

**Intersectoral team members'
understanding of and recommendations
for a mental health promotion
programme in a rural sub-district,
Western Cape Province**

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DECLARATION

I declare that this dissertation is my own work and has not been submitted to any other institution before. I declare that this work has not been plagiarised, nor did I violate any copyright restrictions. I declare that I gave due references to all the sources used in the dissertation and that the sources are completely and accurately referenced in the list of references.

DEDICATION

This dissertation is dedicated to my sister Lizelle Hattingh and my mother Charlotte Hattingh

PREFACE

This dissertation is presented in article format as approved by the North-West University. The dissertation consists of an introduction, motivation, methodology and a 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 a consideration of ethical principles throughout the research process.

Chapter 2: Author's guidelines for the journal article for submission and continues into an abstract, introduction, method, research findings, discussions, and conclusion.

Chapter 3: The evaluation, limitations, and recommendations of the study. The results are presented and analysed.

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 (scientific journal).

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I want to thank my heavenly Father for his grace in this difficult time. This research was truly a struggle but rewarding in the end. I remember Prof. P Bester mentioning at the beginning of this study: “never expect that everything will be smooth sailing... as life happens”. This is precisely what happened. Not only did I experience personal health issues, but there was a global pandemic and death in the family. My passion for mental health started when I was busy with my Bcur. I became a manager but my passion for mental health remained. In 2008, my sister Lizelle tried to commit suicide and that reawakened my passion. She survived, but her life was a constant struggle between happiness and survival, resulting in alcohol addiction. On 28 October 2022, she sadly passed away due to poor health. I hope that focusing on mental health promotion will prevent these types of sad endings. I strongly believe that mental health promotion should start from childhood and be a continuous, intentional action that is not just a paper exercise but is actively enforced.

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The intersectoral team members in the Cape Agulhas sub-district for their valuable perceptions in this research and their passion and commitment despite obstacles and challenges.

ABSTRACT

Key terms: Mental health, mental health promotion, primary prevention of mental disorders, intersectoral collaboration

Mental health and health promotion are in a dire state worldwide. Urgent action is required to ensure that mental health does not further cripple an already overburdened mental health system, specifically in South Africa. For the sub-district of Cape Agulhas in the Western Cape Province, mental health promotion is a challenge due to a lack of resources exclusively available for mental health and a curative focus on treating mental illness rather than preventing and promoting mental health. Intersectoral collaboration in rural districts is essential to promote mental health in the Cape Agulhas sub-district. However, there is a lack of published literature on the intersectoral team members' knowledge of mental health promotion, specifically in the Cape Agulhas sub-district. Therefore, the need for a qualitative study to help unpack the intersectoral team members' knowledge of mental health promotion in the Cape Agulhas sub-district was identified. This led to the research questions “what is the intersectoral team members' understanding of mental health promotion, and what are their recommendations for a mental health promotion program in the rural Cape Agulhas sub-district of the Western Cape.”

A qualitative descriptive design was used to gather data on an intersectoral team's knowledge regarding mental health promotion. This approach enabled a straightforward yet rich description. Data collection included online asynchronous semi-structured interviews combined with photographs through the social media communication application of WhatsApp. Ethical clearance was obtained from the Health Research Ethics Committee of the Faculty of Health Sciences, North-West University (NWU-00477-20-S1). In addition, the researchers obtained permission from the Western Cape Department of Health, the Department of Education, the Department of Social Development, and the Cape Agulhas Municipality.

Four (4) themes, 13 categories and 41 sub-categories emanated from the data and the categories were also mapped to the Socio-ecological Model (SEM) of Stokols (1996:285). The results indicate that the intersectoral team in the Cape Agulhas sub-district tended to have reasonable knowledge of which inter-and intrapersonal dynamics are required for a mentally healthy person. The four themes identified were i) the dynamics of a mentally healthy person, ii) an inclusive mental health system, iii) Mental health promotion and education, and iv) leaders should be knowledgeable regarding mental health with a platform to share. It was clear, however, that the intersectoral team's knowledge of the social determinants of mental health and their role in addressing these to ensure mental health promotion as leaders in the community was lacking. All

the photos that were acquired through photovoice confirmed this statement. A unique finding from the data is that the intersectoral team expressed a need for training to act as leaders in promoting mental health, particularly in a rural context. They also indicated a need for training and education regarding the social determinants of health and how these impacts mental health promotion.

ABBREVIATIONS

AUTHeR	Africa Unit for Transdisciplinary Health Research
CA	Cape Agulhas
COPC	Community-orientated primary care
DoE	Department of Education
DoH	Department of Health
EVD	Ebola Virus Disease
DSD	Department of Social Development
HP	Health promotion
HREC	Health Research Ethics Committee
ICT	Information Communication Technology
LMIC	Lower middle-income country
NCD	Non-communicable disease
NDoH	National Department of Health
NGO	Non-governmental organisations
NHI	National Health Insurance
NHPPS	National Health Promotion Policy and Strategy
PGWC	Provincial Government Western Cape
PHC	Primary health care
QR	Quick response
SA	South Africa
SAP	South African Police

SDH	Social determinants of health
StatsSA	Statistics South Africa
SEM	Socio-ecological model
WC	Western Cape
WHO	World Health Organization

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CHAPTER 1 RESEARCH PROTOCOL

1.1 Introduction and overview

There are many mental health challenges in South Africa due to the increase in mental disorders. These disorders could be linked to the inequalities in the social determinants of health like poverty, unemployment, violence, substance abuse, and other differences between communities (World Health Organisation, 2022:xiv; World Health Organisation & Calouste Gulbenkian Foundation, 2014:17). Social determinants of health are those aspects in life that affect individuals, families, and communities adversely and can lead to mental illness (Compton & Shim, 2020:215; World Health Organisation, 2022:20-23). South Africa faces a quadruple burden of disease related to poverty, which include non-communicable diseases (also referred to as chronic diseases), injuries, and communicable illnesses, human immunodeficiency virus (HIV) and tuberculosis (TB) (Department of Health, 2014:8; Samodien *et al.*, 2021:32). The burden of commonly diagnosed mental disorders such as anxiety, depression and psychoactive substance or alcohol abuse cohorts can exacerbate other chronic diseases in low- and middle-income countries (Massyn *et al.*, 2020:123; Petersen *et al.*, 2019:32; Samodien *et al.*, 2021:32).

The presentation of mental illness together with other chronic diseases complicates treatment (Department of Health, 2013). With the onset of a mental disorder, options are limited and treatment does not necessarily change the course of the illness (Millan *et al.*, 2016; Samodien *et al.*, 2021). Comprehensive service delivery cannot be offered by concentrating on curative measures only (Bailey *et al.*, 2017; Petersen *et al.*, 2019). Fusar-Poli *et al.* (2019:1303) propose a shift in focus from treating mental disorders to promoting mental health. Health promotion has been a global focus since the Ottawa Charter in 1986. In the South African context (Department of Health, 2014:17), a health promotion strategy and policy was developed but mental health promotion was limited to pregnant mothers, children under five, older people, and vulnerable groups. Treating the complexity of mental health requires a physical, psychological, and social approach that will promote, protect, and restore mental health during a person's lifespan. It will require partnerships with different stakeholders as some of the social determinants of mental health are located outside the health sector (World Health Organisation, 2008; World Health Organisation, 2013a:5).

Intersectoral collaboration is a governmental strategy that endeavours to establish universal health care, but it will fail if it is not supported on the rural sub-district level to address health inequities (World Health Organisation, 2008:4). Intersectoral collaboration in mental health promotion on the sub-district level in South Africa is underestimated and implementation has thus

far failed (Babatunde *et al.*, 2022:45; World Health Organisation, 2008:3). Many obstacles diminish the focus on mental health promotion. This research explores mental health promotion from an intersectoral team's perspective.

1.2 Background of study

1.2.1 Increased prevalence of mental illness

Mental illness is increasing worldwide and is burdening the already strained health system (World Health Organisation, 2017:5; World Health Organisation, 2022:xiii). The World Health Organization (WHO) identified the most common mental disorders as depressive and anxiety disorders, with 280 million people living with depressive mood disorders and 301 million people living with anxiety disorders in 2019 (World Health Organisation, 2022:40). Anxiety disorders have increased by 14.9% worldwide from 2005 to 2015, with an estimated 264 million people suffering from anxiety globally (World Health Organisation, 2017:11). Of the 970 million people living with mental disorders, 82% are living in low- to middle-income countries (LMICs) (World Health Organisation, 2022:40). In Africa, approximately 29 million cases of depression and 26 million cases of anxiety disorder were reported for the year 2015 (World Health Organisation, 2017:8). A stress and health study conducted in 2004 found that South Africa had a high prevalence of anxiety disorders at 8.1%, as well as mood disorders (Stein Dan *et al.*, 2009). According to a mental health report that targeted the online community in South Africa, 11 887 people took part in an online assessment tool called the Mental Health Quotient in which the country scored 46%, the lowest score (Newson *et al.*, 2021:15). Data on mental health issues are not easily obtainable and are not included in the key performance indicators report of public health services in South Africa (Bimerew *et al.*, 2014:445; Docrat *et al.*, 2019:708; Massyn *et al.*, 2020:150; Massyn *et al.*, 2017:22).

1.2.2 Mental health promotion as a strategy to improve mental health

Health promotion was defined in the Ottawa Charter as the process of “enabling a person to increase control over and to improve their health and to reach a state of complete physical, mental and social wellbeing” (World Health Organisation, 1986:1). Health is a person's ability to function in society and be able to lead a productive life, which includes working, socialising and making a positive contribution in the community in which they live (World Health Organisation, 2005:12). In 2017 the world again pledged its allegiance to health promotion with the Shanghai Declaration, stressing the importance of using the key pillars of health promotion, namely good governance for health, healthy cities, social mobilisation and health literacy (World Health Organisation, 1986:4). In South Africa the planned National Health Insurance (NHI) system's focus is on

universal health coverage, leaving health promotion on the back burner. This despite its importance in improving health and mental health (Coe & de Beyer, 2014:11).

Factors that reduce the success of health promotion strategies in Africa are weak leadership and stewardship, reduced involvement of role players in health promotion and a lack of evidence that campaigning activities are effective (Coe & de Beyer, 2014:17). This is in addition to the fact that mental health promotion budgets are restricted or non-existent, and human resources for the development of health promoters are lacking (Coe & de Beyer, 2014:17).

1.2.3 South African mental health policy

Mental health care was deinstitutionalised and integrated with the primary health care (PHC) service package in 2004 to address the lack of resources (Petersen *et al.*, 2009:147). The Mental Health Plan 2013–2030, published in 2013, identified mental health as a national priority with a specific focus on mental health promotion activation across all sections and governmental departments (Department of Health, 2013:3; World Health Organisation, 2013b:16). The DoH's health policy and strategic plan for 2013–2020 emphasised mental health as a vital part of health and focuses on the re-engineering of PHC, the implementation of NHI system, human resource development, and infrastructure revitalisation that is echoed across political, financial and departmental spheres (Department of Health, 2013:3).

1.2.4 Policy implementation failures

In sharp contrast to the official policy, in a 2017 cost-cutting measure, the Gauteng DoH transferred 1 400 patients from Life Esidimeni psychiatric institutions to unregistered NGOs when their contract expired in 2016, resulting in 144 deaths (Lund & Docrat, 2019:3; Nwachukwu & Segalo, 2018:11237). This illustrates that focusing on mental health treatment remains a lesser priority. The South African strategy remains reactive where mental health is concerned (Lund & Docrat, 2019:3). Butcher and Gilchrist (2020:4) stated that the reactive nature of public policies often interferes with finding better ways of doing things in practice, e.g., programmes, services etc. The availability of beds in psychiatric hospitals is limited partly due to the extended stay of these patients and poor resource management as reported in hospital key performance indicators (Lund & Docrat, 2019:3). The average length of stay in a psychiatric hospital is 157 days, with a readmission rate of one in four patients post-discharge (Lund & Docrat, 2019:3). The majority of the mental health budget (86%) is spent on inpatient care (Docrat *et al.*, 2019:706; Lund & Docrat, 2019:3). The remainder is spent on outpatient care, with little or no funds allocated for mental health promotion by the National DoH (Docrat *et al.*, 2019:717). To improve universal health coverage, South Africa released a bill on the NHI system. The NHI system (2019:20) provides for

health promotion activities, with no clarification on whether the focus will be exclusively on physical health promotion or if mental health promotion is included in the health promotion package.

1.2.5 South African mental health reports

In South Africa, PHC mental health data are fragmented, incomplete, and unreliable and can therefore not be used to make clear decisions regarding mental health services (Bimerew, 2019:7; Massyn *et al.*, 2020:150). The annual District Health Barometer reports on mental health in the non-communicable disease chapter but mental health reports were incomplete and did not give a true reflection of the mental health patients being seen in the PHC system (Massyn *et al.*, 2020:148). Massyn *et al.* (2020:153) suggest that mental health data quality and completeness must improve to evaluate the impact of the integration of mental health in PHC services. The key performance areas that were measured were the number of new mental health patients seen in PHC compared with other chronic diseases (Massyn *et al.*, 2020:148). In South Africa, 0.4% of patients seen at PHC were patients with new mental health disorders but no data were submitted from the Western Cape (Massyn *et al.*, 2020:148).

