
<td>Create enabling environments that promote healthy behaviour.</td>
</tr>
<tr>
<td><strong>Implementation</strong>: Carrying out effective and efficient culturally sensitive and ethical strategies to ensure the greatest possible improvements in health, including management of human and material resources.</td>
<td>Strengthen human resources capacity to deliver health promotion services.</td>
</tr>
<tr>
<td><strong>Evaluation</strong>: Determining the reach, effectiveness and impact of health promotion programmes and policies. This includes utilising appropriate evaluation and research methods to support programme improvements, sustainability and dissemination.</td>
<td>Strengthen systems to monitor and evaluate health promotion interventions.</td>
</tr>
<tr>
<td><strong>Advocacy</strong>: Advocating with and on behalf of individuals and communities to improve their health and wellbeing and building their capacity for undertaking actions that can both improve health and strengthen community assets.</td>
<td>Empower local communities on health promotion approaches. Create enabling environments that promote healthy behaviour.</td>
</tr>
<tr>
<td><strong>Partnerships</strong>: Working collaboratively across disciplines, sectors and with partners to enhance the impact and sustainability of health promotion programmes and policies.</td>
<td>Advocate for healthy public policies.</td>
</tr>
</tbody>
</table>

The table above supports South Africa’s health promotion strategy's alignment to international health promotion standards. However, there seems to be paucity in literature on success of actions adopted by South Africa to be on a par with the Galway Consensus competencies. There are not considerable stories to convey how the country has advanced on capacity building, needs assessment, monitoring, evaluation and leadership in health promotion. The South African health promotion strategy outlines activities and approaches to address this gap and could be re-evaluated for its impact beyond 2019.

1.6.4.2 Training on health promotion

McFarlane *et al.* (2016:132) argue that implementing health promotion and treatment services within the same level often results in health promotion not being identified as a priority in the organisation’s strategic focus. There is a need to understand competing priorities with the health sector and their interdependent relationship to enable equitable resource allocation through reorientation of health services. An adequately resourced health promotion programme with knowledgeable, skilled workforce is required to enhance health promotion capacity in the PHC setting (Judd & Keleher, 2013:163).

The National Department of Health acknowledges lack of skilled health promotion workforce and suggests collaboration with institutions of higher learning to create formal standardised health promotion training (DoH, 2014:17). According to an internal report compiled within the NWPDoH, there are no qualified health promoters in the system and most of them do not have university
entry. This may be due to limited institutions in South Africa providing opportunities for formal health promotion qualifications. Literature confirms two institutions providing health promotion qualifications at different levels. The University of Limpopo (UL) offers a Bachelor’s degree in Health Sciences with health promotion (UL, 2017:2), and the University of the Western Cape (UWC) offers a postgraduate management course in health promotion and a postgraduate certificate in public health with a focus on health promotion (UWC, 2013:1). The fact that the North West Province does not have any institution providing health promotion training could be an aggravating factor to the shortage of qualified health promoters in the province.

1.6.4.3 Political and economic challenges

Mozambique advocated for PHC services after the colonial Portuguese government between 1975 and 1976 (Hanlon in Sanders et al., 2008:512) and managed to make great strides in health promotion activities. Some of the achievements included: increased women’s rights; community mobilisation led to the building of latrines; small collective gardens and adult literacy classes were developed (Sanders et al., 2008:512). However, the political environment in the 1980s caused by RENAMO, a counter-revolutionary organisation, resulted in huge economic impairment, increased infant mortality and many deaths (Sanders et al., 2008; Funada-Classen & Osada, 2012:8).

In Zimbabwe, a Village Health Workers (VHWs) programme was eroded due to the economic structural adjustment programme and bureaucratisation between 1980s and 1988 (Sanders, 1992). Initially, VHWs were elected by communities and trained to promote health through addressing the determinants of ill health. Sanders (1992) refer to them as “agents of change, promoting health through awakening people to their potential”. The VHWs programme embodied the Ottawa Charter definition of “enabling people to take control of their health”. Policymakers need to be directed to strengthen public health policies due to the influence these policies can enact in addressing behavioural, environmental and social determinants of health as seen in Canada and Australia (Bryant et al., 2011:54; Baum & Fisher, 2014).

1.6.4.4 Policy and financial implications

Denmark’s administration reform in 2007 assigned local disease prevention, health promotion programmes and PHC services to local government (Rod & Høybye, 2015:693), which triggered the development of the new era of policy development in health promotion. A health promotion package was developed and includes policies on different health promotion aspects. One of the policies that forms part of the health promotion package includes the alcohol policy for the municipality’s workplaces and institutions to focus on alcohol consumption among employees and people who use the institutions (Rod & Høybye, 2015:693). These processes contributed to the increased life expectancy in Denmark, from 77.9 years in 2005 to 80.6 years in 2015, with women
having a higher life expectancy (82.5 years in 2015) than Danish men (78.6 years in 2015) (Ministry of Health Denmark, 2017:29).

The South African health system made positive strides in the provision of healthcare services post-apartheid, including improved life expectancy rates estimated at 61.1 years for males and 67.3 years for females (Stats SA, 2018:2). Despite these achievements, the country is still faced with challenges of inequitable financing of the healthcare system (Chinwe & Obuaku-Igwe, 2015:97). As a result, effectiveness and efficacy remain obstacles to providing comprehensive quality healthcare services. Low- and middle-income countries continue to strive to achieve universal health coverage (UHC) (Hofman et al., 2015:739).

According to Maharaj, Robinson and McIntyre (2018:190), inequitable health budget allocation amongst districts in the NWPDoH has been noted as one of the challenges to deliver PHC services. This is due to healthcare financial resource allocation in South Africa being based on historical budgeting. Reorientation of health services to promote equity requires intense analysis of the population size and demographic composition using a needs-based approach to equitable resource allocation (Maharaj et al., 2018:190). In 2012, South Africa instituted the National Health Insurance (NHI) system in 10 pilot districts with the aim to hasten the attainment of UHC (DoH, 2014:32). This process is crucial to guide South Africa on the mechanism of financing and governance of the health system over the next decades within the current limited budgets (Hofman et al., 2015:739). At the core of this new policy development, prioritisation of appropriate health interventions remains crucial in areas of health promotion, disease prevention, diagnosis and treatment, rehabilitation and palliation (Hofman et al., 2015:739).

Integration of theories, principles and strategies of health promotion presented in the Ottawa Charter may strengthen efforts to improve health. The cadre required for health promotion interventions need to have competencies and skills in and knowledge on different health promotion frameworks. Investing in competent health promotion workforce will ensure a properly designed health promotion programme yielding positive health outcomes.

### 1.7 METHODOLOGY

The research design and methods are discussed in this section.

#### 1.7.1 Research design

A qualitative, explorative, descriptive and contextual approach research design was applied in this study. As human resources for health promotion is relatively under-explored and implies a relatively multidimensional unknown phenomenon, best comprehended through the perspectives of people within practice, a qualitative (Botma et al., 2010:182) exploration and description towards a greater understanding of barriers and enablers were suitable.
1.7.2 Context

The context was the Dr Kenneth Kaunda (DKK) District in the North West Province. This district is one of four districts in the North West Province with a population of 796 823, comprising four sub-districts, namely Matlosana (population of 476 334), followed by Tlokwe (population of 170 652), Maquassi Hills (population of 91 991) and lastly, Ventersdorp (population of 57 846) [Health System Trust (HST): 2011]. This district was selected for the following reasons: it is the NHI pilot district within the North West Province; it is challenged by the quadruple burden of disease, which affects all races and genders; and it has a fairly accurate representation of the Black, White and Indian communities as compared to the other three districts in the province. Moreover, it is the district with the highest number of health promoters within the North West Province.

There are nine community health centres (CHCs), 26 clinics and six satellite clinics. All CHCs and clinics are assigned community health workers (CHWs) to re-engineer PHC services in line with the PHC re-engineering model. Health promoters are expected to form part of these teams. Currently, Tlokwe sub-district has four health promoters, whilst Matlosana has 18, Maquassi Hills has two, and Ventersdorp has three. The district further comprises district hospitals, Ventersdorp and Maquassi Hills. Potchefstroom Hospital serves as a referral hospital for Tlokwe and Ventersdorp. Klerksdorp Tshepong Hospital complex, which is situated in Matlosana, serves as a referral hospital for the other three sub-districts. Witrand Hospital is a specialised psychiatric hospital and is situated in the Tlokwe sub-district.

The top 10 causes of death in the district are rated, with tuberculosis (TB) as the primary cause, followed by HIV, hypertension, cerebrovascular diseases, diabetes mellitus, influenza and pneumonia, other forms of heart diseases and chronic lower respiratory diseases (Stats SA, 2015). The risk factors related to these causes of death include, amongst others, poverty, high HIV prevalence, unemployment, the proximity of the residential areas to national roads, illiteracy, industrialisation, informal settlements, highly mobile citizens and communities and lastly, an influx from other provinces and countries.

1.7.3 Population

The population (Burns & Grove, 2009:204) comprised health workers within the DKK District, ranging from health promoters, operational managers, programme coordinators, and senior managers based at PHC facilities, the sub-district office and district office (see Table 1.4).
### Table 1.4: Categories of health promotion-related health workers within the Dr Kenneth Kaunda District included in the population

<table>
<thead>
<tr>
<th>Category of health workers</th>
<th>Sub-district</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Health promoters</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Professional nurses contracted as operational managers in PHC clinics</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Senior management</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>69</td>
<td></td>
</tr>
</tbody>
</table>

The table above indicates the number of health workers in the sub-districts and their categories. For example, in sub-district A, two health promoters, five operational managers and one senior manager formed part of the population.

### 1.7.4 Sample

The population was a heterogeneous group and therefore participants were interviewed at different levels within the district. Purposive proportional quota sampling (Botma et al., 2010) was used to sample health workers in different categories who were knowledgeable about and fully involved in health promotion action areas. The sample included health promoters, operational managers based in facilities, programme coordinators and senior managers based at the sub-district or district office who were willing to participate.

A proper description of the identified population enabled the researcher to provide evidence of the generalisability of the results (Botma et al., 2010:124). Reasons for the sample were based on the following:

- health promoters who implemented health promotion action areas at different settings within the community on a daily basis as their key performance area, hence more health promoters were interviewed than health workers in the other categories;
- professional nurses as operational managers who worked in and managed PHC facilities on a daily basis, identifying health problems/diseases of concern, and together with the health promoters developed health promotion initiatives with the involvement of other stakeholders for the facility catchment population. With this information, operational managers might inform health promoters of disease trends and plan for the facilities together;
- senior management whom supported health promotion programmes by providing human and material resources to enhance health promotion action areas.
1.7.4.1 Inclusion criteria

The inclusion criteria were as follows:

- participants had to be permanently employed by the Provincial Department of Health for a period no less than three (3) years, since they would have been able to provide experiences of health promotion and its relation to PHC-, sub-district- and district levels;
- participants had to be from diverse cultural backgrounds and genders. However, they had to be able to communicate in English as an official mode of instruction within the DoH;
- participants had to be available for the interview despite staff shortages;
- participants participated voluntarily and had to sign a consent form and give permission that individual semi-structured interviews may be recorded by means of a digital voice recorder.

1.7.4.2 Exclusion criterion

Health workers who transferred to the DKK District with the same period of employment within the Department but served for less than three years in the DKK District, were excluded from the study. They might have lacked understanding of the barriers and enablers specific to the DKK District, being an NHI pilot site. This is supported by the literature, which suggests incongruence between health promotion healthcare workers’ capacity between provinces in South Africa.

1.7.5 Permission and recruitment of participants

The researcher requested permission from the Provincial DoH and the DKK District health office. A summarised presentation, full protocol with a cover letter and example of the written informed consent form were presented to the Department. The proposal highlighted, amongst others, why the site was chosen for the study, the process and activities that would be conducted during the study, and how ethical issues would be handled. After goodwill permission was granted, the Department (DKK District) allocated a mediator who communicated with the researcher to ensure that all logistical arrangements were in place and that the research was explained to prospective participants.

1.7.6 Obtained informed consent

All participants were given an informed consent form which outlined expectations of participants during the research prior to the study through the mediator. The expectations were written in simple, clear English and included the following: purpose of the research; benefits of the study; explanation of the manner in which data would be collected; duration of the interviews; criteria for selection; responsibilities of participants and of the researcher; risks involved; voluntary participation; confidentiality; protection of information; dissemination of results; and contact details
of the researcher and ethics committee for any complaints as outlined in Botma et al. (2010:14). Participants were given at least 24 hours to go through the information, ask questions and clarifications, and could ask for more information if necessary. Only after they made their final decision, and if they wanted to, they were introduced to the independent interviewer by the mediator. To ensure that consensus was reached and no one was either manipulated or coerced to participate, an informed consent was signed by participants prior to the interview with the independent interviewer. The principle of respect was applied by allowing participants to decide whether or not they wanted to participate in the study (i.e. voluntary participation).

Furthermore, to avoid selection bias and protect privacy and confidentiality of the participants, the gatekeeper and mediator ensured recruitment and enrolment of participants. This process ensured that the perception of undue influence was managed, given that the researcher is the health promotion manager in the NWPDoH.

1.7.7 Data collection

Semi-structured interviews were used to collect data. Interviews involved face-to-face interaction with the participants as it allowed the interviewer flexibility to follow up on topics of interest that may have emerged from each interview (Botma et al., 2010:208).

1.7.7.1 Individual semi-structured interviews

Interviews were digitally recorded and transcribed verbatim to provide a full record and to allow the interviewer to concentrate on the interview. The interviewer recorded the interview using a digital voice recorder placed inconspicuously so as to avoid making participants uncomfortable (Botma et al., 2010:214). To enhance the quality of the interview, the interviewer used verbal and nonverbal communication techniques. Verbal communication techniques included paraphrasing, reflecting, clarifying, probing, summarising, encouragement, listening and acknowledgement as outlined by Okun (1997 in Botma et al. 2010:206). Nonverbal communication techniques included eye contact, an open and relaxed posture, and active listening (Greeff in Botma et al. 2010:219). The interviews were conducted behind closed doors in a private room that was provided by the DoH. The request for this private room was made in the proposal that requested permission to conduct the research. The researcher followed a schedule agreed upon with the gatekeepers, mediators, interviewer and the participants. No interview exceeded the proposed length of 60 minutes. Below (Table 1.5) is a typical schedule that was followed.

<table>
<thead>
<tr>
<th>Date</th>
<th>Area</th>
<th>Time</th>
<th>Participant category</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>Sub-district A (B, C, D)</td>
<td>09H00</td>
<td>Operational manager</td>
<td>Health facility office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11H00</td>
<td>Health promoter</td>
<td>Health facility office</td>
</tr>
</tbody>
</table>
This schedule was used for all the sub-districts on dates that were agreed upon with the participants and management of the DoH. In some cases, however, times changed due to pressing commitments by participants. To avoid transport inconvenience and work disruptions, interviews were conducted in operational managers' offices within the PHC facility. Health promoters were also interviewed in the same offices. Senior managers were interviewed at the sub-district office.

As the researcher is a programme manager for health promotion in the Department, personally conducting the interview could have resulted in the participants defending or overselling the programme to impress. To eliminate any ambiguity resulting from the association of the researcher with the participants, a skilled and experienced independent interviewer was selected and trained, in the context of this specific study, to conduct the interview on behalf of the researcher (Botma et al., 2010:205). The interviewer met with the researcher before the interviews so that she (the interviewer) could be briefed on the study aim, objectives and research questions.

1.7.7.2 Interview questions

In order to understand or to get meaning of the phenomenon, the research questions applicable for the study included the following: You have been working within the NWPDoH for at least three (3) years and you have been exposed to health promotion as part of comprehensive care to patients. **Question 1:** Share with me your perspectives (views/opinion) of the barriers in health promotion human resources in the Dr Kenneth Kaunda District. **Question 2:** Share with me your perspectives (views/opinion) of the enablers in health promotion human resources in the Dr Kenneth Kaunda District. **Question 3:** How do you suggest can human resources capacity be strengthened for health promotion in the North West Province at PHC clinics/sub-district and district/provincial levels?

The interviewer asked follow-up questions to explore the experiences of the participants and also used paraphrasing, clarification, reflecting and summarising in her line of questioning. Taking into consideration that the interview process could have been exhausting for both the researcher and the participant, interviews were planned to not exceed 60 minutes (Botma et al., 2010:208). Data were collected in each of the participant categories until data saturation was reached in each category. Participants were given light refreshments during the interview.
1.7.7.3 Field notes

Field notes are a written account of what the researcher hears, sees, feels, experiences and thinks about during the interview (Botma et al., 2010:218). The independent researcher made field notes after conducting each interview, which were used as part of data collection and data verification (Botma et al., 2010). The field notes were grouped into descriptive notes, which included participants, physical settings and events/activities verification (Botma et al., 2010:218). The interviewer obtained demographic descriptive information during the interviews which contained the time, date and place of the interview and other demographic notes about the participants (Creswell, 2009:182). The interviewer used methodological, theoretical and personal notes as outlined by Polit and Beck (in Botma et al. 2010:218).

1.7.7.4 Transcribing the data

Transcriptions need to be accurate and must reflect what happened during the interviews (Botma et al., 2010:214). The researcher transcribed the interviews verbatim, and to verify the accuracy of the transcriptions, the researcher listened to the recordings whilst reading the transcriptions.

1.7.8 Data analysis

In order to ensure a careful and thorough analysis, the data were analysed in a way that defended against selectively picking evidence that confirmed the researcher's assumptions, thereby ensuring that the researcher did not see merely what he was hoping to see (Green & Thorogood, 2009:29). The data were first prepared and organised for analysis, after which the data were reduced to themes through a process of coding and condensing the codes. In analysing data, Creswell's (2009) steps, as outlined in Botma et al. (2010:224), were followed:

- Data were organised and prepared for analysis by transcribing the interviews, typing field notes and categorising the data into different types.
- All transcriptions were read to obtain a general sense of the information and to reflect on the overall meaning.
- In coding the data, data gathered were organised into chunks or segments of text before giving meaning to the information. To ensure richer codes, the researcher used Tesch's (1990) eight steps typically used in forming codes as described by Creswell (2014:198). As multiple minds generate multiple ways of analysing and interpreting data, the researcher requested the assistance of a co-coder to code and analyse data as a means of generating new and richer codes (Saldana, 2009:27). The researcher and co-coder did the coding separately and later discussed the coding until a consensus was reached. The discussion during the coding process provided an opportunity for clarifying emergent ideas and an opportunity to provide information about the data (Saldana, 2009:28). The researcher used
ATLAS.ti 8 (a software program) to quickly and easily locate material and store it in one place. This assisted in looking closely at the data and deriving meaning from each sentence (Creswell, 2013:202). The researcher developed the database of the transcribed interviews and field notes with the voice recordings in ATLAS.ti. This enabled the researcher to use the voice recordings actively in the coding process as was required. This suggestion was made because of the explorative and descriptive nature of the research. The network view option and filter options in ATLAS.ti allow for this to be done with ease and leave a trail of evidence in the coding process.

- A description of the setting and people was generated and themes from the categories were identified.
- The findings of the analysis were represented by using a narrative passage: this includes discussions of themes and interconnecting themes by means of tables and figures as adjuncts to the discussion.
- Interpreting data involved the researcher’s personal interpretation in combination with literature and theories.

1.8 TRUSTWORTHINESS

Lincoln and Guba (in Botma et al. 2010:232) suggest trustworthiness as another strategy to ascertain the consistency and accuracy of a qualitative study. Botma et al. (2010:230-4) introduce truth value, applicability, consistency and neutrality as four standards that could assist the researcher in ensuring trustworthiness of the study. For the purpose of this study, the Table 1.6 describes how the researcher maintained trustworthiness as illustrated by Klopper (2008) in Botma et al. (2010:234).

Table 1.6: Measures used to maintain trustworthiness in this research

<table>
<thead>
<tr>
<th>Standard</th>
<th>Strategies</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truth value</td>
<td>An experienced interviewer was employed for data collection. The interviewer engaged in discussions with each participant for periods not exceeding 60 minutes to gain the trust of the participants. The interviewer made field notes and was flexible, whilst the researcher presented discrepant information found in the study to ensure the account is more realistic.</td>
<td></td>
</tr>
<tr>
<td>Applicability</td>
<td>In the results section, the researcher provides detailed (thick and rich) descriptions from the sample (participants’ experiences in health promotion) to convey the findings. Data collection continued until saturation was reached.</td>
<td></td>
</tr>
</tbody>
</table>
### Standard | Strategies | Criteria
--- | --- | ---
Consistency | All processes followed for data collection were recorded, and the data collected are kept safe for audit purposes. The thick and dense description of the methodology was taken into consideration. An experienced co-coder was used to assist in coding and analysing the data to avoid drifting of codes. The use of ATLAS.ti 8 enhanced dependability. | Dependability
Neutrality | Information obtained has been used to create a coherent justification for themes. The researcher clarified the bias he might have brought to the study to create an open and honest narrative that will resonate with the reader. Reflections from the supervisors on this matter were discussed and a consensus was reached before any conclusions were drawn. | Conformability
Authenticity | The researcher ensured that any conclusions are compatible with what other authors have found. Verification of findings was discussed with the co-author, co-supervisor and supervisor to develop a heightened sensitivity to the issues being represented. | Truthful

### 1.9 ETHICAL CONSIDERATIONS

Ethical issues that may surface during the study were considered during the process of planning and designing of this study. Therefore, ethics was integrated within each phase and aspect of this study from conceptualisation, literature review, sampling, implementation of the intervention, data gathering and analysis to writing the report and dissemination of results (Botma et al., 2010:1-4).

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, formed in 1978, compiled the Belmont Report, which discusses three (3) principles relevant to research. These principles are: respect for persons; beneficence; and justice. These were taken into consideration in the research process (Botma et al., 2010:3). Ethical considerations in this study were further guided by the health research ethics guidelines of the DoH (DoH, 2015:14-25).

#### 1.9.1 Respect for persons

Dignity, wellbeing and safety interests of the participants were the primary concerns of the researcher. Thus, personal information of participants was only accessed by those who were directly involved in the study. Only the researcher, the interviewer, the co-coder and the supervisors were directly involved in the study. The following key areas were addressed in maintaining confidentiality: limited access to data; safe and secure storage of data; and anonymity of the participants. All members of the above-mentioned research team signed a confidentiality pledge.
1.9.2 Justice

To ensure justice, there was a fair balance of risk and benefits among all research participants. The category involvement and reasons for their involvement were clearly outlined in the sample and the inclusion criteria of this study.

1.9.3 Beneficence and non-maleficence

The DoH (2015:14) refers to beneficence and non-maleficence as an “ethical obligation to maximise benefit and to minimise harm”. This study did not have direct benefits to the participants. However, there is a likelihood that the Department will benefit from the study and that the participants will benefit indirectly from the research results in the future. There was no pre-empted harm, as the study aimed to improve service delivery by strengthening health promotion action areas.

1.9.4 Relevance and value

As outlined in the problem statement, the researcher intended to explore the human resource barriers and enablers for health promotion action areas in the DKK District. This study is relevant to the current re-engineered PHC system of the country and will be valuable to the DKK District, the Department and the country.

1.9.5 Scientific design, aims and objectives

The research design was discussed, presented and deliberated with the supervisors. A consensus was reached that the design and methods used were appropriate for the research integrity and realisation of the aims and objectives of the study. However, to ensure scientific integrity and determine whether the research was worth doing, the methodology and design were further reviewed and assessed by the Scientific Review Committee and the Health Research Ethics Committee (HREC) of the North-West University.

1.9.6 Inclusion and exclusion criteria

The inclusion criteria were considered to be fair based on the categories identified as described in the sampling process and the inclusion criteria. These categories were critical in ensuring valuable contribution to the implementation of health promotion action areas. A detailed justification for each inclusion and exclusion criterion was provided in the HREC application form.

1.9.7 Selection of study population and sampling

The principle of distributive justice requires all persons to contribute to the advancement of knowledge that the research aims to achieve (DoH, 2015:20). Table 1.3 summarises the
categories and number of participants that was involved in the study. All participants played a crucial role in health promotion action areas and followed a comprehensive approach to PHC.

1.9.8 Research procedure

Prior arrangements were made with gatekeepers to ensure that there were no disruptions with service delivery and the Department’s routine work. The researcher used the services of a qualified independent interviewer to conduct interviews, as was outlined in the data collection section. Constant communication occurred between the researcher and the mediator so as to address challenges.

1.9.9 Reimbursements, inducements and costs for participants

Participants did not incur any expenses during the study. The study was conducted during working hours, hence prior arrangements were made with the mediator, and no travelling or inconvenience expenses were incurred. The participants received light refreshments and a pen as a token of appreciation for their time.

1.9.10 Privacy and confidentiality

According to the health research guidelines of the DoH, “researchers should take measures to ensure privacy and confidentiality interest throughout the research period, including when disseminating results or findings” (DoH, 2015:17). Therefore, confidentiality and privacy were maintained throughout the stages of the research. Interview data and research information were kept safe during the interview process and after completion of the study. All transcriptions were coded, and original recordings were erased after transcription. The independent interviewer signed a confidentiality agreement in order to ensure privacy and confidentiality were maintained. The recorded interviews were deleted from the audio recorder directly after each interview and stored on a password-protected computer.

1.9.11 Approval and permission

To protect the researcher and participants, the researcher adhered to the local appropriate legislation and obtained approval from the HREC of the Faculty of Health Sciences of the North-West University as guided by the NHREC (Botma et al., 2010:11). After they granted approval, the proposed research was presented to and reviewed by the NWPDoH Research Committee for approval. Thereafter, the proposal was submitted to the DKK District for local approval and the data collection process commenced (Botma et al., 2010:12).

1.9.12 Data management, storage, archiving and destruction

As regards respect for people, the researcher maintained confidentiality by informing the participants that only people who were directly involved in the research and had access to the
data – for example, the supervisors and the co-coder and that these members were to sign a confidentiality pledge (Botma et al., 2010:18). The recorded interviews and transcriptions were stored on the supervisor’s password-protected computer. All hard copies of data related to the study are kept safe in the lockable office of the supervisor on the premises of the NWU. All other documents related to the data collection were destroyed in accordance with the NWU policy for record management and destruction. The soft data will be kept at the University for a period prescribed by the University in terms of keeping of research data.

1.9.13 Data analysis and report writing

Botma et al. (2010:26) emphasise the value of being truthful in analysing data. Creswell (2009:92) reiterates that researchers should not falsify, suppress or invent findings to meet their needs. Therefore, the researcher adhered to the principles of respect during data analysis and reporting the findings. The researcher used pseudonyms to protect individual participants’ identities during data analysis. The data has also been reported in an aggregated form so as to avoid identifying individuals from the results to be published.

1.9.14 Dissemination of results

The researcher discussed with the DKK District how they wanted the research results to be disseminated. The researcher was advised to present the results during the District’s health conference, which is held annually, and the provincial office of the DoH requested a brief report and recommendations on the study. Participants requested a brief report on the study results and recommendations.

1.9.15 Role of the research team

The researcher engaged in all relevant communication and made the logistical arrangements with the gatekeepers and the mediator. The mediator ensured recruitment, venue and that the time schedule was adhered to. The independent interviewer conducted the interviews. The researcher transcribed the interviews and shared them with the co-coder for coding. The supervisors were involved in an advisory capacity and to provide guidance and support.

1.9.16 Risk of harm and likelihood of benefit

When considering risk in the research, “the potential benefit should always outweigh the risks” (Botma et al., 2010:24). The researcher is the provincial deputy director in health promotion and conducted explorative research into health promotion; therefore, there could have been conflict of interest in terms of the participants. Participants could have felt coerced and scared to give honest feedback, or uncomfortable and could have said what they thought the researcher ought to hear. To mitigate the probability of this risk, the researcher used the services of an independent interviewer to conduct the interviews.
In general, the probability of harm in this study was minimal. Participants were all employees of
the DoH, working with health promotion issues as one of their co-functions on daily basis. They
are more often interviewed by external people to assess programme performance and other
related health promotion strategies. Thus, the researcher risk level was viewed as minimal. Table
1.7 illustrates how some of the risks were mitigated.

1.10 CONCLUSION

Chapter 1 served as the foundational chapter in this dissertation, sketching the research problem
and proposing the research methodology. Despite a global positioning of health promotion as an
integral part of comprehensive care, South Africa lags behind the realisation of health promotion
on grass-roots level within the public health system. South Africa presents with unique healthcare
challenges and a quadruple disease burden. Whilst health promotion realised internationally,
South Africa struggled with the management of HIV whilst redressing past socio-economic and
political inequities. Today, despite an informative national health promotion policy and strategy,
the human resources for health promotion was identified as a health promotion action area
necessitating deeper investigation. There is not a golden standard for health promotion human
resources nationally or on a provincial Departments of Health. This is especially true to the North
West province where health promoters don’t have standardised training, is a diverse group and
requires to integrate into the larger PHC re-engineering system.