The 2017/18 District Barometer focused on the rising cost of mental health services in the PHC field, which was R911 137 712 for a headcount of 1 756 514 patients, with an expenditure of approximately R539 per patient per month (Massyn *et al.*, 2017:411). In contrast, a study conducted by Docrat *et al.* (2019:3) found that in the year 2016/17, South African mental health patient costs increased to R615.3 million for in- and outpatients, representing 5% of the overall health budget. Medical aid patients with major affective disorders, including unipolar and bipolar depression, had the highest expenditure outside the hospital, resulting in R5.6 million respectively to coincide with treatable diseases like hypertension (Council for Medical Schemes, 2018:140). Due to the poor measurement of mental health indicators in South Africa the real burden and impact of mental health issues on the chronic disease profile is concealed (Massyn *et al.*, 2020:260).

In the Western Cape, the leading mental health disorders presented were anxiety disorders at 18.9%, mood disorders at 13.7%, and substance use disorders at 20.6% (Stein Dan *et al.*, 2009:342). Data on the burden of mental illness in the Western Cape is outdated and the limited measurement of mental health key performance areas is indicative of the lack of focus on mental health in the Western Cape (Jacob & Coetzee, 2018:81). Mental illness furthermore increases the burden on families and there are limited resources and finances allocated in South Africa for mental health (Department of Health, 2013:12; Petersen *et al.*, 2016:29). Mental illness remains a significant burden of disease and has links with chronic conditions in South Africa (Massyn *et*

al., 2020:123). The stigmatisation, judgement, and rejection that people with mental health disorders receive, cause them to rarely seek help, which can also influence mental health statistics (French *et al.*, 2018:81). There is a direct relationship between unhealthy behaviours like poor diet, physical inactivity, and mental disorders. This in turn contributes to an increase in chronic conditions like cardiovascular diseases, hypertension, and diabetes, which highlights the complexity of the effect of mental health on the physical aspect of a person (Berenguera *et al.*, 2017:897; Ellis *et al.*, 2017:2; Mnookin, 2016:5). These secondary chronic diseases shift the attention from mental health promotion to a curative focus on cardiovascular diseases, hypertension, and diabetes.

1.2.6 Social determinants of mental health

The World Health Organization and Calouste Gulbenkian Foundation (2014:17) identified social determinants that can be used to reduce the risk of developing a mental disorder and promote a person's mental health. These social determinants are evident in a person's life and are influenced by parents, families, or households in which a person lives within a community with certain services available in a rural or metro area (World Health Organisation & Calouste Gulbenkian Foundation, 2014:17). Petersen *et al.* (2012:412) emphasised biological, genetic, interpersonal, environmental, political, economic, social and cultural factors, which are either risks or protective factors for mental health. Poverty, alcohol and drug abuse, low educational levels, work difficulties, unemployment, violence, and being disadvantaged individuals during the apartheid regime in South Africa, are also stressors associated with poor mental health and can exacerbate mental illness (Bährer-Kohler & Carod-Artal, 2017:36; Department of Health, 2013:12). These statistics are emphasised in the General Household Survey of 2018, which indicates that 13.1% of households still live in informal settlements, while 31% people benefited from a social grant (Statistics South Africa, 2019). Holmes *et al.* (2020:1083) emphasised that if a patient's social determinants are not considered it can lead to mistreatment, misdiagnosis and harm to the patient.

1.2.7 Rural mental health

"Rural" can describe an environment in terms of ecological, occupational, and sociocultural contexts. Geographically, it is considered a vast area with a large spatial proportion, where the population is small and relatively far from an urban centre (Vergunst, 2018:1). Income is generated for this population mainly from farming, fisheries, forestry, and the population is characterised by unique cultural norms and values specific to the area (Vergunst, 2018:1). South African rural health services is built around a spatial and hierarchical logic with primary, secondary and tertiary health care (Neely & Ponshunmugam, 2019:220). The most basic care is delivered

at the primary level, which offers a nurse-based service at clinics and a doctor-driven service at the district hospital. Advanced-level care is provided by specialists in urban areas. Mental health services were built around tertiary hospitals in urban areas, neglecting the rural areas plagued with access problems like lack of transport, scarce human resources, and poor supply of medication (Neely & Ponshunmugam, 2019:218; Rural Doctors Association of Southern Africa, 2015:iv).

1.2.8 Intersectoral collaboration

Collaboration across different departments and community participation were identified as factors that could enhance mental health promotion and would assist in reaching all people with the stressors that can lead to or contribute to mental disorder (Bährer-Kohler & Carod-Artal, 2017:82; Bteich *et al.*, 2019:253; Petersen *et al.*, 2016:32; Petersen *et al.*, 2017:704). Collaboration can provide opportunities where top-down and bottom-up approaches can meet and more creative solutions can be found to address complex problems like mental health promotion (Butcher & Gilchrist, 2020:6). This is true in the South African context where so many social determinants exist that affect mental health. The intersectoral collaboration team approach is essential in preventing mental disorders, building mental health resilience, and contributing to the individual's ability to thrive (Bährer-Kohler & Carod-Artal, 2017:193; Fusar-Poli *et al.*, 2019:1308; Titova *et al.*, 2018:211). An intersectoral collaboration approach in mental health promotion will further prevent fragmentation and ensure lasting partnerships across disciplines, professionals, non-professionals, and non-governmental organisations (Butcher & Gilchrist, 2020:7; World Health Organisation, 2015:9). Intersectoral collaboration practices aim to place the patient and the community at the centre and to surround them with services beyond the health care sector, thus ensuring comprehensive mental health promotion at the individual, environmental, organisational and community levels (Stokols, 1996:283; World Health Organisation, 2015:12). The optimal division of PHC responsibilities at the sub-district level should be aligned with the primary care needs of the community. These include but are not limited to patients, family, physicians, mid-level providers, nurses, behavioural health staff, public health staff, pharmacists, medical assistants, office staff, lay health workers and community members (Ruddy & Rhee, 2005:251). Bährer-Kohler and Carod-Artal (2017:82) identified the intersectoral team as including local government agencies, political parties, traditional rulers, schools, social welfare, non-governmental organisations, and mental health specialists. Mental health also includes spirituality, which is known to have a positive effect on health outcomes, therefore spiritual leaders also form part of this team (Damari *et al.*, 2018:145). In this research, the team will include teachers, health care workers, health care counsellors, spiritual leaders, non-profit organisations operating in the community, ward counsellors, and social workers.

1.2.9 COVID-19 and mental health

On 23 March 2020, South African President Cyril Ramaphosa announced a nationwide lockdown from midnight on the 26th of March 2020 due to the coronavirus pandemic (Mogomotsi & Meldrum, 2020; South African Government News Agency, 2020). The measures taken to prevent the spread of the outbreak worldwide – isolation, social distancing and quarantine – had detrimental effects on some people’s mental health (Baker & Clark, 2020:237; Haider *et al.*, 2020:s-1). Studies have shown that there is an increase in symptoms like anxiety and depression (Baker & Clark, 2020:237; Soraci *et al.*, 2020:8). With the outbreak of epidemic diseases like Ebola Virus Disease (EVD), studies have shown that symptoms like depression and posttraumatic stress disorders were more prevalent after the epidemic (Rabelo *et al.*, 2016:5). In research done after the EVD outbreak, suggestions were made that there should be a mental health promotion plan addressing the specific mental health of the community after an epidemic (Cénat *et al.*, 2020:19) In the Western Cape, the human resources were channelled to COVID-19 testing and tracing, meaning that mental health services were pushed to the back burner (Massyn N *et al.*, 2020:269). This resulted in reduced PHC headcounts and poor mental health service delivery in the Cape Agulhas sub-district.

1.3 Problem statement

Despite the policy and strategy on health promotion and the mental health policy framework of South Africa, mental health promotion is still neglected. Mental health promotion and primary prevention of mental disorders for at-risk populations in rural areas can break the cycle of mental illness and positively affect a person’s physical health (Petersen *et al.*, 2012:411). The rural sub-districts’ lack of human resources affects mental health promotion programmes (Rural Doctors Association of Southern Africa, 2015:8). The COVID-19 pandemic is not the focus of this research. Still, it highlights the importance of mental health promotion. The primary prevention, or lack thereof, of mental illness as the pandemic progressed had long-term consequences for the community’s mental health (Xiang *et al.*, 2020:2). This pandemic influenced and enhanced social determinants contributing to mental disorders as it directly affected the economic profile of the community. Mental health promotion and support after a disaster or significant event that affects communities have proven to improve mental health and build the community’s resilience (Herrman, 2012:86). Social determinants that influence mental health are located outside the health sphere. Therefore, intersectoral action on mental health promotion is needed (World Health Organisation & Calouste Gulbenkian Foundation, 2014:6). The focus on mental health promotion is significant to ensure that the long-term mental health of this rural community receives attention and is strengthened. This cannot happen if departments and organisations operate in silos.

Therefore, the research is imperative to explore the intersectoral team members' knowledge of mental health, how they would perceive mental health promotion and identify existing resources in their community that can help with mental health promotion.

1.4 Research question

This study aims to address the following research question: What is the intersectoral team members' understanding of mental health promotion and what are their recommendations for a mental health promotion programme in the rural Cape Agulhas sub-district of the Western Cape province?

1.5 Research aim

This research aimed to explore intersectoral team members' understand of mental health promotion and their recommendations for a mental health promotion programme in the rural Cape Agulhas sub-district of the Western Cape.

1.6 Theoretical departure of the research

Stokols' theoretical model was used for this study, namely the social-ecological approach to health promotion (1996:287). According to this model, there are multiple social determinants that influence mental health. These factors interlink within the individual as well as between spheres. Mental health and mental health promotion are influenced by factors that can be grouped into four spheres:

- Individual factors or characteristics that can influence behaviour and include aspects of the individual relating to their biology, like age, sex, hereditary factors, lifestyle factors, skills, knowledge, motivation, spirituality, attitude.
- Social and community networks that determine the individual's relationship with others and social support. This depends on a person's communication, trust, understanding, peer influence, gender equity, and bounded normative experiences, and is influenced for example by child-headed households, large families, separated or divorced households, single-parent households, pensioners.
- Community relating to the individual's environmental sphere as it affects their living and working conditions. This includes factors like work environment, education, agriculture, transportation, health care services, food production, unemployment, water, sanitation, and housing; and

- Societal factors including but not limited to strengthened health systems, ensuring that PHC facilities offer a full package of services, access, community engagement, responsiveness and knowledge transfer.
- Each sphere refers to dimensions of self-esteem, which together influence mental health promotion in a positive or negative manner. Figure 1.1 provides an overview of how these spheres interlink.

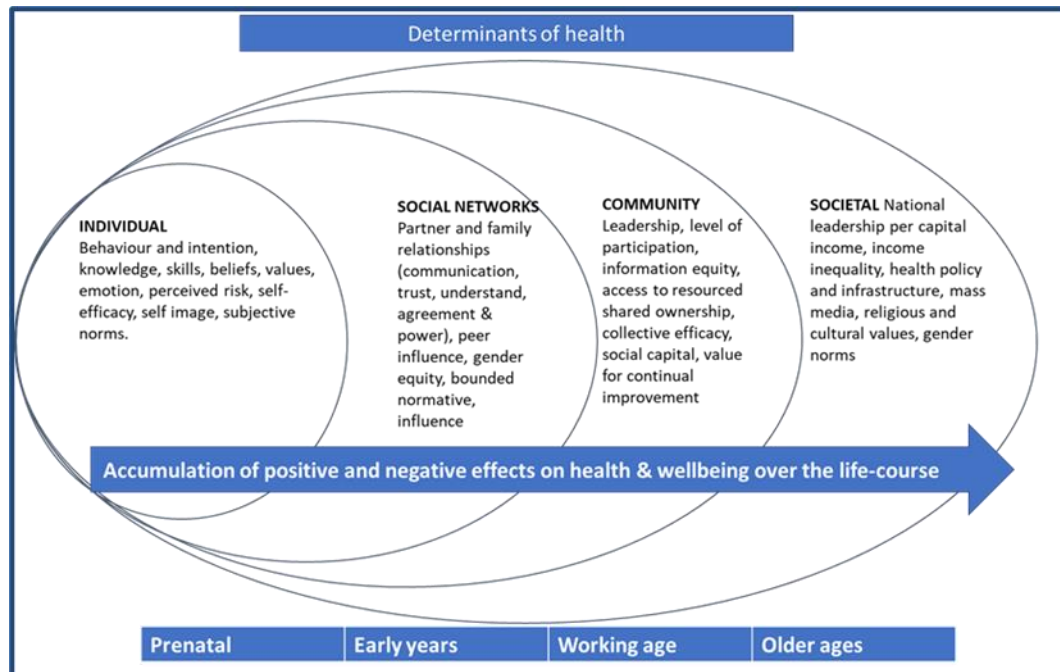


Figure 1 Multi-level interactive influences on mental health and social ecological approach

1.7 Definition of key concepts

The following key concepts are relevant to this study.