The researcher, who is an employee within the health promotion domain within the provincial
office of the North West province, identified the discrepancy in health promotion human resources
within the daily health promotion tasks. These experiences, combined with a literature review led
to a research question to explore and describe the barriers and enablers of health promotion
human resources within all the levels of care, within the Dr Kenneth Kaunda district, in the North
West province. A qualitative design was presented as appropriate as it could enable the
researcher to explore and describe critical role-players’ perspectives regarding the barriers and
enablers for health promotion for human resources. In chapter two the reader is introduced into
the realisation of the methodology as well as the research results, presented in an article format.
<table>
<thead>
<tr>
<th>Types of risks</th>
<th>Example</th>
<th>Probability (Marked with a √ if the probability exists)</th>
<th>Magnitude (1 - mild discomfort, 5 - severe trauma)</th>
<th>Justification</th>
<th>Precaution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical harm</td>
<td>Fatigue</td>
<td>√</td>
<td>1</td>
<td>Providing account of individual experiences in the working environment could be tiring, especially considering the current collapsed state of public health systems in the North West Province and the shortage of staff.</td>
<td>Interviews were conducted in an efficient manner. The interviewer was sensitive to the availability of the participants. No interview exceeded 60 minutes.</td>
</tr>
<tr>
<td>Psychological harm</td>
<td>Emotional discomfort</td>
<td>√</td>
<td>1</td>
<td>Disclosing department information could be uncomfortable. However, the participants were all used to community health challenges and criticism at different levels.</td>
<td>Participants and the interviewer discussed the study and the signing of the consent form to ease participants’ emotional status.</td>
</tr>
<tr>
<td></td>
<td>Coercion</td>
<td>√</td>
<td>1</td>
<td>Due to the hierarchal structure of the health system, there was a risk that health managers and the researcher could be in the position to coerce the participants to participate.</td>
<td>Participants signed the consent form as an indication that they were not forced by anyone to participate. The recruitment was done by the mediator. The researcher did not participate in recruiting the participants nor in collecting the data.</td>
</tr>
<tr>
<td>Types of risks</td>
<td>Example</td>
<td>Probability (Marked with a √ if the probability exists)</td>
<td>Magnitude (1 - mild discomfort, 5 - severe trauma)</td>
<td>Justification</td>
<td>Precaution</td>
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<td>----------------------------------------------------------</td>
<td>-------------------------------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>Boredom</td>
<td>√</td>
<td>1</td>
<td>The length of the interview might have resulted in boredom, but the interview was about participants' work and that created interest and concern in talking about barriers and enablers.</td>
<td>The interviews did not last for more than 60 minutes to avoid boredom.</td>
<td></td>
</tr>
<tr>
<td>Inconvenience</td>
<td>√</td>
<td>1</td>
<td>The interviews were conducted at the workplace and during working hours to avoid any personal inconvenience, although there might have been an inconvenience for work schedules.</td>
<td>When permission was sought from the Department, it was highlighted that the interviews would be undertaken during working hours in order to avoid any inconvenience to participants and that enough time would be given to participants to clear their work schedules. Only one senior manager’s appointment had to be re-scheduled due to pressing commitment on his site, and the interview was conducted at the district office.</td>
<td></td>
</tr>
<tr>
<td>Types of risks</td>
<td>Example</td>
<td>Probability (Marked with a √ if the probability exists)</td>
<td>Magnitude (1 - mild discomfort, 5 - severe trauma)</td>
<td>Justification</td>
<td>Precaution</td>
</tr>
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<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Loss of privacy and confidentiality</td>
<td></td>
<td>√</td>
<td>1</td>
<td>Fear to disclose information concerning the Department, the “employer” and that disclosed information could be linked to a participant’s identity.</td>
<td>Privacy: no names were disclosed in the interviews, making it difficult for the researcher to link a participant’s information to their identity. Once data entered the process of transcription, all identifiers, such as name and title, were replaced with a code. All records were kept safe and co-coding was used to maintain the autonomy and confidentiality of all participants. All data were pooled and no individual participant was linked to specific data in the reporting process. There was no feedback loop between the participants’ willingness to participate and the information they gave to their managers and their performance appraisal.</td>
</tr>
<tr>
<td>Loss of autonomy</td>
<td></td>
<td>√</td>
<td>1</td>
<td>Participants might have to hide the Department’s flaws.</td>
<td>Participants were reassured of the mechanisms to ensure privacy and confidentiality.</td>
</tr>
<tr>
<td>Loss of freedom of choice</td>
<td></td>
<td>√</td>
<td>1</td>
<td>Participants might have felt the study is part of their work and they had no choice but to participate.</td>
<td>The consent form served to ensure the participants had the freedom to choose be part of the study or not.</td>
</tr>
<tr>
<td>Types of risks</td>
<td>Example</td>
<td>Probability (Marked with a √ if the probability exists)</td>
<td>Magnitude (1 - mild discomfort, 5 - severe trauma)</td>
<td>Justification</td>
<td>Precaution</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>---------------</td>
<td>------------</td>
</tr>
<tr>
<td>Economic harm</td>
<td>Direct or indirect financial cost, e.g. travelling</td>
<td></td>
<td></td>
<td>The participants travelled to work on a daily basis. The interviews were conducted during working hours and therefore there was no compensation for travelling or work.</td>
<td>The letter to the Department requested to interview participants during their office hours. The mediator ensured that the functions of patient care within the DoH and within each health facility remained first priority and that data collection appointments were scheduled accordingly. Data collection did not disrupt the standard operations of the participants.</td>
</tr>
<tr>
<td></td>
<td>Loss of income not being on the job</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time spent in the research</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.11 BIBLIOGRAPHY


Thailand.

http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf?ua=1.pdf
Date of access: 10 September 2017.


CHAPTER 2: MANUSCRIPT

2.1 INTRODUCTION

The manuscript reports on the results of this study, intended for publication in the journal *Health Promotion International*. The journal contains refereed original articles, reviews and debate articles on major themes and innovations in the field of health promotion.

2.2 MANUSCRIPT WRITING DECLARATION

The contributions of each researcher are outlined in the table below:

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Ishmael Boboko</td>
<td>Planning of the article, selection of the journal, participated in data collection and analysis, constructed themes, wrote the background and problem statement, methodology, results and discussion.</td>
</tr>
<tr>
<td>Prof Petra Bester</td>
<td>Supervised the research, conceptualised the research, co-authored the manuscript, reviewed and interpreted the results.</td>
</tr>
<tr>
<td>Prof IM Kruger</td>
<td>Co-supervised the research, co-authored and reviewed the manuscript.</td>
</tr>
<tr>
<td>Ms Samantha Marais</td>
<td>Assisted in co-coding and analysing the data and co-authored the manuscript.</td>
</tr>
</tbody>
</table>

The declaration by the author and co-authors of the manuscript to confirm their roles in producing the article.

DECLARATION:

*We hereby declare that we have written the manuscript and that our contribution to this manuscript is indeed as stated above.*

Mr Ishmael Boboko               Prof Petra Bester  
Author             Co-author

Prof Lanthé Kruger              Ms Samantha Marais  
Co-author              Co-author

2.3 AUTHOR GUIDELINES

About the Journal

The articles contained in this journal reflect the views of the authors, and do not necessarily coincide with those of the Editor, Editorial Board, Oxford University Press or the organization to
which the authors are affiliated. Adaptation and use of the Health Promotion International logo for the cover design kindly granted by the World Health Organization.

**Scope**

Health Promotion International contains refereed original articles, reviews, and debate articles on major themes and innovations in the health promotion field. In line with the remits of the series of global conferences on health promotion the journal expressly invites contributions from sectors beyond health. These may include education, employment, government, the media, industry, environmental agencies, and community networks. As the thought journal of the international health promotion movement we seek in particular theoretical, methodological and activist advances to the field. Thus, the journal provides a unique focal point for articles of high quality that describe not only theories and concepts, research projects and policy formulation, but also planned and spontaneous activities, organizational change, as well as social and environmental development.

**Submission of manuscripts**

**General Submission Information**

The Journal publishes original articles - describing empirical research covering the broad field of health promotion. Original articles, perspectives and debate have a limit of 7000 words (see below), letters up to 500 words should be discussed with the Editor-in-Chief before submission.

**Format:** Manuscripts are blind reviewed; therefore two separate documents should be prepared:

1. an anonymised manuscript with any information or citations that reveal the identity of the author(s) removed, for example names of authors, acknowledgments, ethics information, funding information; and

2. a separate cover page stating the title of the submission, the name(s) and email address(es) of the author(s) [and where there is more than one author, the name and email address of the author designated to receive correspondence regarding the submission (the ‘corresponding author’)], and the section of the journal for which the submission is intended.

Information and citations that reveal the identity of the author(s) may be reinserted in the manuscript after review.

**Language**

Manuscripts must be clearly and concisely written in English. The Editors reserve the right to reject without review those that cannot adequately be assessed because of a poor standard of
English. Authors whose first language is not English are encouraged to have their manuscript checked by a native English speaker.

Title

- No longer than 10 words; also include country where research undertaken in title (if relevant).
- Include a minimum of two words “key words” to aid literature searching, and a maximum of four from the pop-up list in the submission system.

Word count

Manuscript length not to exceed 7000 words, allowing the following approximations for elements of the manuscript:

- 3000 words for body of text
- 250 words for abstract
- 1000 words for references
- Total of 3 tables or figures (all tables and figures will be deemed to represent approximately 500 words each, due to the space required if manuscript is published).

Variations can be made to the length of these individual sections (except the abstract which must be 250 words or less) but the total word count must not exceed 7000 words. Breakdown of the total word count should be clearly stated on the manuscript; over-length articles will not be considered.

Unique submissions

Authors may not submit manuscripts that are under consideration for publication elsewhere.

Online submission: Manuscripts must be submitted online via the online submission system http://mc.manuscriptcentral.com/hpi. Please see further submission details below.

Preparing Documents for Submission

Please submit manuscripts in Word (.doc) form.

Enter text in the style and order of the Journal (see "References" section below).

Insert figure captions and tables at the end of the file.

Indicate in the text where tables, diagrams, figures, graphs or illustrations would be most appropriately placed by inserting a hard return, caption between square brackets (e.g., [insert -
Figure 1. Proportion of GDP spent on health expenditures in Pacific Islands - here]) and another hard return.

Save any tables, diagrams, figures, graphs or illustrations generated electronically as separate files and not embedded into the text file. Tables must be in editable format (e.g. Excel). Figures can be in editable or image format.

**Type headings in the style of the Journal**

Where possible use Times for the text font and Symbol for the Greek and special characters. Please use the word processing formatting features to indicate Bold, Italic, Greek, Maths, Superscript and Subscript characters. Do not format your manuscript in the final print style of the Journal (i.e., in columns).

**References**

Reference list:

- References should be listed at the end of the main text.
- Reference citations should be inserted in the text using the author-date system whereby the surname of the author and year of publication of the reference are used in the text.

For example: 'Reports by Author (Author, 1989) have confirmed...' or '...as reported earlier (Author and Author, 1985; Author et al., 1998)'. Do not place text other than the author and date within the parentheses.

- Authors should check all references carefully and in particular ensure that all references in the reference section are cited in the text.
- The list of references should be in alphabetical order of surnames.
- References by the same author(s) should be in chronological order.
- Personal communications, unpublished results, manuscripts submitted or in preparation, statistical packages, computer programs and websites should be cited in the text only, NOT included in the references section.
- Accession numbers may be cited either within the text or in the form of a reference.
- The normal form of listed references is author’s surname, initials; year in parenthesis; article title; journal name in full, volume number and page numbers.

Examples:


Number of authors: Single author: Shaw, S.

Two authors: Kennedy, T. and Jones, R.

More than three authors: Zerjal, T., Singh, L. and Thangaraj, Jr K.

More than six authors: If more than 6, retain first six authors and put et al.


Reference citations in text:

- Single author: (Zhou, 2001)
- Two authors: (McDonald and Norman, 2002)
- More than two authors: (Schoolcraft et al., 2001)
- Same author, more than one citation: (Jones, 2001, 2003)
- Unpublished data: (H.G.Jones, unpublished results/submitted for publication/in preparation [delete as appropriate])

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For the funding statement the following rules should be followed:

- The sentence should begin: ‘This work was supported by …'
- The full official funding agency name should be given, i.e. ‘the National Cancer Institute at the National Institutes of Health’ or simply ‘National Institutes of Health’ not ‘NCI’ (one of the 27 sub-institutions) or ‘NCI at NIH’ (full RIN-approved list of UK funding agencies) Grant numbers should be complete and accurate and provided in brackets as follows: [grant number ABX CDXXXXXX]
- Multiple grant numbers should be separated by a comma as follows: [grant numbers ABX CDXXXXXX, EFX GHXXXXXX]
- Where individuals need to be specified for certain sources of funding the following text should be added after the relevant agency or grant number ‘to [author initials].'

Submission checklist

The HPI submission checklist can be found here. You may find it useful to print and complete the checklist to ensure that all aspects have been covered.

Communications

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2.4 MANUSCRIPT

Human resources for health promotion: Realities from South Africa

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ABSTRACT

Background: In South Africa’s progress towards health promotion, the action area of human resources of health promotion is incongruent between provinces.

Problem statement: Unclear roles and responsibilities of health promoters in South Africa’s public health system and inconsistency of health promoter human resources, especially within the North West Province, prompted the research. In this study, healthcare workers’ perspectives of barriers and enablers in health promotion human resources within the North West Provincial Department of Health were investigated.

Methodology: This was a qualitative, explorative and descriptive study. Healthcare workers from multiple organisational levels (health promoters: n=8; operational managers: n=6; senior managers: n=3) within the Dr Kenneth Kaunda District’s public health system were sampled through purposive proportional quota sampling. Semi-structured individual interviews were conducted and data were collected until data saturation was reached. Interviews were transcribed and analysed by means of Atlas.ti 8.

Results: Five themes and 13 sub-themes emerged from the data, presenting barriers that exceed enablers. The health promotion human resources structure and policies are deficient. Managerial supervision and monitoring lack and health promotion receives insufficient resources. There is a gap in the implementation of health promotion programmes. There is a need for formal and informal health promotion training.

Recommendations: Health promotion within a dysfunctional health system requires a clear human resources system, strengthened by managerial buy-in and efficient monitoring and evaluation. Through formal and informal health promotion training and change management, the significance of health promotion within comprehensive healthcare is strengthened.

(229 words)

Keywords: Health promotion, human resources, health promotion action areas, public health system
INTRODUCTION AND BACKGROUND

Today, the world is captured by unfair global economic and political systems, whereby ecological-, climate-, financial-, social- and political crises manifest significantly in health (Baum, 2019). Yet, as the world of health promotion moulded over decades into an acknowledged movement, South Africa lagged behind, working hard to redress inequities of the past. Since health promotion gained impetus at the Alma-Ata Declaration (1978), aimed to improve quality of life and to promote and protect health as well as provide equal opportunities in health (Bhutta et al., 2018), South Africa has been driving a parallel process, aligning with international trends whilst struggling to adapt to a changing socio-political landscape. Figure 2.1 briefly illustrates some of the major highlights of South Africa’s health system (Coovadia, Jewkes, Sanders and McIntyre, 2009) compared to the global evolution of health promotion.

![Figure 2.1: The global history and evolution of health promotion](image)

In 1994, South Africa endorsed the National Health Plan (NHP), built on a strong primary health care (PHC) philosophy. The remnants of segregation are still visible. South Africa’s divided health system (public and private) first crippled under the burden of human immunodeficiency virus (HIV) and tuberculosis (TB), followed by a wave of non-communicable diseases (NCDs). South Africa experiences a nutritional and epidemiological transition whilst facing a quadruple burden of disease in the form of maternal, new-born and child-related health, HIV/AIDS, TB, and NCDs (Pillay-van Wyk et al., 2016). The co-infection of HIV and TB leads to high mortality and morbidity.
among South Africans. Oddly, while South Africa has the largest antiretroviral (ARV) treatment programme in the world, ARVs have not yielded the same dramatic impact as far as the prevention of HIV opportunistic infections, like tuberculosis (Meintjes, 2014). For close to a decade, there has been a notable change in the causes of death, moving away from infectious diseases towards NCDs, from 49.3% in 2011 to 57.4% in 2016 (Statistics South Africa [Stats SA], 2016). This could be attributed to a rapidly ageing population, the prevalence of multiple chronic conditions, or a high prevalence of risk factors (Goodman et al., 2013). These risk factors include physical inactivity (Wushe et al., 2014), access to unhealthy food (due to urbanisation), globalisation, and tobacco and alcohol use (Mayosi et al., 2009). Beaglehole et al. (2011) suggested population-wide, cost-effective health promotion methods directed at everyone to lower the prevalence of the major risk factors by mitigating the scourge of NCDs. Considering the quadruple burden of disease plaguing South Africa (Pillay-van Wyk et al., 2016), health promotion necessitates more prominence. Explicating a global perspective, health promotion is best described in chronological and historical order. The global burden of NCDs is a major barrier to the development and attainment of the Sustainable Developmental Goals, placing strain on the already resource deficient South African healthcare system (Beaglehole et al., 2011). It is estimated that nearly 80% of NCD-related deaths occur in low- and middle-income countries (Beaglehole et al., 2011; Maimela et al., 2016).

**Primary health care and health promotion**

Primary health care (PHC) is essential health care based on practical, scientific and socially acceptable methods and technology that are made ubiquitously accessible to individuals and families in the community at a cost suitable for the country. To ensure this universal accessibility, community self-reliance and self-determination is essential and can be achieved through full participation during the planning and management of PHC (World Health Organization [WHO] and United Nations Children’s Fund [UNICEF], 1978). PHC is necessary because a health system with strong PHC at its core delivers better health outcomes, efficiency and improved quality of care when compared to other models (WHO, 2019). PHC can also be expressed as social and political efforts to make health knowledge, healthcare skills and the entire health service delivery system more responsive to the needs and situations of individuals, whereas health promotion refers to the process whereby individuals and their environment are geared towards the pursuit of healthy lifestyles. Health promotion, which is a form of social mobilisation for health, is about catering to the needs of developing countries. On the other hand, the principle of PHC, which is beneficiary-oriented, is most beneficial for developing countries (Yuasa et al., 2002), such as South Africa. The PHC re-engineering structure and the proposed National Health Insurance (NHI) system encapsulate health promotion with the intention to improve performance and access
to healthcare, which may have advantages such as: earlier diagnosis of illnesses prior to the
deteriorating; routine care can be consistently provided to children; and those with
chronic illnesses can maintain their wellbeing by receiving regular care at a local level (UWC,
2014). The strategic framework 2004–2009 of the health sector has 10 priorities of which most
involve health promotion (Andrew and Pillay, 2005).

In South Africa, health is promoted through means of intersectoral action (Onya, 2007). Through
a socio-ecological intersectoral model, communities are encouraged to participate in and take
responsibility for their own health, as echoed in the Ottawa Charter (Berenguera et al., 2017;
WHO, 1986). The term “inter-sectoral action for health” is often used to describe the collaboration
between the health sector and other governmental or non-state sectors, aimed at improving health
and wellbeing, addressing the complex risk factors associated with health and ensuring full
access to health and health equity (Rantala et al., 2014). While this model is ideal, the politics
associated with health policy in South Africa has resulted in challenges during implementation.
This can be seen in districts that place little emphasis on health promotion due to the present
political leadership. Similarly, creativity and innovation that could benefit social administration are
usually hampered by silo operations that resist intersectoral collaboration (Wold and Mittelmark,
2018). To enhance intersectoral collaboration, the Ottawa Charter sets out five key action areas
as a framework to implement integrated health promotion interventions, leading to increased life
expectancy, namely: building healthy public policies; developing personal skills; strengthening
community participation; creating a supportive environment; and reorienting health services (Coe

Health promotion in South Africa

Currently in South Africa, health promotion is directed by the National Health Promotion Policy
and Strategy 2015–2019 (NHPPS). It is aligned with the global movement of health promotion
and initiated within South Africa’s overburdened PHC services and focuses on five key action
areas: advocacy for healthy public policies; empowering local communities on health promotion
approaches; creating enabling environments that promote healthy behaviour; strengthening
human resources capacity to deliver health promotion services; and strengthening systems to
Presently, health promotion functions sub-optimally in the Dr Kenneth Kaunda District (DKK
District), one of four districts in the North West Province, South Africa. This might be due to a
lack of sufficient, qualified personnel coupled with budgetary constraints and a lack of
infrastructure. Funding for health promotion activities comes from the Department of Health (DoH)
budget allocated by the National Treasury (Onya, 2007). Health promotion also receives
supplementary funding from the United Nations Agencies, bilateral aid agencies and various other foundations supporting health promotion interventions and research with both technical and financial resources. Regrettably, the allocated funds are not always directed towards building the capacity of health promoters. As such, the strengthening of human resources capacity to deliver health promotion services appears to be inadequate within the North West Province. Dookie and Singh (2012) attribute the challenges in the PHC system to the inequities found in resource allocation and the quadruple burden of disease that places a severe strain on scarce resources.

The insufficient information regarding the human resources within health promotion, targeting redress and equity as well as the resources dedicated to health promotion programmes in the North West Department of Health has prompted the researcher to explore healthcare workers’ perspectives of the barriers and enablers in health promotion human resources. The primary research question that developed from the problem statement was: “What are healthcare workers’ perspectives of the barriers and enablers in health promotion human resources within the North West Province?” The following sub-questions were asked:

**Research Question 1:** What are healthcare workers’ perspectives of the barriers in health promotion human resources in the Dr Kenneth Kaunda district?

**Research Question 2:** What are the healthcare workers’ perspectives of the enablers in health promotion human resources in the Dr Kenneth Kaunda district?

**Research Question 3:** What recommendations can be made to strengthen health promotion human resources in the North West Province at PHC-, sub-district-, district- and provincial levels?

**Research objectives**
The research objectives were to explore and describe the barriers and enablers in health promotion human resources in the DKK District of the North West Province and to make recommendations to strengthen human resource capacity on all levels of health care.

**METHODOLOGY**
The research followed a qualitative, descriptive design to extensively explore and describe healthcare workers’ perspectives of the barriers and enablers in human resources of health promotion in the DKK District. A purposive quota sampling technique was used to sample the participants. Sixteen (n=16) health healthcare workers were interviewed using a semi-structured interview schedule. The interviewees included health promoters, operational managers, programme coordinators and senior managers based at PHC facilities, the sub-district and district offices.
Context of the research

The research was conducted in the DKK District, comprising four sub-districts, in the North West Province, South Africa. This district houses the highest number of health promoters (Figure 2.2) and is challenged by the quadruple burden of disease, which affects all ethnicities and genders, and has the most accurate representation of the Black, White and Indian communities. There are nine community health centres, 26 clinics and six satellite clinics in the DKK District.

![Figure 2.2: Distribution of health promoters in the four sub-districts within the Dr Kenneth Kaunda district](image)

Inclusion and exclusion criteria

Participants were included in the study if: they had been permanently employed by the Provincial Department of Health in the DKK District for a period of \( \geq 3 \) years; were able to communicate in English; were available to be interviewed despite staff shortages; and were willing to sit for an individual semi-structured digitally-recorded interview. Healthcare workers who had served for less than three years in the District were excluded as they may have lacked understanding of the barriers and enablers specific to the DKK District.

Data collection

Preceding the data collection process, a research approval letter was obtained from the Policy, Planning, Research, Monitoring and Evaluation Directorate of the North West Provincial Department of Health (NWPDoH). A mediator recruited participants, and interviews were conducted by an independent, experienced interviewer. Data collection occurred through semi-structured interviews, guided by the following questions:

**Question 1:** Share with me your perspectives of the barriers in health promotion human resources in the North West Province.

**Question 2:** Share with me your perspectives of the enablers in health promotion human resources in the North West Province.
Question 3: How do you suggest can health promotion human resources be strengthened in the North West Province at PHC-, sub-district -, district- and provincial levels?

All interviews were recorded by means of a digital voice recorder and were transcribed. Participants were assigned pseudonyms to ensure anonymity.

Data analysis
Data were prepared and organised for analysis. The researcher followed the six steps of thematic analysis (Creswell, 2013:202). Through a process of coding and condensing the codes, data were reduced to themes using ATLAS.ti 8.

Credibility
Integrity and reliability were obtained by ensuring that the sample was representative of the population. Data were not biased towards certain limited experiences and selected opinions. An experienced co-coder reached consensus with the researcher on the analysed data and final results.

Ethical considerations
Ethical approval was obtained from the Health Research Ethics Committee (HREC) of the North-West University. Participants gave written consent to partake in the study. Confidentiality was maintained by informing participants that only the researcher, supervisors and co-coder had access to the data. Digital copies of the recorded interviews and the transcriptions were transferred to and stored on the supervisor’s password-protected computer, on campus, as well as all hard copies of data related to the study.

RESULTS
The results reflect the perspectives of healthcare workers regarding the barriers and enablers in human resources of health promotion within the DKK District, North West. Seventeen healthcare workers (n=17) participated and data saturation was obtained.

Demographic profile of the participants
Participants were sampled from health facilities and sub-district offices of the DKK District (Table 2.1). The participant comprised eight (n=8) health promoters, six (n=6) operational managers and three (n=3) senior managers. The participant group were almost equally represented by both
genders: male (47%) and female (52%). Most of the participants (70%) were aged 25–45 years. None of the health promoters had any tertiary education. The operational and senior managers, on the other hand, had as a minimum a Bachelor’s degree.

<table>
<thead>
<tr>
<th>Table 2.1: Demographic profile of the participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>African</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Indian</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>25–35 years</td>
</tr>
<tr>
<td>36–45 years</td>
</tr>
<tr>
<td>46–55 years</td>
</tr>
<tr>
<td>Level of education</td>
</tr>
<tr>
<td>Senior Certificate/Grade</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>Higher Certificate</td>
</tr>
<tr>
<td>Diploma</td>
</tr>
<tr>
<td>Degree</td>
</tr>
<tr>
<td>Nr of years employed in Dr Kenneth Kaunda District</td>
</tr>
<tr>
<td>3 years and above</td>
</tr>
</tbody>
</table>

Five main themes emanated from the coding process, indicating that the human resources structure and guiding policies are deficient, managerial oversight and monitoring are absent, health promotion continues to occur despite limited material resources, the presence of disparity in the implementation of health promotion programmes, and a need for specific health promotion training.

**Themes, categories and sub-categories**

The themes, categories and sub-categories are presented in Table 2.2.
Table 2.2: Research results presented as themes, categories and sub-categories

<table>
<thead>
<tr>
<th>THEME</th>
<th>CATEGORY AND SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deficient human resource structures and guiding policies</td>
<td>No guiding recruitment processes and systems</td>
</tr>
<tr>
<td></td>
<td>• Absent human resources structure for health promotion in the department (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Absence of standardised selection criteria to recruit health promoters (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Salary level differs although functions are similar, resulting in the demotivation of staff (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Need for a standardised job description for health promoters (barrier)</td>
</tr>
<tr>
<td>Health promotion less prioritised</td>
<td>• Health promotion is not prioritised for recruitment compared to all other programmes (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Health promotion is a dumping career (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Health promotion is not viewed as part of the health system (barrier)</td>
</tr>
<tr>
<td>Limited health promoters</td>
<td>• Insufficient health promoters for health promotion needs (barrier)</td>
</tr>
<tr>
<td></td>
<td>• No advertisement of health promoters for a sufficient period (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Unable to conduct other health promotion activities due to work overload (barrier)</td>
</tr>
<tr>
<td></td>
<td>• No standard quota of health promoters per facility (barrier)</td>
</tr>
<tr>
<td>Managerial oversight and monitoring are absent</td>
<td>Lack of supervision and support</td>
</tr>
<tr>
<td></td>
<td>• Poor communication between health promoters and operational managers (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Insufficient orientation of operational managers on health promoters’ functions results in poor supervision and support (barrier)</td>
</tr>
<tr>
<td>Absent reporting lines and programme coordination</td>
<td>• No coordination of health promoters at sub-district and district level (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Lack of standardised reporting lines and coordination result in unruly health promoters’ conduct (barrier)</td>
</tr>
<tr>
<td>Lack of monitoring criteria</td>
<td>• No monitoring criteria for health promotion activities (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Health promotion evaluation not done across all sub-districts (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Health promoters excluded during sub-district programme reviews (barrier)</td>
</tr>
<tr>
<td>Limited material resources</td>
<td>Lack of information, education and communication (IEC) materials</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Lack of pamphlets, posters and flyers to create awareness (barrier)</td>
</tr>
<tr>
<td></td>
<td>• Limited gazebos, chairs and tables for events and campaigns</td>
</tr>
<tr>
<td></td>
<td>• IEC material is mostly written in English (barrier)</td>
</tr>
</tbody>
</table>

**Use of technology to create awareness**
- Lack of technological aids for awareness creation (barrier)
- The target market not intrigued by old traditional health education methods (barrier)

**Specific transport challenges**
- There is insufficient transport for outreach activities (barrier)
- Other programmes are prioritised to get transport other than health promoters (barrier)
- Special allocation result in other multiple jobs not within the scope of health promoters (barrier)

<table>
<thead>
<tr>
<th>Insufficient understanding of health promotion programmes</th>
<th>Ignorance about the health promotion policy and strategy (barrier)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health promotion perceived to be only health education, outreach campaigns and door-to-door activities (barrier)</td>
</tr>
</tbody>
</table>

**Insufficient community participation**
- Lack of community participation and interest in health education sessions (barrier)
- Less marketing and poor mobilisation of the health promotion programme within various settings (barrier)
- Communities participate actively if there are incentives and if there are high-profile people or celebrities (barrier)

**Stakeholder collaboration challenges**
- There is collaboration with internal stakeholders listed as enrolled nursing assistants, community health workers and professional nurses (enabler)
- Poor working relations with other external stakeholders, except for the Departments of Basic Education and Social Development (barrier and enabler)
- Non-existing coordination of collaboration between stakeholders (barrier)

<table>
<thead>
<tr>
<th>Health promotion training</th>
<th>There is limited formal tertiary qualification in health promotion available on a certificate-, diploma- or degree level (barrier)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Need to professionalise health promotion (enabler)</td>
</tr>
</tbody>
</table>

**Continuous development**
- There are refresher courses on new policies and mandates, although insufficient (enabler)
- Lack of orientation to operational managers and other senior managers about health promotion (barrier)
- Need to capacitate community health workers with a Senior Certificate (NQF 4) for future health promotion (enabler)
Deficient human resource structures and guiding policies

Participants sketched the deficiency of human resources structures and policies as well as an insufficiency in health promoters’ positions to address the health promotion needs within the district. The human resources’ structure and guiding policies are defiant in the DKK District. This was highlighted as a barrier during the interviews. Participants indicated a lack of “a formal health promotion structure” as the source to disparities in health promoters’ salaries. One participant expressed this concern about salary levels by indicating that the DoH “hired people according to their sub-districts levels”, meaning each sub-district can make its own determination as to what salary to offer. She specifically compared her sub-district with the other sub-district by highlighting that “they are at level seven and I am at a level four”. This matter was emphasised by a professional nurse agreeing that health promoters earn more than others. He alluded that “salary is not enough but at least them being at salary level six at least is a good start is a good salary, it motivates one to be serious about their job”. The latter statement denotes that salary level is an enabler in health promotion human resources. Inconsistent recruitment standards and systems are therefore barriers in health promotion human resources.

Closely linked to deficient health promotion structures is the barrier of non-standardised job descriptions. Participants voiced that “job descriptions are not the same” and one participant acknowledged “I even did my job description myself”. In the absence of standardised job descriptions, it enables the inappropriate application of health promoters to address urgent tasks within an overburdened and under-resourced health system. The majority of participants alluded that health promotion “is not taken serious in the Department of Health”. Another participant described health promotion as “a dumping career and if someone is very problematic, they will dump the person to health promotion”. This sub-category became more evident as some participants indicated that “health promoters are even used as assistant nurses” rather than performing health promotion duties. They (health promoters) are sometimes performing clinical functions, such as “taking vital signs”. One participant acknowledged that various role players in the DoH “don’t think of health promoters as part of the system” and the prioritisation of other staff categories above health promotion resulted in “lack of sufficient human resource”.

Most participants raised concerns over the shortage of health promoters, indicating that there seems to be “much more focus on nursing personnel and doctors”. Yet, there was incongruence in this result. One participant pointed out that there are many health promoters in her sub-district and “[I] don’t think there is any other area that is having such a health promoters”, contradicting a fellow colleague who said, “I think is four clinics, there is no health promoter there, what does human resources do is that problem”. One participant indicated that according to the “policy of
health promotion, each clinic must have a health promoter”, again highlighting the discrepancies in human resources. Health promoters with better salaries appeared to perform better and were more motivated than health promoters on lower salaries. Salary level differences seem to be a barrier and results in demotivated personnel who feel that health promoters are performing the same functions and do not understand the rationale behind the salary gap. Most participants suggested a “review of human resource structure” to strengthen health promotion.

Managerial oversight and monitoring are absent
The second theme concentrates on the governance of health promotion human resources within the health system. The participants highlighted insufficiencies in supervision, programme coordination and monitoring, presented as barriers to health promotion efficiency.