1.7.1 Mental health

According to the WHO, there can be no health without mental health and is seen as a basic human right (World Health Organisation, 2005:10; World Health Organisation, 2022:11). Mental health is more than the absence of mental illness. It underlines the link to physical health and behaviour (World Health Organisation, 2005:12). Mental health refers to the ability of people to cope, connect, function and thrive with daily challenges and the effective management of internal and external stressors in everyday living (Uys & Middleton, 2014:830; World Health Organisation, 2022:11) whereby the individual works at and resolves conflict within their cultural norms

(Townsend & Angelo, 2015:907). A mentally healthy person can be seen as someone who flourishes mentally and socially despite their circumstances (Keyes, 2002:907). The United Nations Children Fund (2018:9) define mental health as an interaction between physical, social, cognitive, emotional, and spiritual elements. Mental health is essential for the person, their family, and their community to ensure a productive individual who experiences a quality life and as a result, adds value to the community (World Health Organisation, 2005:10; World Health Organisation, 2022:12)

1.7.2 Mental health promotion

Health promotion is an empowering process to assist people in taking responsibility for their own physical and mental health (World Health Organisation, 1986:2). Mental health promotion refers to actions or interventions that will lead to the status of good mental health and shift the community's risk profile (World Health Organisation, 2022:151). In the Ottawa charter (World Health Organisation, 1986:3; World Health Organisation, 2005:17), actions referred to public policy regarding health promotion, ensuring a supportive environment for health, strengthening community action, developing skills, and reorganising health systems. Mental health promotion is aimed at creating a healthy community in which people can function despite adversity while using their skills to cope with daily stressors responsibly, not ignoring their thoughts and feelings but resiliently adapting and managing them (World Health Organisation, 2005:26; World Health Organisation, 2022:11). Mental health promotion is the development and strengthening of these attributes and skills in individuals throughout their lifespan while improving and/or eradicating the detrimental organisational, social and environmental factors that may affect mental health (World Health Organisation, 2022:151)

1.7.3 Primary prevention of mental disorders

Petersen *et al.* (2014:120) define primary prevention as universal, concentrating on reducing the onset of mental disorders by focusing on the whole community. This overlaps with mental health promotion in the sense that the focus is to minimise social determinants that can lead to mental disorders by strengthening optimal mental health and protective factors in the community (Petersen *et al.*, 2014:120; World Health Organisation, 2022:149).

1.7.4 Intersectoral collaboration

Intersectoral collaboration is applied in policy and action where a problem or issue involves the whole community and therefore needs collaboration across entities and departments to ensure good effective outcomes (Dennill & Rendall-Mkosi, 2012:13; World Health Organisation, 2015:4).

This includes linking or sharing information, resources, activities, and competencies to achieve a goal, which a single department or organisation could not reach on their own (Butcher & Gilchrist, 2020:1). Each department and entity has different resources that can add value to improve mental health promotion in a sub-district (Dennill & Rendall-Mkosi, 2012:13). To reach optimal mental health promotion in a sub-district with limited resources and to address the rising pressure on the health system, more countries adopt the intersectoral collaborative approach to health care.

In the following section, the aim and objective of the research are outlined.

1.8 Methodology

1.8.1 Research design

A qualitative descriptive design was used to gather data on mental health promotion (Sandelowski, 2000:80). According to Sandelowski (2000:80), a qualitative descriptive design is a factual perspective of data that is an accurate and honest reflection of reality. The results displayed perspectives and events that convey the truth about the understanding of intersectoral team members' understanding of mental health promotion in the rural Cape Agulhas sub-district of the Western Cape. The main purpose of this qualitative design was to generate a transparent description of the participants' perceptions and recommendations in words similar to those of the participants, truthfully and accurately (Sandelowski, 2000:336; Wood & Kerr, 2011:115).

During the social distancing protocol and 'stay-home' campaign under levels three and four lockdown in South Africa to address the COVID-19 pandemic and the resulting state of disaster, the researcher had to adhere to the regulations. Still, qualitative research continued with a different method of data collection (South African Government, 2020). The data collection plan was adapted to an online asynchronous elicited and enacted qualitative research method (Salmons, 2016:33). Elicited asynchronous communication means that participants were able to respond to text messages at their convenience as there was a time-response gap (Salmons, 2016:45). Enactment requires an action from the participant, which makes them a collaborator in the research and to elicit an even richer context for this research (Salmons, 2016:148). Enactment in some ways replaces the fieldnotes that give richer context during more traditional qualitative methods (Salmons, 2016:8). Enacted asynchronous research is also known as the photovoice or photo-elicitation method (Wass *et al.*, 2020:2). In photovoice research the researcher gives the participant specific prompts and allows inspired data to emerge from these prompts (Salmons, 2016:216). To reach the community the researcher used the WhatsApp mobile application. WhatsApp is an American freeware application that is an inexpensive and familiar communication application for smartphones in this community (Koum & Acton, 2020:1). In this research a

smartphone was referred to as a mobile device with additional software functions that have internet connectivity capability and can be used to take and send photos (Tsai & Ho, 2013:1248). The researcher took into consideration the positive and negative impact that online research would have on this research under the risk and beneficence heading 8.1.6.

1.8.2 Study context

1.8.2.1 Demographic context

The study was conducted in the Western Cape province of South Africa. The Western Cape has six districts. Overberg forms part of one of these districts and consists of seven towns and two rural settlements. The sub-district covers approximately 2 411km², which is a vast demographic in which mental health promotion must be offered (Vergunst, 2018:1). As per the Social Development 2018 projections, the Cape Agulhas sub-district population included 35 143 people and households (Cape Agulhas Municipality, 2021:13). The predominant language in the municipal area is Afrikaans spoken by 27 508 people followed by isiXhosa, spoken by 1 951 people and English by 1 828 people (Cape Agulhas Municipality, 2020:12). The researcher wanted to use the Cape Agulhas rural sub-district of the Western Cape as rural areas have inadequate human resources where mental health is concerned and relies on the intersectoral team to address problems in the communities (Rural Doctors Association of Southern Africa, 2015:15). Mental health promotion is not addressed adequately and lacks impact due to the lack of human resources (Hlongwa & Sibiyi, 2019:5; Petersen *et al.*, 2009:146). The population is the intersectoral team within the Cape Agulhas sub-district of the Western Cape and is discussed in detail in 6.2.1.

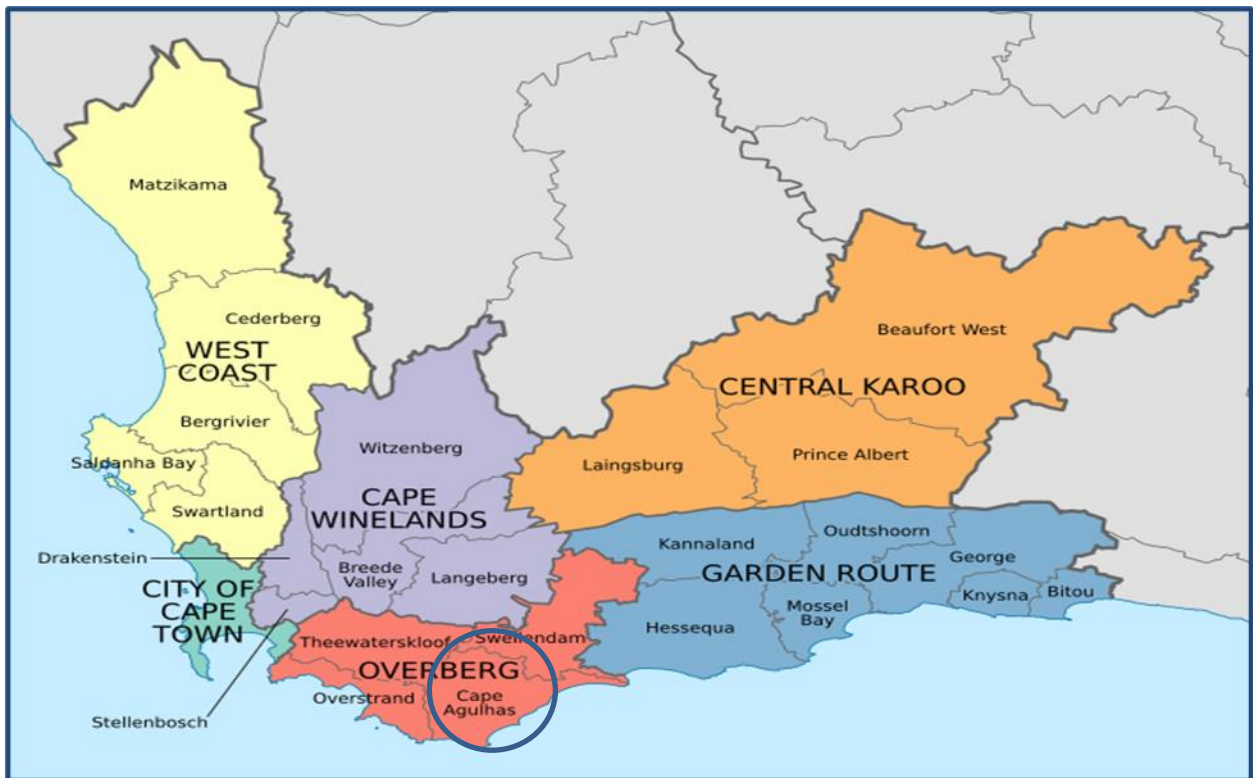


Figure 2 Area where research was conducted

1.8.2.2 Information communication technology (ICT) milieu

ICT is an electronic milieu for research and data collection (Salmons, 2016:36). As stated above, the ICT milieu the researcher has chosen is a mobile application called WhatsApp, which is used extensively in the community under study. However, exact statistics are difficult to obtain. In South Africa, there are 98 million mobile connections. This means that 170% of the population has smartphones, of which 84% uses prepaid mobile connections. This made it possible to do the research using this ICT, as each participant has their own smartphone which has WhatsApp and can take photographs (cited by Mwaura *et al.*, 2020:2072). The statistic of 170% of the population having smartphones suggests that some people have more than one smartphone in their possession (cited by Mwaura *et al.*, 2020:2072). Nine out of ten South-Africans make use of WhatsApp as a communication medium which ensure that most South African's are familiar with this software and were able to use it during the data collection phase (cited by Mwaura *et al.*, 2020:2072). Smartphones have been proven to provide data collection opportunities and improve health care in rural areas of South Africa (Twis *et al.*, 2020:50; Watkins *et al.*, 2018:145). During the Ebola epidemic in Sierra Leone in 2014, WhatsApp was used to spread information and also used to support communities during this crisis by encouraging them to share their experiences online (Berman *et al.*, 2018:8). Furthermore, the privacy of WhatsApp on a smartphone includes 'end-to-end' encryption, which ensures that only the researcher and the participant will see the

messages between them (Koum & Acton, 2020). WhatsApp is also one of the most inexpensive forms of communication in South Africa with all networks providing WhatsApp data bundles to customers so that they could communicate. WhatsApp Business was used as it has advanced features that can manage conversations. This application can be downloaded onto a personal computer which helped with the downloading of interviews to ensure privacy and data collection.

1.8.3 Population and sampling

1.8.3.1 Population

A population can be defined as the members of a defined group (Brink *et al.*, 2012:131; Gray *et al.*, 2017:53; Polit & Beck, 2012:59). The target population was intersectoral team members focusing on the social determinants of the community in the rural Cape Agulhas sub-district of the Western Cape. The population was determined according to the involvement of the indicated population in the social determinants influencing mental health in the Cape Agulhas sub-district and who would have the power to change these social determinants. The Department of Health and Social Development cannot take sole responsibility for all the social determinants affecting mental health (Skeen *et al.*, 2010:612). Intersectoral collaboration has been effective in policy formulation but is still ineffective at the district level (World Health Organisation & Public Health Agency of Canada, 2008:2). It has been proven that intersectoral collaboration can be effective in addressing social determinants affecting mental health (Skeen *et al.*, 2010:611). In the research done by Skeen *et al.* (2010:611), the following intersectoral team was interviewed for their role in mental health: the Department of Labour, Department of Education, Department of Social Development, South African Police Services, Department of Justice, Department of Housing, Local Government, Department of Transport. The intersectoral collaborative team members consisted of professionals and non-professionals working in the Cape Agulhas sub-district. The preference for participants in this research were for people helping and developing individuals in all stages of life from conception, prenatal, childhood, adolescence, adults and older persons living and working in Cape Agulhas sub-district, and who have influence in their community (Petersen *et al.*, 2012:412-414). As the duties of the local government in the sub-district involves addressing the social determinants of mental health, they will replace some of the intersectoral team mentioned above. Intersectoral team members from health, education, welfare, municipality, non-profit organisations, the community, spiritual leaders, and other voluntary groups were approached for participation in the study.

1.8.3.2 Sampling

A sample refers to a subset of the accessible population that for this study was willing to be interviewed online through written text messages (Asiamah *et al.*, 2017:1609; Dejonckheere *et al.*, 2019:3; Gray *et al.*, 2017:53). Here it represented the intersectoral team members in the Cape Agulhas sub-district who signed the informed consent document as an indication that they would like to participate in the research voluntarily. A sampling plan comprises a sampling method, sampling size, and a procedure to recruit participants (Moser & Korstjens, 2018:10). The researcher, a health professional, works at the local hospital in the Cape Agulhas sub-district and had indirect access to these members within reason. The researcher was therefore seen as an 'insider', which is known as the emic approach and made recruitment of online participants easier (Salmons, 2016:101).