The lack of supervision and support is captured in insufficient orientation of operational managers regarding health promoters’ functions. This causes supervision to be insufficient and a barrier to health promotion human resources. Insufficient supervision and support are also due to the “lack of communication between the facility (operational manager) and the health promotion services (health promoter)”. When “somebody (sic) been brought under your supervision without documents, how you will know what to expect”. This echoes the overall absence of appropriate governance structures. On the one hand, health promoters voiced the absence of supervision and support structures and on the other hand, operational managers confirmed this fragmented governance structure, because even if “health promoters will know of (health promotion) policies, all of us we (facility personnel) don't even know them”.

In addition to operational managers and supervisors plus health promoters being unclear about supervision and governance support, participants voiced the absence of clear reporting lines. This is a dualistic challenge with uncertainty from operational managers and health promoters alike. Operational managers “are not sure where to report to” when it comes to health promotion matters in general. Health promoters explained being confused on reporting lines because “you report to the facility manager at the same time to the community liaison officer”. Participants confirmed the lack of standardised reporting lines and coordination, which may result in unruly health promoters’ conduct. One participant highlighted that health promoters “[do not] come on duty when they supposed to” and “not even informing the employer of their whereabouts”.

In the absence of supervision and support, clear criteria lack to monitor health promotion within the sub-district: “…being a manager and not knowing what is it that you are supposed to monitor” increases the already established dissonance between management and health promoters. A
participant pointed out that, “if I don’t know the responsibilities of the health promoter, how will I be able to can monitor the performance?”. This view was voiced by most of the operational and senior managers across the sub-district. As health promotion is not monitored in an aligned system with the outcomes of health facilities, health promoters are spontaneously negated from sub-district programme reviews. Participants sketched a reality where health promoters are not viewed as essential role players in health systems outcomes as a senior manager acknowledged that he could not remember “… having to request that health promoters must be in the meeting when discussing clinical issue or clinic performance”. The deficiencies in supervision support and monitoring seem to emanate from mainly a lack of orientation of managers, both operational and senior managers, on the functions and scope of health promoters and health promotion within the health system. This was captured in the words of a participant, explaining that “the sub-district doesn’t know anything about health promotion; they don’t understand exactly health promotion itself.”

**Limited material resources**

A barrier that emanated from the interviews were the limited resources allocated to the operationalisation of health promotion. Limited resources stretched from the direct and hands-on material required for health promotion to outdated technology and ultimately the difficulties to be mobile due to insufficient transport. Health promotion is, amongst other action areas, engaged with health literacy, health education and behavioural change on an individual, group, community and society level, and all of these activities require specialised IEC materials. The majority of health promoters voiced that they had “struggled with the IEC material for more than two years” in the form of pamphlets, posters and flyers to create awareness in facilities and to disseminate to communities during campaigns. In addition to insufficient IEC materials, the majority of materials available are printed media, mainly in English, not using local languages. Having IEC with health messages printed in non-appropriate languages for a target group serves as a barrier to reach communities. Participants explained that available gazebos, chairs and tables could not be scaled up to reach maximum coverage during campaigns and outreach activities. Furthermore, participants explained that there was not a dedicated budget for health promotion activities due to deficiencies in procurement. Considering the ages of target groups and the dawn of the Fourth Industrial Revolution, several participants urged that trending technology for awareness creation is essential. Yet, the current resources in health promotion lags behind. One participant voiced concerns by saying, “technology has advanced and ourselves we are lacking far behind in providing health promotion through digital means”.

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Inadequate transport to conduct outreach activities presents as a dominant barrier to health promotion activities, considering that health promotion is not facility-bound only and health promoters have to travel to target audiences. One participant acknowledged that “there is no transport because of budget problems”. When transport has been requested, “other programme managers might take the fore front and be provided, health promotion will be ahhgg man (wait first) will see you”. Closely linked with the negated status of health promotion in health systems, health promotion is also not a priority in the allocation of transport. Yet, in isolated cases, health promoters had access to a vehicle, as one health promoter indicated that he was “assigned… the TB bakkie (a dedicated vehicle)”. This can be considered an enabler. However, decentralisation of health promoters with accessible transport was viewed as disadvantaging a health facility, as an operational manager voiced “he is not doing his job effectively” due to having to collect condoms from the district and distributing them in all health facilities, which is the sub-distRICT drivers’ responsibility. The allocation of transport does enable health promotion within communities, but in the current health system, health promoters have multiple tasks not within their scope but necessitated by the organisational challenge of the current health system.

**Disparity in health promotion programme implementation**

The fourth theme presents the incongruence between critical role players regarding the meaning of health promotion. It emphasises that health promotion is not acknowledged as a significant contributor to providing comprehensive health care. This serves as a barrier when there is not a clear understanding of health promotion programmes, with inadequate community participation and stakeholder collaboration.

Although South Africa has a health promotion policy and strategy, only one participant mentioned it. Overall, the participants were ignorant about the directing health promotion strategy and guiding policies, highlighting that participants did not really understand health promotion programmes. The only participant knowledgeable about the NHPPS alluded that “as an enabler, I think health promotion is becoming…, at least we got a policy that was recently out as well to make it more structured”. Regrettably, most of the participants viewed health promotion functions as health education applied to different settings. Health promotion was also described as conducting health dialogues, outreach and awareness campaigns, and door-to-door activities. One participant said, “one of their indicators is to conduct campaigns, to visit schools whereby they will be having a dialogue with the teenagers… and they supposed to educate community at facility level”. The role of health promotion, linked to the health promotion action areas, and the functions of advocacy, empowerment and to enable were not recalled by any of the participants, nor were health promotion programmes viewed on the health–illness continuum or as a part of comprehensive
care. Participants highlighted the lack of communities’ interest in health education sessions during health talks in facilities. In addition to negating the role of health promotion within the health system, participants perceived that communities were also not as engaged as needed, because “when we are busy talking, others are busy going outside, maybe they don’t like the topic”. Another concern raised by the participants was the insufficient marketing and poor mobilisation of the health promotion programmes within various settings. Operational managers voiced that health promoters are “supposed to go outside there because they have been trained to mobilise, they are not doing that” and that results in non-performance. In response, another participant indicated that communities participate actively only if there are incentives and high-profile people or celebrities.

Although health promotion does not enjoy a high priority in the sub-district’s health system, collaboration for health promotion on grass-root level was highlighted. There seems to be eminent collaboration with internal stakeholders, which can be listed as a health promotion human resource enabler. An area of collaboration is the integrated school health system as part of primary healthcare re-engineering. One participant explained that “re-engineering and school health at least they do much at the community when they having (sic) some campaigns”. Collaboration and coordination occurred at least through main events and campaigns. Most participants highlighted that they “might need nurses, HIV councillors, outreach team leaders and community healthcare workers” to provide support. Yet, teamwork during campaigns remained fragmented with internal and external stakeholders.

**Specific training needs**

The fifth theme draws on participants’ perceptions of specific training needs for health promoters. Training is presented as both a barrier and an enabler in health promotion human resources. Although training and especially formal education are highlighted as essential steppingstones to render significant health promotion and provide health promotion human resources, there remains insufficient training opportunities.

Health promoters “are actually not having a formal training”. There are no formal tertiary qualifications for health promotion available in the sub-district on any tertiary training level. One health promoter frustrated admitted that “the problem that we encounter through health promotion, ultimately our plans just die from nowhere [be]cause there is no one coming to help us how to implement the plan”. Another health promoter indicated that they “would just have to go to the professional nurse to acquire information” before a health education session. It seems as if the lack of formal training coupled with support challenges the implementation of health
promotion programmes directly. A participant eagerly stated that, “I wish I go to certain training to so that should I just more equip to more knowledgeable about health promotion.” Despite the absence of formal training and a health promotion career path, most of the participants recommended “structured formal training through higher learning institution(s)” in the form of certificates, diplomas or degrees to equip health promoters with the relevant skills. One participant suggested professionalising health promotion in order to “have representation at sub-district level”, with the view that it would probably give an opportunity to entertain continuous professional development courses.

In the absence of formal training, participants explained that there are internal training opportunities to stimulate self-development of health promoters. They “attend workshops that have been arranged by district RTC (Regional Training Centre)”. Participants explained how workshops aim to develop health promoters by updating them on trends within the current health agenda. The RTC is further responsible to capacitate community healthcare workers. Participants raised concerns of the undefined roles of this trained group which differ from other untrained community healthcare workers and health promoters. However, participants concluded that trained community health workers could be valuable to the health promotion programme. Finally, participants suggested the capacitation of the current community healthcare workers with relevant qualifications to be future health promoters.

**DISCUSSION**

Presently, the health system within the North West Province is dysfunctional and on the brink of collapse (South African Human Rights Commission, 2018). It is well known that the NWPDoH has been severely resource-strained since July of 2018 (South African Government, 2018). However, health care has to continue amidst severely overburdened and under-resourced systems (Van Rensburg, 2014). It seems that the absence of specialist health workers (Mash et al., 2014) encourages the alternative utilisation of health promoters in healthcare facilities to account for the limited staff availability. This has been reported in the Hammanskraal region of the North West Province, South Africa, where health promoters are assigned to clinical support units in PHC facilities (Mthombeni and Peu, 2013). Human resources for health promotion are fragmented within the DKK District and sub-district levels. Understaffing and high workloads are realities amongst health promoters (Mthombeni and Peu, 2013). The problem of health promotion human resources has previously been identified (Austin-Evelyn, 2017) in the Tanzanian (Manongi and Marchant, 2006) and Kenyan (Mbindyo et al., 2009) health systems. Therefore, the issue of health promotion human resources appears to be a challenge that is not unique to South Africa. Nonetheless, the health system of a middle-income country like Cuba, which integrated health
promotion into its national agenda in the early 1980s, is proof that, through good administration, PHC services may be delivered through adequate staffing of locally-trained clinical and health promotion staff (Keck and Reed, 2012).

Health promotion is acknowledged in the organisational structure of the National DoH as the Directorate for Health Promotion (DoH, 2014). The roles and responsibilities of health promoters and the strengthening of human resource capacity (DoH, 2014) are also declared in the South African NHPPS. However, health promotion presents as less-prioritised within the DKK District, unlike other areas such as Cape Town where health promotion is an active part of PHC within under-served areas (Mash et al., 2014). Negation of the role of health promotion within comprehensive care is echoed in the absence of an efficient human resources structure (Mthombeni and Peu, 2013), including health promoter recruitment. Furthermore, variance in health promoters’ salaries risks dissatisfaction, considering that financial remuneration plays a significant role in the motivation of health workers in general (Willis-Shattuck et al., 2008). Presenting health promotion as a dumping career emanated as a new finding from this research. This sentiment was echoed by health promoters from Hammanskraal, who also expressed negative opinions about their area of expertise by other healthcare workers (Mthombeni and Peu, 2013).

Similar to the funnel effect, the negation of health promotion in the current health system presents with insufficient human resource systems, which results in insufficient health promotion management. When management is uninformed or unaware of the key performance indicators neither present for health promoters nor understand the role of health promotion in comprehensive care, it is challenging to monitor and evaluate their performance and can therefore not be reported on in sub-district reviews. Although appropriate supervision impacts positively on health promotion outcomes (Earth Institute, 2011), efficient supervision and monitoring lacks within the DKK District. Singh et al. (2015) confirmed insufficient supervision in health promotion in low- and medium-income countries such as South Africa. The overall monitoring and evaluation of employees may facilitate intrinsic motivation, enabling target-setting and goal achievement (Lau and Roopnarain, 2014). In the absence of clear reporting lines and in the presence of unclear coordination, miscommunication can lead to workplace conflict and disciplinary matters (Almost et al., 2015). Literature shows a link between unmotivated health workers and lower health system performance (Khim, 2016). Policy knowledge for both health promoters and their supervisors is therefore crucial in order to facilitate healthy and productive working relationships and ultimately achieve a well-functioning unit (DoH, 2014).
The current human resources system and the less-prioritised status of health promotion bear testimony to unequal resource allocation for health promotion (Mthombeni and Peu, 2013). Sufficient health promotion resources, particularly in antenatal health promotion within the South African setting, was confirmed by Lau et al. (2014). Insufficient IEC materials (Mthombeni and Peu, 2013), materials presented only in English and not in communities’ local dialect (Spronk, 2014; Seid, 2016), utilisation of trendy technology (Baum and Fisher, 2014) and transport challenges (Liljas et al., 2017) were also confirmed. Consequently, eHealth may assist to strengthen health promotion (Kgasi and Kalema, 2014) when following suit of the empirical evidence for eHealth readiness from Pakistan (Qureshi et al., 2012) and Western Nigeria (Justice, 2012). Transport challenges have also been identified as hurdles for health promoters, particularly those who need to travel to remote areas to perform their duties (Liljas et al., 2017). Special allocation results in other multiple jobs not within scope of health promoters and this is seen as a major barrier experienced by health promoters in the carrying out of their duties (Luquis and Paz, 2015).

Health promotion is predominantly viewed as health education, outreach campaigns, and door-to-door activities. The multilevel knowledge gap about health promotion and health promotion programmes is confirmed by Lau et al. (2014) and Rongen et al. (2014). Contemporary health promotion strategies are either applied to large population groups or targeted to a local area or risk group (Baum and Fisher, 2014). Poor working relations with other external stakeholders, except for the Departments of Basic Education and Social Development remain a challenge. Health promotion is a multidisciplinary field which seeks to enable people to manage and improve their health (WHO, 2019). As such, it is imperative that the Health Promotion Directorate of the Department of Health closely interact with stakeholders such as the Departments of Social Development, Human Settlements, civil society, universities, research organisations, such as the Medical Research Council, as well as the private sector (Perez et al., 2013) to strengthen health promotion and find solutions to existing barriers experienced by health promoters. Currently, the Health Promotion Directorate functions in relationship with stakeholders such as the Department of Basic Education through the Integrated Health Promoting Schools Programme and National Treasury for increases in tobacco taxation and the Department of Sport and Recreation to promote physical activity (DoH, 2014).

Training needs in health promotion were confirmed by the DoH (2014), stating the need for skills development of existing health promoters. Standardised health promotion training on different levels was not confirmed in literature and serves as a new result. Formal health promotion training is scarce in South Africa. The University of Limpopo (2017) offers a Bachelor’s degree in Health
Science with health promotion and UWC (2013) a postgraduate management course in health promotion and a postgraduate certificate in public health focusing on health promotion. Within the context of the North West Province, there is no formal health promotion training available. The need to professionalise health promotion emanated as a new finding. The evolution of health promotion occurs in Canada (Pederson et al., 2017), Australia (Rosenberg and Yates, 2010) and the United States of America (Korda and Itani, 2013). The South African HPPS stipulates the need to provide refresher courses on new policies and mandates (DoH, 2015). However, the finding of the current study is that such refresher courses are insufficient as they are provided irregularly, which results in a significant number of health promoters not being aware of existing policies in their field (Mthombeni and Peu, 2014).

There is a need to orientate operational managers and other senior managers about their health promotion role in enhancing the implementation of health promotion policy and strategy (DoH, 2014). Moreover, the capacity building of community health workers with a Senior Certificate for future health promotion is something which has been documented as a priority in the NHPPS. This capacity building can only be achieved through collaboration with academic institutions. The benefit of such continuous development lies in the building of a career path for health promoters (DoH, 2014) – something that is lacking in the existing health system.