Sampling technique: A purposive sampling method in combination with quota sampling was used (Botma *et al.*, 2010:201). The researcher wanted to ensure that the participants were knowledgeable and passionate about mental health promotion. She also wanted to ensure that each intersectoral team was equally represented (Botma *et al.*, 2010:201). The sampling technique in this research was a rational decision. The permission of gatekeepers in the province was requested, including the district and the sub-district into which the Western Cape demographic is divided. Should there not have been enough participants, snowball sampling would have been used to reach an equal representation of the intersectoral team (Botma *et al.*, 2010:201).

The researcher: The researcher used an emic approach to the research, namely an insider approach, as she had inside knowledge of the departments and entities she used in the research (Salmons, 2016:100). This helped her gain access through the gatekeepers. The researcher remained impartial and objective. Objectivity and impartiality were established by using a research assistant during the recruitment and selection process. The researcher ensured that the communication regarding the research was clear and unambiguous. After obtaining ethics approval from the Western Cape Provincial Health Research Committee (WCPHRC) via the National Health Research Department (NHRD) website, the researcher approached the district management team of the organisation and management at the sub-district level of each organisation and obtained goodwill permission. Clear communication with the management team on the district and the sub-district levels was essential to establish transparency. The researcher ensured that she got all relevant email information and telephone numbers of the gatekeepers. An email was compiled, which included a cover letter indicating the nature of the research, what impact it would have on their services and participants, and the ethics approval letters (North-

West University Health Research Council, 2018). Rules, regulations, and ethics of the NWUHRC and each organisation was taken into consideration during the research process.

The gatekeeper: The gatekeeper has value as the person plays a role in ensuring quality research (Singh & Wassenaar, 2016:45). A gatekeeper is someone who controls the access to a defined group and can therefore grant or deny access to their personnel (Singh & Wassenaar, 2016:42). Gatekeeper permission for this study was multi-layered. Access was requested at the district and the sub-district levels as an intermediate gatekeeper by emphasising the value of the research for the community and the possible impact it would have on their services (Singh & Wassenaar, 2016:43). The researcher understood the internal operational hierarchy and professional etiquette of the different entities and approached each management team for goodwill permission. The management functioned as the gatekeeper in the Cape Agulhas sub-district (Singh & Wassenaar, 2016:43). Informal access and cooperation were obtained by respecting the conditions under which access was granted and the researcher maintained professional objectivity even if the gatekeeper was known to her (Singh & Wassenaar, 2016:43). The researcher compiled a letter with the relevant information regarding the mental health promotion research and the potential value it could have for the community in Cape Agulhas sub-district of the Western Cape. This was supplemented by a good, summarised version of what the research entailed on a PowerPoint presentation. The researcher sent an email to the gatekeeper and made an appointment for a telephone discussion within 48 hours after the email was sent and discussed the research with the gatekeeper at a pre-established time to establish rapport. The gatekeeper was allowed to ask questions to clear up any reservations or unclear messages. The researcher's communication was clear and indicated what impact this research could have on their services. This gatekeeper had the opportunity to participate if they liked to and could be included in determining the inclusion criteria (Botma *et al.*, 2010:201). The gatekeeper was requested to disseminate the information regarding the research to the facilities in their care. They were asked to identify a contact person at each facility that the independent person appointed by the researcher could contact regarding the research. The independent person was appointed by the researcher and considered neutral in the research study.

The independent person: This is a third person and is a 'bridge maker' between the participant and the researcher's needs. The independent person was appointed as research assistant affiliated with the university. The assistant ensured that the researcher gains credibility by staying impartial and ensuring that participants feel safe had they refused to take part in the research. After access was granted by the gatekeepers, the gatekeeper was contacted telephonically for names, contact numbers, and email addresses of the potential participants. Their names and contact details were given to the independent person. The research assistant contacted potential

participants to ensure that the participants being selected were knowledgeable and complied with the inclusion criteria for the research and would provide rich data. The independent person shared their knowledge of what the research entailed but also ensured that the participant's right to refuse was protected (Marshall & Hurworth, 2010:142).

The participants: This subsection of the community includes professionals and non-professionals working with people (Petersen *et al.*, 2012:412) as part of the following management teams in the sub-district: Department of Health, Department of Education, Department of Social Development, NPO organisations like the ACCV, health and welfare organisations, spiritual leaders of local churches, the municipality and ward committees. Participants were therefore selected according to characteristics in the inclusion and exclusion criteria (Botma *et al.*, 2010:211). In online research, the participant is the person on the other side of the cellular phone answering the questions being asked (Salmons, 2016:74). For this type of sampling technique to work effectively, explicit inclusion and exclusion criteria were set to ensure varied and valuable data (Botma *et al.*, 2010:201).

1.8.3.3 Sample size

According to Sim *et al.* (2018:630), the sample should be re-evaluated regularly during the research. The researcher intended to source 26 (twenty-six) online interviews. Only 12 (twelve) responded to the online questions. Another 4 (four) were sourced through snowball sampling. The researcher conducted sixteen (16) online text interview after which data saturations were reached. At this point no new quality themes emerged from the data gathered from text messages, which indicated that data saturation had been reached (Botma *et al.*, 2010:200). Quality of data referred to data sufficiency, thus enough data in the form of length and rich text messages that ensured analysis and comparison of themes and sub-themes during the data analysis process (Suri, 2011:73).

The intersectoral participants consisted of the following:

- Non-professionals who worked for non-profit organisations in the community (n=3)
- Professional nurses who worked at PHC facilities (n=3)
- Mental health professionals (n=2) - there were only two registered mental health professionals in this community
- Health care workers affiliated with specific PHC facilities (n=3)

- Teachers (n=3)
- Municipal employees (n=3)
- Social workers (n=3)
- Ward councillors (n=3)
- Spiritual and religious leaders or traditional healers (n=3)

Botma *et al.* (2010:201) stated that clear and concise inclusion and exclusion criteria must be used to ensure quality data collection. The following inclusion and exclusion criteria were applied to this study

Table 1 Inclusion and exclusion criteria

Inclusion criteria	Rationale
Participants had to be 18 years and older.	This ensured that the potential participant could legally give informed voluntary consent.
Participants had to be able to understand the question and communicate effectively in English or Afrikaans.	This ensured rich description in English or Afrikaans. These are the main languages spoken in the area. This was essential to ensure validity.
Participants had to have been a member of the entity or organisation for at least one year and had to have rendered services to the community in the area where the research was conducted.	The researcher needed participants who knew the environment and community of the sub-district to add valuable, rich data and would volunteer to spend the time to answer the questions.
Participants had to have their own smartphone.	Participants with this technology were able to respond and send pictures, messages, or voice notes via applications.
Participants had to be confident enough to express themselves on paper, via text messages, or voicemail features via WhatsApp.	This ensured that the participant did not feel intimidated by the technology. The assumption was the more comfortable they were with this application, the more at ease they would be when responding to the questions in text messages.
Participants had to be interested in mental health promotion and be a person to whom colleagues and community members turn for help in difficult situations.	This ensured an in-depth, rich discussion on mental health promotion.
Participants had to be motivated to participate in the study and comply with deadlines being set.	This ensured that enough responses would be received.

Exclusion criteria	Rationale
Undergraduate students undertaking clinical practice or work-integrated learning under the supervision of a team member.	The participant had to be part of the community in the rural Cape Agulhas sub-district to provide rich information.
Newly appointed members, with less than one year of experience at the time of the research.	Such members would not have been able to provide rich, relevant information.
Lack of acquaintance with WhatsApp on a smartphone or without Web 2.0 capabilities.	Those who were unfamiliar with technology would have been hesitant or slow to answer questions and would not be able to install WhatsApp.

1.8.3.4 Recruitment of potential participants

After goodwill permission had been obtained, the researcher requested the email addresses of the direct managers who were the gatekeepers in this research. The same email to the management and middle management in the district was then sent to the gatekeepers, as well as a PowerPoint presentation that summarised the research that would be conducted. The content included the following:

- A detailed description of the aim and the objective of the research
- The gathering of data through a semi-structured online interview via WhatsApp
- The time that would be given to the participants to answer the questions
- Voluntary participation and what voluntary entails
- How consent was obtained and how confidentiality was ensured
- Benefits and risks of the research
- Rights and responsibilities of the independent person, participants, and the researcher
- In which way data would be disseminated
- Relevant approval letters from the Health Research Boards

The language was in Afrikaans and English, although Afrikaans is the predominant language of the area. The gatekeeper disseminated the research to their teams. They were also the contact person at each facility who the research assistant could then contact for possible names and contact details of participants. The research assistant contacted the possible participants and

compiled a list with more detailed information: possible participant name and surname, age, cellular number, type of cellular phone, alternative contact number, role in organisation or facility, years in the district, and email addresses. Potential participants were then discussed with the researcher, which ensured the participants would be able to provide rich in-depth data.

1.9 Process of obtaining consent

Informed signed consent was needed to conduct research. This is a continuous process and must be voluntary (Botma *et al.*, 2010:16; Department of Health, 2015:17). The independent research assistant sent a well-formulated email about the research and what it entailed and a summarised PowerPoint presentation to potential participants. The email also explained the role of the research assistant. The gatekeeper then distributed it to the employees and gave them time to decide if they wanted to participate in the research. The research assistant emailed the gatekeeper a list that had to be completed with the potential participants' details: participant name and surname, age, cellular number, alternative contact number and email addresses. The research assistant then made an online appointment with a date and time at which delayed consent was signed (Greeff, 2020). Informed consent forms were attached to an email that was sent to the possible participants. A period of 48 working hours was granted for online consent. The researcher and research assistant phoned 48 hours after the email had been sent at a predetermined date and time agreed with the participant. Consent was then signed by two persons on the participant's side - a witness and the participant - and two persons on the researcher's side - the researcher and a witness - while on a WhatsApp video call with the participant. Participants had to take a photo of the signed informed consent form and send it to the researcher on WhatsApp, and the researcher did the same. The phone call will also have the function of establishing rapport with the participant. The original signed consent document was placed in an envelope and kept in a safe place by the participant until such time that the researcher picked it up. The steps taken during consent enhanced respect, privacy, anonymity, and confidentiality (Botma *et al.*, 2010:17).

1.10 Data collection

Ethics approval was obtained from the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences at the North-West University (Annexure A). The researcher requested permission to conduct the research from the Western Cape Provincial Department of Health (Annexure B). The informed consent was outlined, see Addendum C. Goodwill permission was sought from the management team of the entities identified in 6.2.2.2. After submitting all the approvals, HREC provided approval and data collection started. The researcher will submit the research to the National Health Research database.

In this study, the data collection method followed an online asynchronous elicited and enacted qualitative descriptive method facilitated by semi-structured interview questions on mental health promotion in the Cape Agulhas sub-district (Salmons, 2016:33). Confidentiality and anonymity were ensured as the research assistant created a broadcast group called 'Research group' where participants were identified on the application by code names only. In the broadcast group, a message was sent to multiple participants, but they were not be able to see the other participants in the same broadcast list, ensuring participants' privacy (WhatsApp, 2020). Participants were linked on the desktop with their personal information and smartphone, which was password-protected. The participants received a one-gigabyte data bundle for their preferred cellular network, purchased after informed consent had been obtained. In South Africa, the leading cellular network companies are Vodacom, MTN, Telkom, and CellC. A broadcast message was sent to all participants after consent had been obtained as per Annexure D. Semi-structured questions were posted and were carefully planned and designed as an interview guide so that the data collected were rich and unique (Botma *et al.*, 2010:2; Dejonckheere *et al.*, 2019:1). The participants could answer it in three ways:

- They could use texting to answer the questions, including emojis
- They could write or type the answers and send them as pictures or scans
- They could use the voice recording mode on the WhatsApp keyboard

An interview guide was developed based on the research and refined with the input of subject specialists to ensure rigorous quality data collection by focusing the conversation with the participant on the research topic. The interview guide was approved by the scientific committee (Rosenthal, 2016:510).

- In your profession or area of expertise, how do you see a mentally healthy person?
- What does mental health promotion mean to you?
- In your work and private environment – take a minimum of one or a maximum of three photos of resources that may help with mental health promotion. Please send a text message or voice note to elaborate on why you see this as resources that could be used in mental health promotion.
- As part of an intersectoral team, what recommendations can you give to support mental health promotion?

The researcher had the technological skills to be able to use WhatsApp as ICT in asynchronous online eliciting and enacted interviewing. However, with elicited interviewing rapport could be limited, but it could be nurtured to establish trust (Salmons, 2016:8). The researcher contacted the participant during the process to clarify emojis and text messages where needed. Emojis are a way to communicate affection in text messages in the form of pictures and are commonly used in WhatsApp (Riordan, 2017:549).

The participants were guided regarding the photos. Specific guidelines for photovoice were sent to the participants as is seen in Annexure D. The participants were collaborators in the research by taking pictures themselves and contextualising the meaning of these pictures and sending it on WhatsApp to the researcher (Wang & Burris, 1997:380). A pilot online interview was conducted to test the interview guide to ensure that the information extracted from the interview was relevant and provided rich content (Kallio *et al.*, 2016:2960). The text message and photos were submitted to the research supervisor for review of in the interview guide and the ICT. The interview did extract the correct information needed for quality data, the questions were therefore kept the same (Kallio *et al.*, 2016:2960). The research supervisor made no further recommendations in the interview milieu and the interview guide. The asynchronous online interview was conducted according to the participants' preference, at a time that suited the participants (Whiting, 2008:36).

1.11 Data analysis, management, and dissemination

A thematic analysis format was used, which indicated that the researcher looked for identifiable patterns in the words that were collected electronically on WhatsApp (Clarke & Braun, 2013:120). In this case, ATLAS.ti 9 analysis was used. Data analysis was discussed according to the type of data collected. The researcher and independent coder was used and was then discussed with the research supervisor and co-supervisor. Consensus was then reached. The researcher had practical experience as a manager regarding document analysis and identifying themes and core issues that had to be addressed. The researcher was supervised by her main supervisor, Prof. Lanthé Kruger and co-supervisor, Prof. Petra Bester. Prof. Lanthé Kruger's interest lies in health promotion and transdisciplinarity. She has successfully supervised nine master's degree students within the field of health promotion and transdisciplinarity. Prof. Petra Bester has supervised more than 40 master's degree students and has a strong interest and practical experience in qualitative research methodology (data collection methods and data analysis).

Audio voice notes: The first step in data analysis was to get all data collected in the same format, namely words. The researcher listened to the audio voice notes, familiarising and immersing herself in the research as suggested by Terre Blanche *et al.* (Botma *et al.*, 2010:226). A transcription – a 'word for word' typed document of the voice notes – was done by the researcher

(Halcomb & Davidson, 2006:38). A study by Greenwood *et al.* (Greenwood *et al.*:91) on transcription has shown that direct analysis from audio files is just as effective, but for ethics considerations and an audit trail the researcher relied on transcription for data analysis. This was done verbatim. Code names were given to each participant. The pseudonyms were linked to the participant's factual details, which was kept in a password-protected file on the researcher's desktop used for this research alone. A hard copy will be kept for five years in a safe lockable filing cabinet at the researcher's supervisor.

Text messages typed or written documents: Text messages were also transcribed in the same manner as audio voice, in a preformatted verbatim style so that analysis could be done with ease. No emojis were used in the text messages. No language editing took place unless the researcher intended to use a direct quotation in the research, at which time language editing was done.

Photovoice: The participant reacted to the photos they had taken, so the same content analysis was used, namely words. Here the researcher identified the picture by extracting the characteristic in words, identifying metaphoric content to capture the complexity of the question raised and their more emotionally-laden interpretation (Wass *et al.*, 2020:3). Photos were saved with the participant's code name and the interview questions. The researcher used Tinkler's tool (Capous-Desyllas & Bromfield, 2018:3) in the analysis of the photos. The following questions guided the analysis:

Table 2 Photo analysis

Look and observe	What does the participant see that relates to mental health promotion?
Contextualise	How does it fit into the participant's community life?
Listen or read	What does the participant say or not say?
Compare	Does the image correspond with what is said about the photo?
Trace	In what way does the photo relate to mental health promotion?

One of the actions of the Tinkler's tool was to watch how the participant interacted with the photo, which cannot be used with online asynchronous enacted research (Salmons, 2016:33). The participants could take up to three photographs. All the photographs were analysed in the same manner. This can become the tool that will give voice to each participant's vision for mental health promotion in the Cape Agulhas sub-district of the Western Cape (Wang & Burris, 1997:382).

Managing the data: Voice recordings, text messages, and photos were downloaded daily on the web-based WhatsApp module, ensuring no data loss. This method was only allowed when the researcher scanned a pixelated QR (quick response) code on the laptop from her phone's WhatsApp settings, ensuring that no one else was able to access the web-based WhatsApp module on her computer without the phone being present. The researcher saved the data on an online collaborative work management programme via Microsoft TEAMS to be viewed by the researcher, research supervisor and co-supervisor. The laptop used by the researcher for this research was password-protected and used for this research only. No one else except the researcher had access to this laptop. After the voice note, pictures or audio voice were downloaded, it was saved in a password-protected file on the laptop. A backup password-protected file was also kept on a hard drive, which was only used for this research and was locked away with the participants' linked code names in a lockable cupboard at the researcher's home.

Data were sorted in voice notes, written text, and photovoice. The answers were arranged according to the questions. After the transcription and language editing had been completed, this data as well as the photos were stored on the researcher and research supervisor's computers in a file demarcated and organised according to the pseudonyms of the participants. A hardcopy that links the participant to the pseudonym was kept in a lockable filing cabinet in the researcher supervisor's office. These measures ensured the anonymity and confidentiality of the participants of the research. When the two-week due date of data collection was reached, the data were finalised, downloaded and then the conversation on the cellular phone was deleted. The participant was asked to delete the research questions and answers as well, to ensure confidentiality and to prevent the data from being distributed before the research had been concluded (Department of Health, 2015:17).

Review of data collected: Prominent themes were deduced from the research. This was done with ATLAS.ti 9 by the researcher and independent coder. The researcher started reading through the transcript and immersed herself in the data.

Thematic analysis: Thematic analysis is a systematic process of looking at data from different angles to identify themes in the transcripts that will assist the researcher in understanding and interpreting raw data (Botma *et al.*, 2010:223). Thematic analysis is a process during which the researcher looks for similarities and differences in the text that contribute to rich descriptions in an understanding of the intersectoral team members of mental health promotion (Clarke & Braun, 2013:120). Words or phrases were used as the 'data' and linked with the themes and sub-themes (Botma *et al.*, 2010:226). As per Moustakas (cited by Holloway, 2017:292), the researcher:

- Reflected on each transcript and searched for statements that hold significance;
- Documented these statements;
- Deleted repetitive and overlapping statements;
- Identified relationships and linked themes across all transcripts;
- Identified differences in the themes represented by different entities;
- Integrated the themes;
- The researcher then reflected and drew conclusions.

A coding framework was developed and discussed with the research supervisor and co-supervisor via a Microsoft TEAMS meeting, which ensured the triangulation of the analysis to add to the validity of the research (Botma *et al.*, 2010:232). The researcher used 'in-vivo' coding, which stems from using the exact phrases of the participants and focussing on the 'stand out' elements of the data collected (Thomas, 2019:59). She stayed with the participant's exact words and identified central themes and sub-themes by incorporating it in line-coding or in vivo codes (Botma *et al.*, 2010:226; Holloway, 2017:291). New codes could be added as required. The coders were the researcher and the research supervisors.

The themes that were identified were broken down to give a new perspective and a fresh view on mental health promotion. This was done to combine similar or contradicting text (Botma *et al.*, 2010:226). The researcher then interpreted the text by writing an in-depth report that was rich and gave context to the research being done to ensure that there was new knowledge that came to light in this research (Botma *et al.*, 2010:226).

Dissemination of findings: The findings of this study are specific to this research and any future research that requires the anonymised information should apply for approval from the Committee of the Faculty of Health Sciences on the Potchefstroom Campus (HREC). The findings will be summarised in a report and on request feedback will be given to the respective management with the participants in attendance. Findings will be presented at the quarterly municipality stakeholders meeting where many of the organisations will be in attendance. Another forum is the Health and Welfare open meeting, which is conducted bi-annually and where the community members are also in attendance. Findings and recommendations will be discussed. This will then be actioned to improve mental health promotion in the community. The findings of the study will be used to publish an article.

1.12 Measures to ensure trustworthiness

1.12.1 Rigour

Rigour can be seen as scientific value and refers to the soundness of the research (Gray *et al.*, 2017:54). Sandelowski summarised this beautifully as “creating the evocative, true-to-life, and meaningful portrait stories, and landscapes human experiences that constitute the best test for rigour in qualitative work” (1993:1).

1.12.2 Trustworthiness

According to Guba and Lincoln (Botma *et al.*, 2010:232), trustworthiness in a qualitative research design has four epistemological standards: truth value, applicability, consistency, and neutrality, with an added fifth standard of authenticity. These standards were met by applying the following strategies:

Truth value: The researcher ensured that the research and research findings reflected her integrity to relay truth in the research as a whole (Botma *et al.*, 2010:230). The researcher followed the protocol in the execution of the research and carefully documented all events. During the data collection and data analysis phase, triangulation was applied. Triangulation is used to ensure authenticity and truth by applying more than one data collection method and multiple individuals in the analysis of data (Botma *et al.*, 2010:232) The researcher included more than one data collection method, namely the elicited and enacted asynchronous qualitative methods to ensure accurate representation of the data (Botma *et al.*, 2010:232). Data analysis was done by the researcher, research supervisor and the co-supervisor, who acted as the quality assurer to ensure that objectivity and truth value was maintained throughout the data analysis phase.

Applicability: According to Klopper and Knobloch (Jooste, 2010:317), the standard of applicability can be met by following the strategy of transferability. Applicability was assured in this study by using appropriate inclusion and exclusion criteria and a suitable sampling technique to ensure that the intersectoral team was well represented through purposive sampling, guided by the principles of appropriateness and adequacy (Botma *et al.*, 2010:199). The research continued until no new information emerged and data saturation had been reached. This was guided by the research co-supervisor as quality assurer.

Consistency: The strategy to ensure consistency was dependability. Dependability measures whether the researcher would produce comparable results if a study were duplicated with the same participants (Botma *et al.*, 2010:233). Consistency was ensured by keeping a comprehensive reference list of all sources and literature used. A dense description of the

research context, data collection, and data analysis embedded in literature provides other researchers with sufficient information to evaluate contextual similarity (Gray *et al.*, 2017:519).. The research supervisor acted as a co-coder, while the research co-supervisor acted as the quality insurer to guarantee consensus discussions following independent data-analysis sessions.

Neutrality: The standard of neutrality was ensured by conformability. Conformability refers to the unbiased and objective status of the researcher during the research (Botma *et al.*, 2010:233). The researcher prevented bias by appointing a research assistant who was responsible for the recruitment of participants and the consent process. The researcher had no limitations to declare in this research and undertook to maintain ethics considerations. Objectivity was enhanced by the research supervisor, who was an experienced co-coder during the data analysis and interpretation phase of the research (Botma *et al.*, 2010:233).

Authenticity: The standard of fairness was used to ensure authenticity. Both the researcher and the research supervisor were involved in the process of coding (see attached Curriculum Vitae as proof of qualitative experience). The research supervisor, an experienced co-coder, coded data independently to ensure that the results were free from any bias (Botma *et al.*, 2010:233). A framework on how themes and sub-themes have emerged was provided to the research co-supervisor. Conflicting viewpoints was discussed objectively.

In the next section, the ethics considerations are outlined.

1.13 Ethical consideration

1.13.1 Ethics

The importance of adherence to ethics considerations when conducting a research study is outlined in the National Department of Health (NDoH) research ethics guidelines (2015:3). Ethics consideration is essential to ensure that the research is conducted responsibly and ethically. Permission to conduct research was obtained from the Health Research Ethics Committee (HREC) of North-West University, Potchefstroom Campus, followed by the Policy and Research Committee of the Western Cape Department of Health. Goodwill permission was obtained from intersectoral team managers of entities identified to be part of the research. The ethics norms and standards applicable to this study are outlined in the paragraphs below. The researcher had chosen to do qualitative elicited asynchronous online research with an added photovoice question. Although standard ethics applied here, the researcher took the changing ICT environment into consideration when discussing her ethics.

1.13.2 The role of the researcher

The researcher ensured that permission was granted by the NDoH, the North-West University HREC, and the DoH Western Cape before conducting the research. She is registered with the South African Nursing Council and abided by their ethics standards. She obtained goodwill permission from the management of entities so that they served as gatekeepers to their employees who had been recruited for this research. The researcher formed part of the rural sub-district of the Western Cape. She was responsible and accountable to the participants, the public, and the community in the Cape Agulhas sub-district of the Western Cape (Salmons, 2016:66). The researcher applied virtue ethics, which relates to her moral standards and intuitions to identify ethical issues that may have arisen and would have had to be addressed in using this method (Salmons, 2016:67). The researcher discussed these issues with the research supervisor to clear any uncertainties and collaborated regarding possible solutions for ethics dilemmas.

The researcher identified gatekeepers who had a managerial position at the time and had access to employees. A research assistant was appointed for the recruitment of participants and the consent process. Due to the online ICT data collection process, the researcher was able to maintain objectivity as there could not be any undue influence on participants as the questions were pre-designed. Instructions were clear and discussed in the letter and attached PowerPoint presentation. Inclusion and exclusion criteria were clear for the gatekeeper and participants. The researcher used the ICT WhatsApp milieu to conduct her research. She was familiar with the application and continued with online research and visual teaching platforms like YouTube to enhance her skills with this application. The participants did not feel intimidated to take part in the research, and it was easy for them to withdraw even if they knew the researcher.