The barriers and enablers in human resources for health promotion in the DKK District are illustrated in Figure 2.3. Barriers are summarised as health promotion being less prioritised in the current health system and negating the value proposition health promotion in comprehensive care. There is a shortage of health promoters and absent human resources for a health promotion system. Health promotion management and governance and community integration are insufficient. Appropriate health promotion resources are lacking and there is no sufficient formal health promotion training. Enablers are listed as limited resources present, although not always appropriate and only in English, collaboration with internal and external stakeholders, a need to professionalise health promotion, and limited informal training opportunities.
Figure 2.3: Barriers and enablers in health promotion human resources

The reductionist view of health promotion human resources based on barriers and enablers does not portray the multidimensional complexity thereof within the current health system. As presented in Figure 2.4 (below), the relational nature of barriers and enablers presented as contradictory within a dysfunctional system. For example, although there were IEC materials (enabler), these materials were not presented in the mother tongue of the target audience (barrier). Although there is a call to professionalise (enabler) health promotion, ignorance amongst management on the role and responsibilities of health promoters (barrier) remains. The contextual boundaries of health promotion within a district health system on the brink of collapse and administered by National Department of Health cannot be denied. The dissonance between the health promotion strategy and policy and the barriers and enablers in health promotion human resources calls for a revisiting of the health promotion agenda for the DKK District.
Figure 2.4: The relational nature of the barriers and enablers in health promotion human resources in the North West Province
CONCLUSION

The barriers ranged from deficient human resource structures, lack of managerial oversight and monitoring, limited material resources, training needs and disparity in health promotion programme implementation. Conversely, intersectoral collaboration and localised training through the regional training centre were generally perceived as enablers in health promotion human resources. Despite these challenges, health promotion officials are innovative in implementing health promotion programmes with limited resources. Some of the highlighted barriers can be reduced through the optimal realisation of the NHPPS.

RECOMMENDATIONS

The development of a district health promotion plan, supported by adequate financial resources and a clear plan to build the capacity of health promoters, should include the harmonisation of health promotion training at training institutions such as institutions of higher learning. The health promotion plan should clarify the roles and responsibilities of health promoters in relation to other healthcare workers. Ideally, the health promotion plan should integrate both internal and external programmes, while simultaneously clarifying reporting lines and establishing effective monitoring systems. There should be well-defined linkages between the provincial health and national health on the recommendations of the health promotion human resource structure that will include selection criteria, salary levels and job description. As the DKK District is a pilot NHI system, it is imperative to initiate a model for the North West Province that would link the NHI with health promotion and PHC re-engineering.

LIMITATIONS

Due to severe staff shortages, the recruitment of participants and appointments for interviews were complex. Future research should seek the opinions of health promotion workers from a nationally-representative cohort sampled from all nine provinces.
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CHAPTER 3: EVALUATION, LIMITATION AND RECOMMENDATIONS

3.1 INTRODUCTION

Chapter 2 presented the data collection, analysis and research results in an article format. This chapter concludes this research by evaluating the research, stating the limitations of the study and making recommendations.

3.2 EVALUATION OF THE STUDY

3.2.1 Aim and objective of the research

The problem was significant to investigate due to the new developments in South Africa of introducing the NHI system (DoH, 2015:32), of which the PHC re-engineering stream is more focused on health promotion. This research assists in guiding the Department of Health on measures to strengthen health promotion in the era of NHI. The research aim and objectives were reached. The sample managed to identify the barriers and enablers in health promotion human resource within the North West Province. The barriers and enablers in health promotion human resource were explored and described. Objective 3, which is to make recommendations to strengthen health promotion human resources in the North West health system at all levels, is further discussed in this section.

3.2.2 Research methodology

A qualitative, explorative, descriptive and contextual design (Botma et al., 2010:182) was suitable for this research because limited literature was available but ample perspectives were shared by the participants. The design and methods led to a greater understanding of the barriers and enablers in health promotion human resources in the DKK District. Data saturation was reached in each category with a total of 17 participants.

3.2.3 Self-reflection

The interviews revealed that health promoters were more knowledgeable regarding health promotion human resources, while operational managers focused more on management of health promoters. Senior managers had knowledge about health promotion structures but lacked insight into the realities of health promotion programmes on grass-roots level. Health promoters seemed to be eager for formal training in health promotion and continuous in-service training. The gap between health promoters and operational managers was evident, as some operational managers raised complains about health promoters rather than indicating their contribution to comprehensive health care rendered at PHC facilities. Despite the challenges the health
promoters voiced, they still comprised themselves to enhance health promotion objectives. In some events, health promoters used their own vehicles with no compensation, thus self-funding, to assist patients in need. It was heart-warming to read that various health promoters declared a passion for health promotion and their feeling of fulfilment after educating communities towards lifestyle improvement and health-seeking behaviours.

3.3 LIMITATIONS

The following limitations were identified:

- There is a health workforce shortage throughout the North West Province, complicating the recruitment process and appointments for interviews.

- We found that human resources for health promotion is a relatively unfamiliar theme and therefore there is a limitation in available South African literature.

- Although conflict of interest was declared and risk of bias was mitigated throughout the research process, the researcher was in a senior position within the NWPDoH and might have hindered participants' honesty, although a very good interviewer was employed.

3.4 RECOMMENDATIONS

Recommendations are made in line with the main themes that emanated from the data.

3.4.1 Recommendations for health promotion human resources policy

Health promotion needs to be governed by a set of policies and procedures for its effectiveness and uniformity. This may include, but is not limited to, personnel recruitment and development policy, performance agreement, indicators/programme monitoring and evaluation framework. In consultation with Department of Public Administration (DPSA), market research in other provinces and the private sector should be conducted to determine job ranking in hierarchy of their significance to the department objectives. Table 3.1 compares different levels within health promotion as a recommendation to the Department. The levels recommend and reflect the need and opportunities relevant to the PHC re-engineering programme.

<table>
<thead>
<tr>
<th>Table 3.1: Levels of health promotion human resources</th>
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<tbody>
<tr>
<td>Proposed job role</td>
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<tr>
<td>Health promotion officer</td>
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</table>
3.4.2 Recommendations on deficient human resource structures

The linkages between provincial health departments and the national health department’s human resource systems should be established to ensure the establishment of a sustainable, well-resourced health promotion human resources structure that will include selection criteria, salary levels and job description. This is to be followed by the development of a policy on recruitment of health promoters across all levels of care. Ensure that the human resources structure details effective management systems to coordinate health promotion programmes, activities, partnerships and networks within the department and across all sectors.

The development of a health promotion structure, setting appropriate policies, would enhance the performance and productivity of the department in relation to preventative and promotive health services. In developing the structure, a user-friendly matrix that matches the level of care to the type of health promoter to qualifications to remuneration is recommended. Specific human resources of health promotion elements with associated recommendations for health promotion human resources based on comprehensive care (PHC facilities, sub-district-, district- and provincial levels) are presented in Table 3.2.

Table 3.2: Recommendations to strengthen health promotion human resources in the Dr Kenneth Kaunda District linked to elements in human resources

<table>
<thead>
<tr>
<th>Health promotion human resources element</th>
<th>Recommendations to strengthen health promotion human resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>Do an assessment and benchmark with fellow LMICs to establish the ideal staffing levels on all levels of care (sub-district, district, provincial).</td>
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<tr>
<td><strong>Staff development</strong></td>
<td>NDoH human resources to use the WHO Workload Indicators of Staffing Need (WISN) software to determine staffing norms. This was used to determine staffing norms for the PHC re-engineering model.</td>
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<td><strong>Conduct an audit of</strong></td>
<td><strong>Compensation</strong></td>
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<td><strong>the current cadre</strong></td>
<td>The human resources unit to consult with the Department of Public Service Administration (DPSA) to develop an occupational classification.</td>
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<tr>
<td><strong>performing health</strong></td>
<td>The process of developing the occupational classification (which involves assessing qualifications, experience, job weight, etc.) would direct what should be the compensation package for health promoters within different levels.</td>
</tr>
<tr>
<td><strong>promotion duties on</strong></td>
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<td><strong>their qualifications,</strong></td>
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<td><strong>years of experience,</strong></td>
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<td><strong>salary levels and</strong></td>
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<td><strong>age.</strong></td>
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<td><strong>Identify trainable</strong></td>
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<td><strong>ones and collaborate</strong></td>
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<td><strong>with tertiary</strong></td>
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<td><strong>institutions for health</strong></td>
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<tr>
<td><strong>promotion qualifications.</strong></td>
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<tr>
<td><strong>Safety and health</strong></td>
<td>Current health promoters are covered by the Department’s occupational health and safety policies, considering the fact that health promoters do functions in different settings.</td>
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<tr>
<td><strong>Clear safety</strong></td>
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<td><strong>protocols need</strong></td>
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<td><strong>to be developed for</strong></td>
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<td><strong>legal, economical,</strong></td>
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<td><strong>ethical and moral</strong></td>
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<tr>
<td><strong>reasons.</strong></td>
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<tr>
<td><strong>Employee and labour</strong></td>
<td>Engage with the Labour Relations unit within the Department on the nature of the problem and a plan to develop a health promotion structure that would support department goal(s) and how it would benefit the current health promoters.</td>
</tr>
<tr>
<td><strong>relations</strong></td>
<td>Facilitate communication by remaining open to suggestions, engage different structures for inputs, including health promoters effected to intercede and resolve disputes.</td>
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<tr>
<td></td>
<td>Consider internal department policies and guidelines to ensure compliance to prescripts.</td>
</tr>
<tr>
<td></td>
<td>Propose different levels of health promotion suggested in table 3.1 and with options for current health promoters.</td>
</tr>
<tr>
<td><strong>Performance</strong></td>
<td>Identify and set measurable indicators for health promoters linked to the department objectives.</td>
</tr>
<tr>
<td><strong>management</strong></td>
<td>Health promotion key responsibility areas to be reflected and monitored in their annual performance agreements.</td>
</tr>
<tr>
<td>Health promotion human resources element</td>
<td>Recommendations to strengthen health promotion human resources</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Employee motivation</td>
<td>To keep health promoters motivated, the Department needs to appreciate employees for the work done. Ensure continuous development and improve working conditions and recognise good achievements.</td>
</tr>
<tr>
<td>Recruitment</td>
<td>A standardised recruitment guide, indicating qualifications, experience, knowledge, skills, competencies and key performance areas to be clearly spelt out in advertisements for each level of health promoter posts.</td>
</tr>
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</table>

3.4.3 Recommendations on lack of managerial oversight and monitoring

A consolidated line of reporting to direct communication is essential. This will be augmented by clarifying roles of supervision at different levels. For example, the coordinator at provincial and district level may look into health promotion operational systems, programme implementation, monitoring framework, and human and material resources required. The supervisor at facility level mentors, supports, identifies individual specific training needs, monitors and evaluates programme and individual performance. The role of educating and orientating all management (all levels) on the job roles, monitoring and evaluation of health promoters can be shared by the programme coordinator and supervisor. It is therefore recommended that the operational manager (professional nurse) be the supervisor, while the health promotion practitioner be the coordinator, as proposed in the table above.

3.4.4 Recommendations on training needs

Through the support of the Provincial Department of Health, a clear plan to build the capacity of health promoters should include the harmonisation of health promotion training at institutions of higher learning. The recommendation will therefore be to negotiate cost-efficient measures with local institutions of higher learning on health promotion training. A five-year training and capacitating programme is recommended to qualify health promoters as health promotion officers (one year), practitioners (three years) up to speciality (one year) in health promotion. This process should further explore ways of establishing a national network of health promotion practitioners for benchmarking and also enhance access to continuous professional development programmes and an in-service training plan. The incorporation of health promotion in other professions as a core module in their curricula warrants integration of health promotion in all health professions.
3.4.5 Recommendations on disparity in health promotion programme implementation

It is essential for the health promotion plan to clarify the roles and the responsibilities of health promoters in relation to other healthcare workers, non-healthcare workers and external sectors. The need to establish sustainable partnerships and networks internally and externally is inevitable.

Internally, health professionals and non-health professionals within health facilities need to be oriented on health promotion interventions and their impact. Therefore, conduct a comprehensive stakeholder analysis to understand exactly who should be engaged. Also develop a user-friendly document explaining where and how health promotion fits into comprehensive health care; propose a roadshow to advocate health promotion programmes; and present a bi-annual workshop on health promotion programmes and the value thereof. This would enable them to address the risk factors associated with NCDs, new and re-emerging threats to health.

Externally, private sector, civil society and other government departments need to integrate health promotion into their policies through the support of the DoH and put in place monitoring systems to monitor health outcomes within the DKK District. The District is a pilot NHI district – strengthening networks and partnerships will be imperative in initiating a model for the District that would link to NHI and, most importantly, to the PHC re-engineering programme. It will be critical to therefore develop a district framework to assess planning, implementation and evaluation of the health promotion model.

3.4.6 Recommendations on limited material resources

Development of a district health promotion model supported by adequate financial resources should become central to the health promotion district model. The Department must develop a health promotion resource plan, with priorities and different technologies. The plan must find expression in the equitable shared budget allocation and be supplemented with conditional grants. A link with private industry and universities should be created in the development of resources and advice on cost-effective, researched approaches should be expected. Heads of organisations and departments should advocate for health promotion to be the key focus of all sectors. This would ensure that adequate human and financial resources are allocated to health promotion within external organisations and sectors. Collaboration with institutions of higher learning should be fundamental in ensuring evidence-based programmes and initiatives. This should be done through documentation of success stories, developing documentaries through community interviews, case studies, survey and research, which can be used in different settings as information, education and communication of health messages.
3.4.7 Recommendations for future research

In view of the barriers and enablers identified in this research, the following have been identified as topics for future research:

- research to develop a human resource strategy for health promotion;
- research to develop a financial model for health promotion programmes;
- research to establish how health promotion monitoring and evaluation can be established in practice;
- intervention research to develop health promotion resource material.

3.5 SUMMARY

In this chapter, the research findings were evaluated and recommendations were made on mechanisms to strengthen health promotion human resources capacity to deliver health promotion services within the current overburdened healthcare system. The research problem was deemed to be significant and the methodology was considered as appropriate. The limitations confirmed that the health system is under stress. The results confirmed that there are definite barriers and enablers and each cluster was highlighted and discussed. Finally, recommendations were made to improve practice and research.
LIST OF REFERENCES


ANNEXURE A: INFORMED CONSENT

INFORMED CONSENT TO PARTICIPATE IN SEMI-STRUCTURED, INDIVIDUAL INTERVIEWS

TITLE OF THE RESEARCH STUDY: HEALTHCARE WORKERS’ PERSPECTIVES OF THE BARRIERS AND ENABLERS IN HEALTH PROMOTION HUMAN RESOURCES IN THE NORTH WEST PROVINCE

ETHICS REFERENCE NUMBERS: NWU-00091-18-S1

PRINCIPAL INVESTIGATOR: Prof Petra Bester

POST GRADUATE STUDENT: Mr Ishmael Boboko

ADDRESS: North-West University, Building G16, Room 248a, Potchefstroom.

CONTACT NUMBER: 079 8819 195

This information is part of an invitation to you to participate in an interview for research. This research is a part of the MHRo in Transdisciplinary Health Promotion which I am completing at the North-West University. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is entirely voluntary and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00091-18-S1) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.
What is this research study all about?

- We plan to conduct a study to explore and describe healthcare workers' perspectives on the barriers and enablers in health promotion human resources within the North West Province.
- Research will be conducted at your workplace. An experienced interviewer will visit you to conduct an individual, semi-structured interview. You will be invited to talk to the researcher in an interview for about 60 minutes.

Why have you been invited to participate?

- You have been invited to be part of this research because you are permanently employed by the North West Department of Health for more than three years and therefore understand healthcare workers and health promotion within the integrated health system of PHC, sub-district and district levels.
- You are either a health promoter, programme coordinator or operational manager or senior manager in the district and can help us to understand the barriers and enablers for human resources on all levels of care.
- You are able to communicate in English during the interview.
- You are willing to sign informed consent whereby giving permission for the researcher to record the interview.
- If you have served for less than three years in the DKK district you cannot part take in the study.

What will be expected of you?

- You will be expected to indicate your willingness to participate in the study to the mediator. The mediator and the interviewer will together explain other areas where you need clarity before the interview. On the day of the interview you will sign an informed consent to confirm you agree to the interview.
- During the interview you will be asked to talk about the following research questions:
  - Share your perspectives (views/opinion) of the barriers to health promotion human resources in the Dr Kenneth Kaunda district?
  - Share with your perspectives (views/opinion) of the enablers to health promotion human resources in the Dr Kenneth Kaunda district?
  - Share your ideas on how human resources capacity be strengthened for health promotion in the North West Province within PHC clinics/sub-district and district/provincial levels?
- The interview will take about 60 minutes. The interview will be digitally recorded and during and after the interview you will be provided with refreshments. You will also receive a pen as a token of appreciation.
- You can further explain to the researcher how you want to get feedback about the research.
Will you gain anything from taking part in this research?

- There is nothing that you can gain directly for talking with the interviewer. But the research will enrich the growing body of evidence of health promotion in South Africa. If the outcome of this research can inform the Department of Health of mechanisms to strengthen the human resources in health promotion, then an indirect benefit could be greater efficiency in health promotion interventions within the greater public health systems.

Are there risks involved in you taking part in this research and what will be done to prevent them?

There might be some minimal risks involved for you when you partake in this research. Below are the risks that might be and how we can handle it together:

| You might feel a bit tired and maybe bored talking with us. | The interviews will not be longer than 60 minutes and during this time, we will make sure that you sit comfortable, have some refreshments and if you are feeling too tired, we will stop the interview. |
| Feeling inconvenienced or that your manager might charge you for participating in the interview during working hours. | Permission has been requested from the North West Department of Health highlighting that the interview will be taking place during working hours to avoid any inconvenience to your work schedule. If you cannot participate at a pre-scheduled time and appointment due to work challenges, then the appointment will be rescheduled. |
| It can be a risk that you don’t actually want to talk to us but you felt pressured by management/supervisor. | Even if you signed the form to talk to us and you still don’t want to talk, then we will stop the interview and there will be no discrimination. |
| Disclosing department information could be uncomfortable; you might feel coerced and to disclose information. | Anonymity, confidentiality, respect, and dignity will be maintained on all disclosed information. By signing the consent form you will be indicating that you are not forced to participate by anyone. There will be no way that the researcher will be able to link your response to the larger pool of data. No participant’s identity or any identifiers will be decoded in the reporting of the data. No information that you declare will be reported back to your manager. Your name will be replaced with a code. |
| You might not want to participate due to financial implications you may incur. | There will be no economic harm as you travel to work on a daily basis. The interviews will be done during working hours and therefore there will be no need for any expenditure. |

How will we protect your confidentiality and who will see your findings?

- Your privacy will be respected by, once again, not including any identifying details of yourself in the interviews. The interviews will be given numbers so no one besides the interviewer, will know who the numbers belong to.
- Nobody will be able to link your name to your interview.
• All your information will be kept confidential with codes after they are transcribed. These transcriptions will only have the relevant information that was given and no information that will reveal who gave the information.

• Only the interviewer and members of the research team will be able to look at your findings. Furthermore when the data (information from all the interviews) is anonymised (all identifying detail excluded) the database will be available to other researchers who want to use the information.

• Findings will be kept safe by locking hard copies in cupboards in the researcher’s office and for electronic data it will be password protected.

• As soon as data (information from the interviews) has been transcribed it will be deleted from the recorders and an anonymised data base will be kept for other researchers.

• Data will be stored for 6 years thereafter all data will be destroyed, electronic and hard copies.

What will happen with the findings?
• The findings of this research will be used for this research and also for future studies that may require the information regarding health promotion services in the health care system. However it must be understood that whoever requests the use of the information it will be done through HREC and will fully conform to this committee’s requirements for the use of this data.

How will you know about the results of this research?
• The researcher intends to organise a health promotion conference as soon as the study has been finalised to share the results with the department. If you are unable to attend, a copy of the findings will be mailed for your convenience.

Will you be paid to take part in this study and are there any costs for you?
• You will not be paid to participate for participating in the study. The interview will be conducted on your working day and at your workstation thus you will not need reimbursement for travelling. Refreshments will be served during and after the interviews and you will receive a pen as a token of appreciation for your participation.

Is there anything else that you should know or do?
• You can contact the study supervisor (Prof Petra Bester) at 082 298 3567.

• You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 296 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.

• You will receive a copy of this information and consent form for your own purposes.
Declaration by participant

By signing below, I .................................................. agree to take part in the research study.

Healthcare workers’ perspectives of the barriers and enablers in health promotion human resources in the North West Province.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is voluntary and I have not been pressured to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (place) .............................................. on (date) ......................... 20....

________________________________________________________________________

Signature of participant

Declaration by independent person obtaining consent

I (name) .......................................................... declare that:

- I clearly and in detail explained the information in this document to ..........................................................
- I did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
• I am satisfied that he/she adequately understands all aspects of the research, as discussed above.

• I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (place) .................................................... on (date) ............................, 20....

---------------------------------------------
Signature of person obtaining consent

Declaration by researcher

I (name) ................................................................. declare that:

• I explained the information in this document to ........................................ or I had it explained by ........................................ who I trained for this purpose.

• I did/did not use an interpreter.

• I encouraged him/her to ask questions and took adequate time to answer them or I was available should he/she want to ask any further questions.

• The informed consent was obtained by an independent person.

• I am satisfied that he/she adequately understands all aspects of the research, as described above.

• I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (place) .................................................... on (date) ............................, 20....

---------------------------------------------
Signature of researcher
ANNEXURE B: APPROVAL FROM NORTH WEST PROVINCIAL DEPARTMENT OF HEALTH AND GOODWILL PERMISSION FROM DR KENNETH KAUNDA DISTRICT

<table>
<thead>
<tr>
<th>Name of researcher</th>
<th>Mr. G. I. Boboko</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West University</td>
<td></td>
</tr>
</tbody>
</table>

| Physical Address (Work/Institution) | HOPPENLAAN 81R NORTHEAST STREET 2030 NORTH WEST UNIVERSITY |

| Subject | Research Approval Letter – Healthcare workers’ perspectives of the barriers and enablers in health promotion human resources in the North West Province. |

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards.

Dr. FRM Reichel
Director: PPRM&E

NORTH WEST PROVINCE
REPUBLIC OF SOUTH AFRICA

Date: 05/11/2018

Researcher

Date: 05/11/2018

Healthy Living for All
Ishmael Boboko - Fwd: Request to conduct semi structured interviews

From: Nela Mojanaga
To: Erica Du Plessis; Everitt Lesupi; Gloria Tlhapi; Ishmael Boboko; Kei...
Date: 14/11/2018 09:09
Subject: Fwd: Request to conduct semi structured interviews
Attachments: HEALTH FACILITIES IN DR KENNETH KAUDA IDENTIFIED FOR THE SEMI STRUCTURED INTERVIEWS.docx; APPROVAL NWU-00091-18-S1_01-11-2018.pdf; NWDOH Research Approval letter.pdf; Request for Approval to conduct interviews.pdf

Good day Colleagues

Please find attached request from Mr Boboko

Mr Lesupi please assign someone to work with Mr Boboko

Regards

N. Mojanaga

>>> Ishmael Boboko <ishboboko@gmail.com> 2018/11/13 08:17 AM >>>
Good morning

I am Ishmael Boboko (HP Provinicial Coordinator), kindly find attached formal request to conduct health research through semi structured interviews in the Dr Kenneth Kaunda District.

The study has been approved by the Department, see attachments.

I will appreciate if you could nominate an official I will work with for logistical purposes.

Kind regards

Ishmael Boboko

file:///C:/Users/Ishmael%20Boboko/AppData/Local/Temp/XPgrpwise/5BE8660MMB... 19/11/2018
Dear Sub District Managers,

As tele-phonically communicated:

Please note the request for an interview based research which will be conducted in the District by Mr. Boboko and NWU official. The research has been approved by the province, please refer to the attached approval.

The suitable dates for these interviews are as follows:

Maquassi Hills Sub District - Monday, 26 November 2018
Matlosana Sub District - Tuesday, 27 November 2018
Venterdorp Sub District - Wednesday, 28 November 2018
Tlouke Sub District - Thursday 29 November 2018

Would you please populate the attached (Participants for the Semi Structured) document confirming your availability and those of the requested officials (Health Promoter and Operational Managers) for the said date and submit to me by Monday 20 November 2018 in the Morning.

The informed consent form is also requested to be filled (It may be printed in your Sub Districts and given to interviewees to fill and give it back to Mr. Boboko and the NWU Official on the day of the interview).

Please refer to the attached documents for all the information for this research.

Hope you find this in order.

Regards,

Calvin Mmisele
081 047 6063

file:///C:/Users/Ishmael%20Boboko/AppData/Local/Temp/XPgrpwse/5BF27E90MMBD... 25/11/2018
TO: MS NELLA MOJANAGA  
CHIEF DIRECTOR  
DR KENNETH KAUNDA DISTRICT  
NORTH WEST DEPARTMENT OF HEALTH

Date: 13 November 2018

SUBJECT: REQUEST TO CONDUCT INTERVIEWS IN SUB-DISTRICT HEALTH OFFICES AND HEALTH FACILITIES

I am a student in the North West University pursuing my Master's Degree in Health Science, Transdisciplinary Health Promotion. My study title is “Healthcare workers’ perspective of the barriers and enablers in health promotion human resources in the North West Province”. I have been given permission by the Provincial Department of Health North west to conduct the study; however my proposal requires the District office to also give permission to conduct the study in sub-district offices and Health facilities.

I have selected to conduct the study in the Dr Kenneth Kaunda district. The study will be conducted through semi structured interviews targeting health promoters, operational managers, programme coordinators, and senior managers based at PHC facilities, sub-district office and district office. See table below.

Categories of officials within the Dr Kenneth Kaunda district that can be included into the population

<table>
<thead>
<tr>
<th>Category of officials</th>
<th>Sub-district</th>
<th>Total per category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Health promoters</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Professional nurses contracted as operational managers in PHC clinics</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Senior management (Sub-district or District office)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
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</tbody>
</table>

I am also the Deputy Director Health Promotion in the Department, to avoid selection bias and protect privacy and confidentiality of the participants I therefore request the Department to identify a mediator (an official within the Department of health) who will ensure recruitment and enrolment
of participants. This will ensure the perception of undue influence is managed. I will communicate with the mediator in ensuring all logistical arrangements are in place. The following schedule is proposed for interviews within the district.

### Preliminary typical interview schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Area</th>
<th>Time</th>
<th>Participant category</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 November 2018</td>
<td>Maqassi Hills</td>
<td>09H00 - 10H00</td>
<td>Senior manager</td>
<td>Sub-district office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11H00 - 14H00</td>
<td>Operational manager</td>
<td>Health facility 1</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Health promoter</td>
<td>Health facility 1</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Operational manager</td>
<td>Health facility 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15H00 - 16H30</td>
<td>Health promoter</td>
<td>Health facility 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Operational manager</td>
<td>Health facility 3</td>
</tr>
</tbody>
</table>

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<tr>
<th>Date</th>
<th>Area</th>
<th>Time</th>
<th>Participant category</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 November 2018</td>
<td>Matosara</td>
<td>09H00 - 10H00</td>
<td>Senior manager</td>
<td>Sub-district office</td>
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<td></td>
<td></td>
<td>11H00 - 14H00</td>
<td>Operational manager</td>
<td>Health facility 1</td>
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<td></td>
<td></td>
<td></td>
<td>Health promoter</td>
<td>Health facility 1</td>
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<td></td>
<td></td>
<td>Operational manager</td>
<td>Health facility 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15H00 - 16H30</td>
<td>Health promoter</td>
<td>Health facility 2</td>
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<td></td>
<td></td>
<td>Operational manager</td>
<td>Health facility 3</td>
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</tbody>
</table>

<table>
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<th>Date</th>
<th>Area</th>
<th>Time</th>
<th>Participant category</th>
<th>Venue</th>
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</thead>
<tbody>
<tr>
<td>28 November 2018</td>
<td>Venterdorp</td>
<td>09H00 - 10H00</td>
<td>Senior manager</td>
<td>Sub-district office</td>
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<td></td>
<td></td>
<td>11H00 - 14H00</td>
<td>Operational manager</td>
<td>Health facility 1</td>
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<td></td>
<td></td>
<td></td>
<td>Health promoter</td>
<td>Health facility 1</td>
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<td></td>
<td>Operational manager</td>
<td>Health facility 2</td>
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<tr>
<td></td>
<td></td>
<td>15H00 - 16H30</td>
<td>Health promoter</td>
<td>Health facility 2</td>
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<td></td>
<td></td>
<td></td>
<td>Operational manager</td>
<td>Health facility 3</td>
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</tbody>
</table>

<table>
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<tr>
<th>Date</th>
<th>Area</th>
<th>Time</th>
<th>Participant category</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 November 2018</td>
<td>Tlokwe</td>
<td>09H00 - 10H00</td>
<td>Senior manager</td>
<td>Sub-district office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11H00 - 14H00</td>
<td>Operational manager</td>
<td>Health facility 1</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Health promoter</td>
<td>Health facility 1</td>
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<td>Operational manager</td>
<td>Health facility 2</td>
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<tr>
<td></td>
<td></td>
<td>15H00 - 16H30</td>
<td>Health promoter</td>
<td>Health facility 2</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Operational manager</td>
<td>Health facility 3</td>
</tr>
</tbody>
</table>

Since the researcher is a Programme Manager for Health Promotion in the Department, personally conducting the interview may result in the participants defending or overselling the programme to impress. To eliminate any ambiguity resulting from the association of the researcher with the
participants, a skilled and experienced independent interviewer will be selected and trained, in the context of this specific research study, to conduct the interview on behalf of the researcher.

I have attached to this request the following documents:

- The approval from Provincial Department of Health
- North West University Health Research Ethics Committee approval
- The full detailed protocol.

The district is further requested to indicate how they will like the results of the study to be shared with them. I am looking forward to a good working relationship with the District during the process of this study.

Kind regards,

Ishmael Boboko
Student Number: 2932988
ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North West University Health Research Ethics Committee (NWU-HREC) on 01/11/2018, the NWU Health Research Ethics Committee hereby approves your study as indicated below. This implies that the North-West University Research Ethics Regulatory Committee (NWU-RERC) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Healthcare workers' perspectives of the barriers and enablers in health promotion human resources in the North West Province.
Study Leader/Supervisor (Principal Investigator)/Researcher: Prof P Bester
Student: GI Boboko
Ethics number: NWU-000091-18-A1

Application Type: Single Study
Commencement date: 2018/11/01
Expiry date: 2019/11/30
Risk: Minimal

Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of an annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.

Special in process conditions of the research for approval (if applicable):

- Please provide the HREC with a copy of the final approval letter from the North West Department of Health, indicating that the study can proceed.
- Please provide the HREC with the goodwill permission letters from the District offices, health facilities and sub-district offices of the Department of Health to be included in this study, granting access to their staff and facilities.
- Once the data dissemination strategy has been decided on, it is requested that the researchers please amend the application accordingly, before implementing the data dissemination process.
General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- The study leader/supervisor (principal investigator/researcher) must report in the prescribed format to the NWU-HREC:
  - annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and
  - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.

- The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.

- Annually a number of studies may be randomly selected for an external audit.

- The date of approval indicates the first date that the study may be started.

- In the interest of ethical responsibility the NWU-RERC and NWU-HREC reserves the right to:
  - request access to any information or data at any time during the course or after completion of the study;
  - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;
  - withdraw or postpone approval if:
    - any unethical principles or practices of the study are revealed or suspected;
    - it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;
    - submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or
    - new institutional rules, national legislation or international conventions deem it necessary.