Unclear text messages, audio voice or emojis were clarified on WhatsApp and documented with a summary of what had been discussed. These notes were included in the data analysis. Prompt replies were given to any text questions from the participants. For these prompt replies, pre-created messages were compiled to ensure timeous responses to questions. The research assistant used the business version of WhatsApp with these capabilities. This helped the researcher to reply even when she was occupied during the two weeks of data collection. The researcher reflected on the experience of the research method conducted, where ethics dilemmas were identified, and how they were dealt with.

1.13.3 The role of the participant

The participant had three ways in which they could respond to the questions asked on WhatsApp. This could be either in the form of text messaging, audio voice, or could be written or typed and

sent as a picture. In the case of audio voice, it remained the participants' responsibility to ensure that they could answer audibly and still maintain privacy so that confidentiality could be maintained. With asynchronous interviewing the participant could, therefore, choose the time and place to answer the question in privacy. Typed or written text were destroyed after the picture was taken. This was to ensure confidentiality and it was the participants responsibility to ensure that it is destroyed after sending. When texting answers, the participant was asked to use clear language to ensure that the text couldn't be misinterpreted.

With photovoice, the participant became a 'co-collaborator' in the research and helped create new knowledge on mental health promotion (Allen, 2012:443). According to Wang and Redwood-Jones (Allen, 2012:447), the following ethical steps had to be taken with capturing photographs:

- The person's right to privacy must be maintained in private and public spaces, therefore no photos of people's faces or any specific bodily marks may be taken by which people may be identified. For example, if the participant wanted to take a photograph of children playing soccer, the focus had to stay on their feet kicking the ball
- Participants had to understand how and when to obtain consent for the taking of photographs and then communicate it with the researcher to assist
- The participant had to identify when a photo could affect their safety. It was the researcher's main goal to do no harm, and this was part of the guidance in taking photos
- The photos remained the property of the participant
- What to photograph was the participant's prerogative and therefore the researcher didn't influence the participant in any way
- The researcher stressed that no picture may be drawn from the Internet or from pictures that had been sent to them by someone else, as these photos or images remain the websites or person's property and this could have serious legal consequences

1.13.4 Relevance and value of the research

The relevance of this research study is outlined in the background and problem statement sections of the introductory chapter. It is essential to note the importance of focusing on mental health promotion due to the already existing social determinants exacerbated by the current pandemic COVID-19 disease. The study contributes to the knowledge of mental health promotion by conducting elicited asynchronous qualitative online interviews and photovoice with

intersectoral team members on their understanding of mental health promotion. This data were used to gain an understanding of the intersectoral team's perceptions regarding mental health promotion so that recommendations can be made for mental health promotion in Cape Agulhas in the Western Cape.

1.13.5 Scientific integrity

The scientific integrity of this study was built into the study's design and methodology (Department of Health, 2015:16) (see section 6: Research design and methodology for details). The research was approved by the scientific committee of the Africa Unit for Transdisciplinary Health Research (AUTCHeR), which confirmed the scientific value of this research. An online asynchronous qualitative design was followed with semi-structured interview questions and a photovoice question. The researcher wished to generate methodological options to do justice to the clinical questions that intrigued her and to help the intersectoral team members to advance mental health promotion. Research integrity was further ensured by making sure that photographs taken during the research for photovoice were managed as research data (Jordan, 2014:451). As research data these photographs were not manipulated except for slight alterations like cropping, enhancing the brightness, or colours with the software, but this was documented (Jordan, 2014:451).

1.13.6 Role player engagement

The scientific integrity of this study was built into the study's design and methodology (Department of Health, 2015:16) (see section 6: Research design and methodology for details). The research was approved by the scientific committee of the Africa Unit for Transdisciplinary Health Research (AUTCHeR), which confirmed the scientific value of this research. An online asynchronous qualitative design was followed with semi-structured interview questions and a photovoice question. The researcher wished to generate methodological options to do justice to the clinical questions that intrigued her and to help the intersectoral team members to advance mental health promotion. Research integrity was further ensured by making sure that photographs taken during the research for photovoice were managed as research data (Jordan, 2014:451). As research data these photographs were not manipulated except for slight alterations like cropping, enhancing the brightness, or colours with the software, but this was documented (Jordan, 2014:451).

1.13.7 Favourable risk benefit ratio

The risk level for this study was estimated to be low. The risk-benefit ratio is discussed according to the Kipnis model (Sieber & Tolich, 2013:14).

Cognitive vulnerability: This occurs when participants feel that they do not have the educational background and do not understand the questions, or the terminology used. The researcher ensured that the questions asked were relevant but straightforward. The research assistant clarified any questions from the participants via WhatsApp. The participants' mental health was important to the researcher and therefore the research assistant was sensitive to pick up on any vulnerabilities and discussed it with the researcher for further management.

Vulnerability to authority: This factor plays a role when a power relationship develops with the participants, and they feel pressurised to participate. This was offset by using the research assistant appointed to do the recruitment and consent process. WhatsApp ensured an impartial milieu where participants felt less intimidated should a power relationship exist. This allowed participants to withdraw more naturally.

Differential vulnerability: The participant may be eager to please, nervous, respect the researcher, want to please the researcher, and not want to offend (Sieber & Tolich, 2013:15). A research assistant was therefore used during the recruitment and consent process. During the consent process, the participants had the right to withdraw at any time. All communication was documented and was limited to clarify answers where needed during the data collection phase.

Medical vulnerability: In this research participants were not chosen for a pre-existing medical condition or to share any personal information. The researcher was sensitive during the data collection process to identify any mental distress that a person experienced and ensured immediate referral to a professional to help with the debriefing of the participant.

Allocational vulnerability: There was no monetary reimbursements for these participants. A once-off WhatsApp data bundle was provided to participants after consent was signed, as data in South Africa is an expensive commodity and the researcher wanted to ensure that the participants could converse with the researcher without any costs incurred by the participant. This was not an incentive and was discussed with them during the consent process.

Infrastructural vulnerability: The participants were informed during the recruitment phase and the rest of the research about security measures to be taken with the data being collected. The risk of being identified remained and therefore pseudonyms were linked to each participant's name to guarantee that anonymity was maintained. The ICT WhatsApp milieu was chosen for its

end-to-end encryption of conversations. The researcher assistant informed participants on the security measures of the phone to ensure privacy and confidentiality, how data would be saved on an encrypted file on the computer that could only be accessed with a password, and the fact that hard copies were filed in a lockable cabinet with restrictive access. Web-based WhatsApp could only be accessed on a laptop with a QR code. The security programme on the laptop was updated regularly to secure privacy and confidentiality. A firewall was set on the highest level of security. The laptop is the property of the researcher and was only used for research purposes. No one used the laptop or the cellular phone except the researcher and was the only system administrator on both objects.

1.13.8 Fair selection of participants

The participants were selected fairly and were not targeted unfairly. The population and the process of sampling is clearly outlined in 6.2.

1.13.9 Informed consent

Consent took the form of disclosure of the research, ensuring that the participants understood what they consented to, and ensuring the emotional and cognitive ability of the participant to give consent and the willingness of the participant to take part in the research (Sim, 2010:83). Thus, the basis of consent was establishing autonomy (Sim, 2010:83). In South Africa written informed consent for research is compulsory (Department of Health, 2015:24). A cover letter detailing the informed consent was formulated in simple language (see Annexure C). Letters to request participation and consent were emailed to prospective participants in their choice of language, either English or Afrikaans, explaining the research topic, the objectives of the research, as well as the researcher's expectations of their role. The participant was given a 48-hour workday period in which they could consult regarding consent. A pre-determined WhatsApp video call appointment was set with specific instructions for the adjusted delayed signing of informed consent. The process adhered to the legal requirements of social distancing and other lockdown regulations:

- Date and time were discussed.
- The consent form was printed by the researcher before the appointment date.
- The participant was asked to ensure that there was a witness present to sign the documentation with her.

- After the consent had been signed the participant took a picture of the signed form and sent it to the researcher via WhatsApp.
- The researcher and the witness signed at the same time on their side on the documentation.
- The consent form was photographed and sent to the participant as well.
- The photographs were printed and kept in a lockable filing cabinet at the researcher's home. Photographs were also filed in a password-protected file on the researcher's laptop.
- The original was placed in an envelope. The original was picked up by the researcher at a predetermined time at their place of work. This was kept in a box for five days before opening it to ensure that the form is correctly completed. This was then filed in a filing cabinet at the researcher's home.

1.13.10 Respect, privacy, anonymity, and confidentiality

There is a distinct difference between anonymity and confidentiality. Confidentiality relates to the information collected during the research and what the researcher will do with it (Sim & Waterfield, 2019:3008). Anonymity is the certainty that the participant is unidentifiable relating to research content (Sim & Waterfield, 2019:3008). The participants were linked with a pseudonym. The pseudonym was linked to their names on a list only accessible to the researcher. The researcher ensured privacy, confidentiality, and anonymity of all participant information and discussed this issue during the research information session. The research environment was WhatsApp with end-to-end encryption to ensure privacy. This was discussed with the participants. The WhatsApp of the research assistant was on the researcher's phone and the web-based WhatsApp program was installed on her laptop.

The cellular phone uses a password unique to the research assistant and was needed to open the cellular phone and the WhatsApp application. The researcher always kept the phone nearby. The laptop was protected with up-to-date Windows security and was password-protected. The WhatsApp application on the laptop could only be accessed by scanning the QR code, which is a two-dimensional barcode, with her cellular phone. This was another mode of security. Only then the messages were downloaded and saved in an encrypted file on her laptop. All messages between herself and the participants were deleted after filing them. All members of the research team who required access to data were required to sign a confidentiality agreement, namely the researcher, research assistant, supervisor, and co-supervisor (Department of Health, 2015:14).

After receiving a transcription, the researcher listened to the audio file, transcribed it, and the final password-protected transcriptions was sent to the research supervisor. All collected raw data e.g., evidence of data analysed and printed verbatim transcripts are kept in a locked cupboard in the research supervisor's office for five years after completing the study. An electronic backup of all interviews and verbatim transcriptions password-protected will also be stored with the raw data in the locked cupboard. On completion of the study, these voice recordings and transcripts will be loaded on an external drive and removed from the research supervisor's computer. After five years all hard copies will be shredded and electronic data will be removed with the help of an information technology specialist so that no data can be retrieved for any purposes (Department of Health, 2015:14).

1.13.11 Researcher competence and expertise

The researcher has experience at clinical and managerial levels in the field of this research. The researcher was found to be competent in her research methodology theory for a Master of Health Sciences in Transdisciplinary Health Promotion. The researcher underwent research ethics training in 2018. The study was supervised by an experienced research supervisor who had also been part of a broader international research programme dealing with quantitative and qualitative methods. The research co-supervisor is an experienced qualitative researcher. The curriculum vitae of the research supervisor, co-supervisor, and researcher were attached to the ethics application as proof of competence in the research field.

1.14 Conclusion

This chapter offered an introduction and background to the problem statement and the research aim and objective. The theoretical framework for this study was briefly discussed, followed by the research design and methods used to ensure the integrity of the study. Steps to ensure rigour were outlined as well as the ethics standards of the study.

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**CHAPTER 2 “A MENTALLY HEALTHY PERSON CANNOT
FUNCTION WITHOUT AIDS AND INTERVENTIONS” –
INTERSECTORAL TEAM MEMBERS’ UNDERSTANDING AND
RECOMMENDATIONS FOR MENTAL HEALTH PROMOTION,
WESTERN CAPE, SOUTH AFRICA**

This chapter serves as the manuscript for the study. It was completed in accordance with the requirement of the North-West University’s manual for higher degree studies of a dissertation in article format (NWU, 2020:27). The manuscript was completed in line with the guidelines of *Health Promotion Practice* and submitted for publication.

Chapter outline:

Preamble 1: *Health Promotion Practice* manuscript submission guideline

Preamble 2: Cover letter to the editor of health promotion practice

Preamble 3: Manuscript submitted for publication

Reference: List of references used in the manuscript

2.1 Article format

Taylor & Francis Word Template for journal articles

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“A mentally healthy person cannot function without aids and interventions” – Intersectoral team members' understanding and recommendations for mental health promotion, Western Cape, South Africa.

ABSTRACT

Key terms: Mental health, mental health promotion, primary prevention of mental disorders, intersectoral collaboration

Mental health and health promotion are in a dire state worldwide. They need urgent action to ensure that mental health does not further cripple an already overburdened mental health system, specifically in South Africa. For the sub-district of Cape Agulhas in the Western Cape Province, mental health promotion is a challenge due to a lack of resources exclusively available for mental health and a curative focus on treating mental illness rather than preventing and promoting mental health. Intersectoral collaboration in rural districts is essential to promote mental health in the Cape Agulhas sub-district. However, there is a lack of published literature on intersectoral team members' knowledge of mental health promotion, specifically in the Cape Agulhas sub-district. Therefore, the need for a qualitative study to help unpack the intersectoral team members' knowledge of mental health promotion in the Cape Agulhas sub-district was identified. This led to

the research questions “what are the intersectoral team members' understanding of mental health promotion, and what are their recommendations for a mental health promotion program in the rural Cape Agulhas sub-district of the Western Cape.”

A qualitative descriptive design was used to gather data on an intersectoral team's knowledge regarding mental health promotion. This approach enabled a straightforward yet rich description. Data collection included online asynchronous semi-structured interviews combined with photographs through the social media communication application of WhatsApp. Ethical clearance was obtained from the Health Research Ethics Committee of the Faculty of Health Sciences, North-West University (NWU-00477-20-S1). In addition, the researchers obtained permission from the Western Cape Department of Health, the Department of Education, the Department of Social Development, and the Cape Agulhas Municipality.

Four (4) themes, 13 categories and 41 sub-categories emanated from the data and the categories were also mapped to the Socio-ecological Model (SEM) of Stokols. The results indicate that the intersectoral team in the Cape Agulhas sub-district tended to have reasonable knowledge of what inter-and intrapersonal dynamics are required for a mentally healthy person. The four themes identified were i) the dynamics of a mentally healthy person, ii) an inclusive mental health system, iii) mental health promotion and education, and iv) leaders should be knowledgeable regarding mental health with a platform to share. It was clear, however, that the intersectoral team's knowledge of the social determinants of mental health and their role in addressing these to ensure mental health promotion as leaders in the community was lacking. All the photos that were acquired through photovoice confirmed this statement. A unique finding from the data is that the intersectoral team need training to act as leaders in promoting mental health, particularly in a rural context. They also need training and education regarding the social determinants of health and how these impact mental health and mental health promotion so that it can be addressed in the Cape Agulhas sub-district.

Keywords: Mental health, mental health promotion, intersectoral collaboration, rural

Introduction

Intersectoral collaboration on mental health promotion at the rural sub-district level in South Africa is undervalued, and limited research has been done to date (Rubio-Valera *et al.*, 2014). The National Mental Health Policy Framework and Strategic Plan, published in 2013, identifies mental health as a national priority. It focuses on mental health promotion activation across all sections and governmental departments (Department of Health, 2013:23). Butcher and Gilchrist (2020:4) stated that the reactive nature of public policies often interferes with exploring better ways of doing things in practice, e.g., programmes, services etc. There are many obstacles that diminish the focus on mental health promotion. Despite two critical policy frameworks, the National Health Promotion Policy and Strategic Plan (2015) and the National Mental Health Policy Framework and Strategic Plan (2013–2020), mental health promotion is still neglected. Mental health care was deinstitutionalised and integrated with the primary health care (PHC) service package in 2004 to address the lack of resources available in South Africa (Petersen *et al.*, 2009:147).

In sharp contrast to the two official policies and frameworks, in 2017, the Department of Health instructed the transfer of 1 400 patients from the private hospital group Life Esidimeni psychiatric institutions to unregistered non-governmental organisations (NGOs) in a cost-saving attempt. The result was the deaths of 144 patients (Lund & Docrat, 2019:3; Nwachukwu & Segalo, 2018:11237). There is limited availability of beds in psychiatric hospitals, partly due to poor utilisation and resource management as reported in hospital key performance indicators. The average length of stay in a psychiatric hospital is 157 days, with a readmission rate of one in four patients post-discharge (Lund & Docrat, 2019:3). The majority of the mental health budget (86%) is spent on inpatient care (Docrat *et al.*, 2019:706; Lund & Docrat, 2019:3). The remainder is spent on outpatient care with little or no budget allocated for mental health promotion by the National Department of Health (Docrat *et al.*, 2019:717). South Africa's response to mental health issues remains reactive instead of a more preventative approach (Lund & Docrat, 2019:3).

Enns et al.(2019:7) stated in their research that strategies in mental health promotion require a holistic, multi-level approach. The UK adopted a 'Prevention Concordant for Better Mental Health', focusing on cross-sectoral approaches in mental health prevention strategies (Government United Kingdom, 2022). In Canada, the Mental Health Commission (2012:11) identified six priority approaches, of which one was to promote mental health across the lifespan in homes, at schools and at workplaces, and to prevent mental illness and suicide wherever possible, to foster recovery and well-being for people of all ages living with mental health problems and diseases, and uphold their rights; to provide access to the right combination of services, treatments and supports, when and where people need them; to reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities; to work with First Nations to address their mental health needs, acknowledging their distinct circumstances, rights and cultures and to mobilise leadership, improve knowledge, and foster collaboration at all levels. In the Western Cape, mental health services have been incorporated into the PHC services to make it more accessible. Infrastructure changes to address the growing needs at the district level should include acute psychiatric units at district hospitals. These infrastructure changes were made in 2021 in the Cape Agulhas sub-district. These, however, are only curative measures. The focus has to shift to the prevention and promotion of mental health.

The focus on mental health promotion is important to ensure that the long-term mental health of rural communities receives attention and is strengthened. South African rural sub-districts lack human resources and mental health promotion programmes (Rural Doctors Association of Southern Africa, 2015:8). The COVID-19 pandemic highlighted the importance of mental health promotion as the pandemic has had long-term consequences for the community's mental health (Xiang *et al.*, 2020:2). Nguse and Wassenaar (2021:310) reported that COVID-19 was met with a weakened, impractical mental health system with insufficient physical and human resources to address the impact that the pandemic will have on mental health in South Africa. A study of the effect of the pandemic and the resulting strict lockdown measures found that the prevalence of anxiety and depression were higher due to the isolation of people at home and the bombarding

of people with all the risks, even after excluding participants with pre-existing mental health problems (De Man *et al.*, 2022:126). This pandemic influenced and enhanced social determinants, contributing to mental disorders as by directly affecting the community's economic profile, characterised by inequality among the poor and marginalised, and a high unemployment rate (Nguse & Wassenaar, 2021:310). Social determinants that influence mental health are integrated with the health sphere due to South Africa's strong PHC philosophy and community-based care. However, some are located outside the health sphere, like poverty, housing, family circumstances and many more (Duncan *et al.*, 2021:1699; Enns *et al.*, 2019:1). Therefore, intersectoral action on mental health promotion is needed (World Health Organisation & Calouste Gulbenkian Foundation, 2014:6).

Theoretical approach

Mental health promotion in rural South African communities is framed against the four spheres of the socio-ecological model (Stokols, 1996:282), namely individual factors, social and community networks, community relating to the individual's environment and community and social networks related to the individual's relationship with others and social support. This model encompasses interdependent individual, sociological and environmental influences on mental health promotion, which is managed by an individual, but is influenced by the social environment, community, political and societal networks.

Problem statement

Mental health and health promotion are in a dire state worldwide. Urgent action is needed to ensure that mental health does not affect an already overburdened mental health system, specifically in South Africa. This is especially a challenge in the Cape Agulhas sub-district of the Western Cape due to a lack of resources and the focus on treating mental illness rather than preventing and promoting mental health. Intersectoral collaboration in rural districts is essential to ensure that all the spheres of an individual's environment are incorporated to effectively

promote mental health in the Cape Agulhas sub-district. However, there is a lack of published literature on the intersectoral team members' knowledge of mental health promotion, specifically in the Cape Agulhas sub-district. Therefore, the need for a qualitative study that could help unpack the intersectoral team members' knowledge of mental health promotion in the Cape Agulhas sub-district was identified. This led to the questions: what are the intersectoral team members' understanding of mental health promotion, and what are their recommendations for a mental health promotion programme in the rural Cape Agulhas sub-district of the Western Cape?.

Methodology

Sandelowski's qualitative exploratory descriptive design (2000:80) enabled the researchers to gather data on mental health promotion and enabled a straightforward yet rich description. Data gathering occurred during the height of the COVID-19 pandemic in South Africa. The researcher adhered to the alert-level protocol, which required social distancing among other regulations (South African Government, 2020) and creatively deployed technology for online asynchronous semi-structured interviews combined with photographs (Salmons, 2016:33), using the social media communication application of WhatsApp.

Ethics clearance was obtained from the Health Research Ethics Committee of the Faculty of Health Sciences, North-West University (NWU-00477-20-S1). Afterwards, the researchers obtained permission from the Western Cape Department of Health, the Department of Education, the Department of Social Development, and the Cape Agulhas Municipality.

Data collection

Sub-district managers in the Cape Agulhas Municipality were informed via e-mail about the study and requested to assist in recruiting participants. Data collection took place from November 2021 to March 2022. A combination of purposive, quota and snowball sampling was used based on the following inclusion criteria: i) participants had to be 18 years and older, ii) participants had to be well-versed in English or Afrikaans as these are the dominant languages used in the sub-district,

iii) participants had to have been a member of any health-related organisation within in the sub-district, iv) participants had to have access to a smartphone and be proficient with WhatsApp, and v) participants had to be interested in mental health promotion.

Informed signed consent is needed to conduct research. It is a continuous process and must be voluntary (Botma *et al.*, 2010:16; Department of Health, 2015:17). An independent research assistant was involved for the consent process to ensure impartiality. A pre-determined WhatsApp video call appointment was set with specific instructions for the adjusted delayed signing of informed consent. The process adhered to the legal requirements of social distancing and other lockdown regulations. Once participants had provided written informed consent, the researcher posted the questions on WhatsApp. Participants had two weeks to respond to the questions and were motivated to use photos, voice notes, text messages and written notes in their answers. The interview schedule for the online asynchronous semi-structured interviews were:

- In your profession or area of expertise, how do you see a mentally healthy person?
- What does mental health promotion mean to you?
- In your work and private environment – take a minimum of one or a maximum of three photos of resources that may help with mental health promotion.
- What recommendations can you give to support mental health promotion as part of the intersectoral team?

The intention was to have 26 participants in the Cape Agulhas sub-district. Initially, only 12 (twelve) participants responded. The poor response could be attributed to the local municipal elections and busy schedules. Snowball recruitment was then used to recruit an additional 4 (four) participants. Data was analysed as the data was received and after discussion with the supervisor and co-supervisor it was decided that data saturation was then reached.

Data analysis

Voice notes were transcribed, written text cleaned and ordered, and photographs organised for data analysis. ATLAS.ti 9 was utilised as data analysis method by the an independent coder. Photos were analysed by observing, contextualising, listening, or reading, comparing, and tracing the photos as per Tinkler's tool (cited by Carmen, 2018:457-459; Tinkler, 2013:193-194) according to the Stokols social-ecological approach.

Trustworthiness

Guba and Lincoln's (cited by Botma *et al.*, 2010:232) five strategies were followed to ensure credibility to enhance truth value, transferability to strengthen applicability, dependability to ensure consistency, confirmability to enhance neutrality, and being faithful to support authenticity. This was achieved using two different data collection methods: qualitative asynchronous interviewing and photovoice. The method for analysis were ATLAS.ti 9 (2022), and consensus was reached with an independent co-coder. The researcher followed the predetermined research protocol, remained objective, and did regular peer reflections. This research can be replicated because of a rich description, and the results remained true to the participants' responses.

Results

The demographic detail from the (N=16) is summarised in Table 3.

Table 3 Demographic representation of the intersectoral team members

Type of intersectoral team member	Nr of participants
Non-professionals who are working for non-profit organisations in the community	2
Professional nurses who are working at primary health care facilities	3

Mental health professionals	1
Health care workers affiliated with specific primary health care facilities	2
Teachers	2
Municipal employees	1
Social workers	2
Ward councillors	1
Spiritual and religious leaders or traditional healers	2

The intention was to have an equal representation of different intersectoral team members. However, some of the participants never answered the questions even after reminders were sent via WhatsApp. The data gathered were still rich and data saturation was reached.

Findings

Themes and categories from the semi-structured interviews

Table 4 outlines the research results and guides the discussion. Four (4) themes, 13 categories and 41 sub-categories emerged from the data and the categories were also mapped to the socio-ecological model (SEM) by Stokols (1996:1). The results highlighted that interpersonal dynamics are central to being mentally healthy, and this is closely related to a more conducive and inclusive mental health system. Therefore, mental health education should be an ongoing continuous focus at all levels of society and should be supported by knowledgeable leaders.

Table 4 Themes and categories emerging from the data

Themes	Categories
Dynamics of a mentally healthy person	A person with self-knowledge ✓ A performing person with purpose ✓ Mentally healthy and balanced person participates in lifestyle enriching activities ✓ Using senses to improve mental health ✓ Improves mental health through spirituality ✓ Ability to accept positive and negative emotions ✓ and express emotions constructively ✓ Functions independently through their life course ✓ Has and maintain positive social interactions ✓
An inclusive and conducive mental health system	Promotes inclusion and treat people with dignity and respect ✓ External environment must be conducive for mental health ✓ A well-established intersectoral team focussing on mental health ✓
Mental health promotion education	Educate and create awareness across lifespan which is specific and ongoing by known mental health team ✓
Knowledgeable mental health leadership	Knowledgeable mental health leadership ✓
Categories mapped against the levels of the Socio-ecological Model (SEM) (Stokols, 1986)	
✓	Individual networks
✓	Social and community networks of individuals' relationship with others and social support
✓	Community relating to the individual's environmental sphere
✓	Societal factors strengthening health systems

Theme 1: Dynamics of a mentally healthy person

The inter- and intrapersonal dynamics of the following categories emerged from the dynamics of a mentally healthy person, which serves as the first theme. A mentally healthy person has self-knowledge, can function and has meaning and purpose in life. This person is mentally healthy, balanced and participates in lifestyle-enriching activities. A mentally healthy person uses their senses to improve their mental health. They spend time in spirituality and can accept their positive and negative emotions. A mentally healthy person can constructively express emotions and function independently throughout their life. Mental health is a state of mental well-being that

enables people to cope with the stresses of life, realise their abilities, learn well, work well, and contribute to their community through connections (World Health Organisation, 2022:xiv). The World Health Organization (2022:11) identified that when we are mentally healthy, we are better able to connect, function, cope and thrive. The inter- and interpersonal dynamics of a mentally healthy person were grouped on the individual network level of the SEM.