- NWU-HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.

The NWU-HREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the NWU-HREC or the NWU-RERC for any further enquiries or requests for assistance.

Yours sincerely,

[Signature]

Digitally signed by Wayne Towers
Date: 2024-12-04
22:49:32 <UTC>

Prof Wayne Towers
Chair NWU Health Research Ethics Committee

Current details: (2358192000) M:\3551\19339\Monitoring and Reporting Cluster Ethics Certificates\Templates\Research Ethics Approval Letter\06.5.2.HREC Ethical Approval Letter.doc
9 December 2019
File reference: 915.4.2
ANNEXURE D: CONFIDENTIALITY AGREEMENT BY INDEPENDENT INTERVIEWER

CONFIDENTIALITY UNDERTAKING

entered into between:

I, the undersigned

Prof / Dr / Mr / Ms. Mrs. Amari Meralis

Identity Number: 920206096081

Address: 4 Eros Road, Eros Villas, Villa 31, Olympus, Pretoria 0081

hereby undertake in favor of the NORTH-WEST UNIVERSITY, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borcherd Street, Potchefstroom, 2520

(hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by myself.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.
2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.
7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this 24th April 2007

Witnesses:

1

2

(Signatures of witnesses)

(Signature)
ANNEXURE E: EXTRACT FROM SEMI-STRUCTURE INTERVIEWS

Interview 15
Code: SSI HP 08

Amori Is it a community health centre
HP 15 Yes
Amori Not a Clinic or?
HP 15 Is a CHC (Community health centre)
Amori Is not so busy hey or?
HP 15 It is busy is just that this site they are fixing it, this is the waiting area. So this waiting area they are fixing it so almost everyone is that site, all our clients are that site.
Amori This site seems to be quiet mmmmm
HP 15 Yah, is the busy one on Ikageng
Amori Ok. this one is it the busiest
HP 15 Actually in Potchefstroom
Amori Really
HP 15 Hmm
Amori What is the area that is located in
HP 15 Ikageng
Amori Is it town?
HP 15 No, location
Amori Ok, then
What do you see as possible barriers to health promotion human resources in Potchefstroom, Tlokwe sub-district.
HP 15 Possible barriers can you explain
Amori What are the things that makes it difficult for you to make your job?
HP 15 Ok, firstly we don’t have resources, for example when you get hired they also require your driving licence but there are no cars to use and almost all our workload needs us to be in the community
Amori Yes
HP 15 So is a problem because there are some sites where you will not be able to go without a car.
Amori Yes
HP 15 So for now I have been using my personal car, like when we go to schools, when you do campaigns, you need a Van actually. Because you need to load your Gazebo’s and other staff for the campaign. Those are the things that make everything in this programme impossible for now.
Amori And even if you use your own vehicle do you pay the petrol
HP 15 No, I pay it myself
Amori They don’t give it to you
HP 15 No, actually I got used to it now because is almost four to five years, I will be turning five years next year working in this department.
Amori Mhmm and has not been fixed since the time you started
HP 15 No, and the other thing there is really confusion me sometimes, we are not in the same level with all health promoters.
Amori Ok
HP 15: There are those health promoters for example, in Ventersdorp there are health promoters they are in level seven, they are earning more than us.

Amori: So ok the payment

HP 15: The payment is not the same but I don't know how because the requirement it’s the same, and in anyway if you go back and look at how they earn that much while you are earning the less you don’t even see the reason why. Because...

Amori: Because you doing the same...

HP 15: We doing the same things and I am highly qualified than those who are earning more than me. That is personal it doesn’t motivate you it discourage you. Yah that’s the other thing.

Amori: So you talking about your own personal qualifications, you are more qualified than those people?

HP 15: Than other yah, And there are those that are more qualified than me who are earning lesser also

Amori: Than the other

HP 15: So they didn’t look at our qualifications, but they hired people according to their sub-districts the levels that they had. But in this sub-district and other sub-district we are earning lesser than the one in Ventersdorp.

And listen they are at level seven and I am at level four.

Amori: Yah that’s a big gap is not even like

HP 15: Yah is a big one

Amori: So how do you think HR could sort of address this problem of different levels?

HP 15: I think they must fix it because the organogram says all health promoters must be on level seven

Amori: Ohh hh

HP 15: Yah that’s a reality it must be fixed, so I don’t know when will it be fixed, will it be fixed after we get another job because I am looking forward to find something else. Because I can’t even maintain myself with the salary that I am earning now, especially because I am renting, I am not from Potch I am from Rustenburg. And I am staying with my child

Amori: And you also using your own vehicle to go to different campaigns and schools where ever they need you to go. That’s something they need to address across

HP 15: Yah across, I won’t talk about me only, because we are all having this challenge, level is a challenge, transportation under resource is the challenge, budget is the challenge. We don’t have budget in Health promotion we use budget from HAST, MCHW and other programmes

Amori: So you don’t have actually an allocated budget for health promotion.

HP 15: We don’t have allocated budget for health promotion

Amori: So it becomes an additional thing.

HP 15: It is a problem

Amori: So what qualification did you do before getting into health promotion?

HP 15: Before I got to the department I was with Love Life actually. I did training, I am a facilitator I am a trainer, I also did HIV but those are levels. In level five four of HIV

Amori: Wao, so is that what you mainly focused on?

HP 15: I am an assessor also.

Amori: Assessor of?

HP 15: Of any, I can manage to make a manual, if ever you call me in your company and ask me to do a training I can go back and do a manual for facilitator and do manual for participants.
Amori: Wao, that’s great. Ok in here to do you focus mainly on HIV or do you focus on...
HP 15: I focus on all the programmes they have in the department of health.
Amori: And do you get trained in that programmes or how do yu get information?
HP 15: No, I google it I ask some other professional nurse for help, yah that’s how I get information, that’s how I got information when I got here.
Amori: Wao it wasn’t that they give you formal training you did it on your own.
HP 15: Mmhhmmhh I even did my Job description myself.
Amori: Wao, there was nothing from provincial side.
HP 15: The provincial side saw the job description that I did and they also added on it, and it is being used now. But I don’t think they aware of it. Because the manager that I was working with before, when I was working here he told me to do my own job description, so I took the job description that they did before for health promotion and then I set down with it then I looked at what they said I was supposed to do and I combined everything.
Amori: So there was nothing formal that was even given to you?
HP 15: No, I did it myself and after doing it I gave it to my manager and after several month, about three to four month I saw it being presented this is the job description that you are going to use.
Amori: So they actually took your thing just like that.
HP 15: And added some, but it’s the same thing that I did.
Amori: That’s is actually something that should come from HR side to have something developed. Send out for people who apply for posts. But then how did you know about the health promoters?
HP 15: The other guy I used to work with at love life called me and told me about the advertised post, so that how I applied. Yah because 2013 I got retrenched from love Life, they didn’t have money anymore for other positions so they retrenched us, so afterwards I stayed almost a year at home trying to apply to get another job then one of my former colleagues called me and said there where posts advertised this side so that’s how I applied.
Amori: Where you aware of health promotion before that or?
HP 15: Anyway love life and health promotion is the same thing and it was not difficult for.
Amori: But they focus more on HIV and AIDS.
HP 15: In love life we focused more in HIV and AIDS here we focus in different programmes.
Amori: Ok. So we talked about barriers in Health promotion, are there any enablers or something positive that assist you in doing your job as a health promoter?
Silence
HP 15: Yah the staff that I work with at Boiki Tlhapi when I ask for help, when I ask for information they were always there and still they are always here to help me. And the support.
Amori: So the support that you receive form the people in the clinic, what about like other health promoters within this district?
HP 15: In our district there are no health promoters, it’s only me Matlawe and the other health promoter in Promosa. And the one that works in the sub district with school health Ausi Mapula. The three of them are older and one in Promosa doesn’t even understand the programme anymore. Cause it has changed.
Amori: So they older people?
HP 15: Yes they are older people, So there is no way that I can ask help from them now.
Amori: Even the one focusing in school health, do you also do school campaigns?
HP 15: I go to school, the school that are in my area, I go to them and do campaigns.
Amori: But the other health promoters, you don’t collaborate with them sometimes?
HP 15: We do collaborate, especially when we have quarterly meetings when we have events, yah campaigns we do work together. But that’s the only time they work with me. But when we at our facilities we work alone.
Amori: So you don’t really work with them.
HP 15: Is not frequent that you have to work with other health promoters, but with the professional what support do they give you, is it like sharing information or what?
Amori: So they don’t really work with them.
HP 15: Sharing information with me, also when the clients are asking questions I don’t understand, I call them to explain or tell me what to explain to them.
Amori: So they don’t mind?
HP 15: They don’t mind at all.
Amori: My last question for you is, what are your ideas on how human resource capacity can be strengthened for health promotion, how do you think they can improve like?
HP 15: Because under health promotion we must be mobile every day I believe we must be subsidised with cars, is very important.
Amori: Ok
HP 15: Because we must be mobile each and every day of our life’s. We are working in the community. And the other thing that we must do as health we must stop focusing more in the facility.
Amori: Ok
HP 15: Because here in our sub district they said we must focus more in the facility. We must have a plan to focus more in the community because the clients are in the community not in the facility. And is not everyone who comes to the clinic, the clients who comes to the clinics is the ones on chronic medication. Those are the ones that are coming into the clinic. So they got information because we talk to them every day.
Amori: Yes
HP 15: When they get here in the morning even during the day we talk to them, but the ones that are in the community they are disadvantage because we can’t see them every day. Like we have got this programme is called PHC reengineering.
Amori: Mhmm
HP 15: Primary Health Care re-engineering, the primary health care re-engineering has the CHW’s, if we can integrate with the CHW’s and work with them with the wards, they call them scattered community. They call them wards, we have got ward eight in our area we got ward six, ward 13, we got almost four wards or three wards, so I must be able to work, to integrate with them when they do their outreach.
Amori: Integrate with community health workers because is outreach.
HP 15: Because they do their outreach every day.
Amori: Do you not integrate or collaborate with them, is it not happening yet?
HP 15: Ehh it is integrated with every programme in the facility, I also work with them but I almost work with them 100% when we do campaigns. But not every day like.
Amori: So do you think it should be like work with them 100% every day so you know we they go where the needs are?
HP 15: Yah where the needs of the community are, because as a health promoter I must know that so that when I do campaigns I do the relevant ones.
Amori: Yes, so now how do you decide which campaigns to do and topics, which information to share?
HP 15: We have got meetings every day when we come to work in our facility, they share with us information in what we should focus on and that’s how I get information to know whether which event I must do which campaign I must do. But so far what we focus more on is HIV
cause we got lots of loss to follows. Also for TB that’s where we focus too much. But when we
do campaigns we focus on everything, we do vital signs for everything and we also do HIV
testing.

Amori  Mhmm
HP 15  So my job as a health promoter is check, for example when we talk about HIV counselling I
must check with counsellors whether they reaching their stats with cancelling. If I see they not
reaching the stats I must make more campaigns for them to be able to on the streets in the
community and do campaigns.

Amori  Yes
HP 15  And when we are in the streets people come and test but when we are in the facility people
don’t come and test.

Amori  Do you think they scared or they don’t know?
HP 15  They don’t want to be in a queue, waiting time is the problem.

Amori  OK, So you really see that there is a big need to go out,
HP 15  So that people can have more information. Because those that come for HIV testing they don’t
have to be in the queue they are tested and leave. But for the fact that they know clinics there
is always queues, they believe that when they come here to test they gonna stay in the queue.

Amori  For a long time, don’t you educate them and tell them they don’t have to wait?
HP 15  We do educate them but then as I told you, we educate the people who come to the facility
and they hear one thing every day. And those people they don’t change because they come
here for chronic.

Amori  Yes
HP 15  The ones that are in the community they are not sick they don’t come to the clinic.

Amori  But you also need to share information with them.
HP 15  I need to share information with them also.

Amori  Because there is things like diet, looking out for specific diseases.
HP 15  I don’t go a lot because I also have a problem with petrol.

Amori  Yah its expensive
HP 15  I only go when I see the need
Amori  Ok.
HP 15  Then I must especially at schools, but for now I am no longer going to schools because they are
writing exams.

Amori  Yes, so in terms of getting a car, they say you request a car for a day, how is that process like, is
it easy?
HP 15  It is not easy, because they do not have enough cars in the sub-district.

Amori  So who do they give those cars to then? Do they give them to health promoters or?
HP 15  There are drivers who are driving those car, driving people to training and going to take
material to bring them to our facilities. And as I told you there are no cars, maybe three or four
cars are there.

Amori  Ohhh, so that get prioritised over you going out to campaigns. Area there any other resources
that you feel like you may be lacking?
HP 15  Yah, pamphlets, information sharing we need also pamphlets. So for the past four years they
told us there is no budget so there are no pamphlets anymore.

Amori  Is this now the department of health or who is this?
HP 15  Department of health yah.
Amori  So what do you rely on, do you just don’t use any pamphlets or you

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HP 15 I don’t have pamphlets, we don’t have even A4 papers to make pamphlets
Amori Ok. Wao
HP 15 Because always there are no papers there are no papers. So there is lot that is happening here.
Amori I can see that and is definitely something that...
HP 15 I don’t even have my own office so that when you come like this or maybe or there is a patient
that I need to talk to I come with her in my office together.
Amori So you don’t have the infrastructure
HP 15 I don’t have the infrastructure, I just work normally as any other person
Amori So if you go out, for campaigns do you just speak without having a poster or
HP 15 I don’t have posters, yes I don’t. Unless otherwise the sub-district because is their event they
have papers they make pamphlets and bring them to us.
Amori But is not always?
HP 15 No is not always is not a standard thing.
Amori Let’s say you do a campaign, how do you think it affect people when you don’t give them
pamphlet or when you don’t have posters for example, do you think it affects them?
HP 15 Yah it does, you know when you are a person individually so, you listen to me for some few
minutes but after an hour you forgot everything that I said. But if I talk with you and give you
pamphlets at home you can take that pamphlet and read it again. And understand much well
than when I was talking to you.
Amori I think it helps also to keep messages in people minds.
Ok, do you think there is any other thing you wanna share regarding health promotion in this
sub-district that we have not discussed yet.
HP 15 You know there is this thing again, you can even have ideas like for example you have this
programme, Physical activity programme, I had this idea before of looking for funds. Maybe go
to vision active ask for equipment’s and other staff so that we can have them in our facility for
our clients to come an train and do whatever, and even us as employees we also need to be
healthy.
ANNEXURE F: EXTRACT OF FIELD NOTES

Interview 15
Code: SSI HP 08
Date: 29 Nov 2018
Time: 10h11
Area: Tlokwe Sub-district Boiky Tlhapi CHC, breastfeeding room
Official: Health promoter, black woman early 30’s
- Levels
- Subsidised cars
- Very friendly, vibrant health worker
- Interview done in
- Some disturbances during interview
- Open body language from the beginning
ANNEXURE G: TURNTIN REPORT

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To whom it may concern

This letter serves to confirm that the following dissertation was edited:

"Healthcare workers' perspectives of the barriers and enablers in health promotion human resources in the North West Province"

The onus rests on the client(s) to work through the proposed track changes and to accept or reject proposed changes. Clients should also make sure that all sources have been cited.

Yours sincerely,

Dr Jackie de Vos

7 June 2019
Certificate of Technical Editing

I hereby declare that Engel Oosthuizen, Identity number 840330 0047 089, has done the technical editing of the dissertation of Gi Boboko, student number 29342988, with the title:

*Healthcare workers' perspectives of the barriers and enablers in health promotion human resources in the North West Province*

Technical editing includes relevant styling, captions and updating of the table of contents.

Engela Oosthuizen