A person with self-knowledge

Knowing oneself is a continuous action that involves effort and perseverance and is a lifelong process as we progress through our life cycles. Social determinants of mental health are ever-changing, interacting with each other and influencing a person's mental health ((World Health Organisation, 2022). A mentally healthy person can learn even from their mistakes. The WHO (2022:11) stated in their report on mental health that a mentally healthy person would be able to apply cognitive skills, gain an education, earn a living, make healthy choices and learn new skills. A participant made the statement that a person with good mental health "*will be in a position to love and be loved*", which is an indication of acceptance of themselves and others. This is supported by research done by Gates et al. (2022:31), who stated that love and self-compassion can help a person in difficult circumstances and situations like the COVID-19 pandemic. Such a person will be able to "*feel good and have a positive self-image*". A participant commented that a mentally healthy person would "*feel positive about life and their future,*" which instils hope. People with hope for the future have been shown to be more likely to bounce back from stressful situations and have good mental health (Yıldırım & Arslan, 2022:5718). To know oneself is to know one's own abilities and identify when one's abilities are not enough and one needs to ask for help.

A performing person with purpose

A mentally healthy person can perform at the different levels of society and have a clear life purpose. One participant mentioned that a mentally healthy person could "*work productively and*

is aware of their abilities". This is confirmed in literature, where it is stated that self-knowledge is a person's confidence in their own worth and abilities (Boudlaie *et al.*, 2022:1). In the face of uncertainties of life, crisis, and trauma, a mentally healthy person will be able to make decisions, adapt and change to what the circumstances require. A participant summarised it by saying that such a person will be able to, "*cope with the demands of life*" and "*can make adjustments*" where it is required. Mental health means that individuals can cope with the normal stresses of life (Fusar-Poli *et al.*, 2020:41).

Lifestyle-enriching activities and using your senses

Such a person will involve themselves in lifestyle-enriching activities, for example exercise, rest, hobbies etc. It was interesting how many participants mentioned activities in nature, with animals and where they can use their senses when doing so. As one participant mentioned, "*The calmness of the sea, the outdoors, the warm sand, the colour of the water – all this makes one happy.*" Reuben *et al.*(2022:9) found that people with access to more green spaces can have better mental health. In a study by Drake *et al.* (2021:9) where participants took part in surf therapy, they reported that the programme provided a sense of distraction from negative thoughts and helped them escape their circumstances. Cape Agulhas is known for its pristine beaches and mountainous and conservation areas, which are easily accessible and free. Lifestyle-enriching activities are versatile and enjoyable, which can create happiness. A participant mentioned that you should "*take time to quietly listen to music and your favourite tracks and allow your whole being to become one with the music by dancing, singing along and expressing your feelings through music*" Research by Sanfilippo *et al.* (2021:831) showed that music-based interventions like singing, playing the piano, listening to music reduce symptoms of depression and anxiety. Lifestyle-enriching activities include exercise and a balanced diet with a balance between relaxation and sleep. Participants mentioned the word "*balance*" 78 times. This balancing act should be between responsibilities with enjoyable activities or pleasure.



Improving mental health through spirituality

Spirituality was mentioned by three participants as an essential component of mental health. A participant mentioned that “*mental health promotion involves actions that can improve psychological well-being so that the body, soul and spirit can be in harmony with each other*”. Furthermore, a participant stated that

“*having a religious support structure can be helpful.*” Another participant took a photo of nature and stated that “*by looking at nature, I realise that God is in control of everything. It then helps me to create pleasant feelings towards my negative feelings. It makes me feel emotionally better*” Spirituality teaches people empathy, kindness, harmony in differences, and purpose, and therefore strengthens their self-esteem (Boudlaie *et al.*, 2022:5).

Ability to accept positive and negative emotions and express emotions constructively

Emotionally, a mentally healthy person can deal with unwanted or negative emotions constructively. As one participant mentioned, a “*person may also experience less good day and emotions of being discouraged, upset and sad, but has the ability to process and deal with them*”. In contrast, one participant stated that “*unacceptable emotions and behaviour do not occur*”. Unacceptable emotions can occur, but emotional intelligence is about understanding and

managing your emotions (World Health Organisation, 2022:11). Furthermore, a participant mentioned that it is important to *“make people realise that it is okay not to be okay and that people sometimes go through emotions and situations which they cannot control at that specific time in their lives”*.

Functioning independently throughout the course of life

It is clear that part of the dynamics of a mentally healthy person is that they can function independently according to the different developmental stages of life as required. This, however, does not indicate that it is without the aid or help and assistance at times. In fact, one participant summarised this by saying, *“I think a mentally healthy person is not necessarily a person who can function as described on a daily basis without aids (e.g., medications) or interventions (e.g., therapy or support groups) as these can assist the person to function more optimally and therefore these aids and interventions contribute to the person’s wellbeing”*. According to the WHO (2022:13), mental health is not defined by the presence or absence of mental health disorders as it is a complex continuum that varies from day to day in a person’s life.

Meaningful social interactions

To be mentally healthy means to have positive, meaningful social interactions that can be maintained. As confirmed by a participant, *“spend quality time with family and friends and have those ‘safe’ friends that you can always talk to and that always have your back”*. One participant stated that a person who has good mental health is an *“active participant in society”*, and another said that it is someone who makes a *“positive contribution’ to society”*. Such a person is accepted in the community and will be able to maintain good relationships with partners, family, friends or colleagues, have prospects to earn a living, participate in meaningful activity, and also in the social and economic circumstances in which they find themselves (World Health Organisation, 2022:19). They will have a sense of responsibility and *“see beyond their own needs and desires”*. This was reiterated by another participant who expressed that a mentally healthy person *“should*

have the ability to care for those entrusted to their care". A person's dynamics constantly evolve and change throughout their lifespan and circumstances, which has a direct influence on their mental health. Therefore, mental health promotion must receive attention throughout a person's lifespan and should be reinforced at different levels of society.

Theme 2: An inclusive mental health system

An inclusive and conducive mental health system is essential to promote mental health. This implies actively promoting inclusion and treating people with respect and dignity. The external environment, which includes social, economic, and physical environments per the social determinants of mental health (World Health Organisation & Calouste Gulbenkian Foundation, 2014:8), must be conducive to mental health.


Respect and dignity

Staying mentally healthy in a society that tends to ostracise, judge, and reject people based on colour, culture and religion, it is of great importance to promote inclusion and treat people with respect and dignity. Inclusion, respect and dignity can only be obtained by respecting everyone's rights and freedom and their right to health care as South African citizens. A participant mentioned that to support mental health is to *"treat all people with respect, dignity and fairness"*. This is essential considering the *"stigma and negative connotation to mental health"* and promotes mental health *"instead of labelling individuals"*, as one of the participants noted. Another participant mentioned that *"in our communities, it is still seen as a taboo subject. People are negatively judged for having mental health issues, both at home with your families where you expect to be accepted, and at work"*. Stigma can undermine support factors for individuals as they will not access the support structures in fear of discrimination and being labelled ((World Health Organisation, 2022:23). Furthermore, one participant mentioned a cultural component: *"it is important to be knowledgeable about cultural diversities"*. In a study done by Booysen et al. (2021:5), it was noted that participants understood and made sense of mental health in the context


of their culture, which influences their perceptions. The cultural context in mental health promotion is important and should be considered.

External environment

One of the social determinants of mental health is safety. A participant mentioned *“that each individual in that specific community has a responsibility to act in a way that creates a safe space for other individuals in the same community”*. One person indicated that activities for mental health promotion could include *“creating an environment that supports mental health”* and another stated that a community has a responsibility *“to act in a way to create a safe space for individuals”*. According to the WHO (2022:20), the structural environment includes safety and security; if this is absent, it can negatively affect a person’s mental health. This is linked to the fact that *“where and how one should seek help”*. One of the paths in the transformation of mental health, the WHO (2022:250), identified that we need to redesign the environment, including reshaping our physical, social, and economic characteristics (including the Cape Agulhas sub-district) for mental health. To reshape our environments in homes and at schools, workplaces, health care services, communities, and natural environments, we need to understand the social and structural determinants of mental health (World Health Organisation, 2022:251). Implementing changes in our environment requires an intersectoral team effort.



Confirmation from photovoice: Mental healthcare systems are accessible during and after office hours for any mental health condition and is usually the first contact of support to a person that experiences a mental health issue. **Photo:** An employee within the public health system during the COVID-19 pandemic, is busy and multitasking yet available and willing to assist.



Unique finding from photovoice: The health system's paucity to communicate mental health can make people feel stigmatised. **Photo:** A woman being suffocated by multiple hands, describing that "If mental health is being discussed openly and in a non-judgemental fashion, the person suffering from a mental condition won't feel suffocated by other people's opinions and will not let opinions dictate how they should live their lives".

Intersectoral collaboration

A participant stated that "mental health promotion is not only the responsibility of the health sector, but it needs a multidisciplinary approach where the whole of society can participate to pursuit comprehensive health". Another participant noted that we need to

"mobilise partners like NGOs, school governing bodies, social services, community forums and resources to raise awareness". In a report by the WHO (2022:148), mental health promotion was said to require intersectoral collaboration and actions. Societal change cannot be created by individual entities, like the Department of Health, operating in isolation (Butcher & Gilchrist, 2020:40). One participant noted that "the notion on the approach of engaging with society around mental health should be reassessed". As seen here, different disciplines must work as a team to address mental health promotion in the Cape Agulhas sub-district. Such a team should be knowledgeable regarding each other's strengths, weaknesses, competencies, and experiences. South African evidence on intersectoral collaboration is still lacking. The studies that have been done concentrated mainly on the barriers to intersectoral collaboration (Truter, 2022:10). Truter (2022:7) indicated that the lack of collaborative mental health could be attributed to resource shortages, poor infrastructure, perceptions of poor support and trust between stakeholders, poor information and referral systems, inadequate education and training, low prioritisation of mental illness, power dynamics between stakeholders and problems defining roles. The strategies for improving intersectoral collaboration are to improve the infrastructure and redirect resources,

formalise roles, and relationships, improve leadership, improve communication and supervisory structures, as well as to improve training and education (Truter, 2022:9). Where competencies and experiences are lacking, it can then be addressed and strengthened with training.

Mental health promotion and education

According to the WHO (2022:149) mental health report, mental health promotion is essential to enhance mental health and resilience, to prevent mental health conditions and to lessen the need for mental health care. Education must be a continuous action of creating awareness across the lifespan, which is specific and ongoing and offered by a mental health team that is known and visible in the community they serve.

Educate community across their lifespan

One participant noted that *“mental health promotion programmes improve the well-being of people like in schools, workplaces and in the communities”*. She also mentioned, *“information sessions at schools can abolish discrimination, misuse of multimedia and bullying”*. It was clear from the participants’ perceptions and their experiences in the Cape Agulhas sub-district what type of programmes was important to them. The following advocacy, information sessions and educational sessions were identified as needs in Cape Agulhas: anti-bullying campaigns, suicide prevention, post-natal depression, misuse of multi-media, how to stay mentally healthy, abolishing of discrimination, awareness about the mental health of the elderly, assisting youth with studying programmes, coping skills, and the increase of protective factors. On this, a participant (pastor) made the statement that they *“prefer to serve on the preventative side of mental health”* and that *“in all honesty, we are not adequately trained to assess mental health issues”*. Regarding counselling and education of individuals in facilities, one participant made the statement, *“it breaks my heart sometimes because you only need an hour with that person, but you will never be able to do that in the hospital”*. She went further to say that there should be *“an intermediary between the hospital and the psychiatric clinic nurse”* where she felt that the person should *“listens more*

than talk". It was also mentioned that *"having regular awareness drives at schools, places of work, even churches, about how to be and stay mentally healthy"* is important. It is clear from the statements of the participants that the focus was on patients with already diagnosable mental health issues and not on mental health promotion when answering the questions. Another participant said, *"I use the word actions rather than programmes because programmes only provide information that is not enough for transformation"*. In a study done by Budd et al. (2021:1), they reviewed 32 research articles where interventions were done to improve a targeted population's mental health. Their results indicated that a collective approach, focussing on building resilience and increasing existing strengths, has positive outcomes. At the core of the above, it was clear that the programmes should have longevity, not be time-limited, and must be actionable and not just a paper exercise. The most challenging part of such programmes is their maintenance.

The creation of a physical support system was mentioned, for example, a helpline and/or a counselling unit. As one participant said, *"it is necessary for the public to take note of where and how one should seek help"*. The infrastructure should care for each individual's needs and should not just include hospitals and medication. One participant mentioned that support systems should include support groups for mental health and mental workers. The participants mentioned the following resources or platforms that could be used for mental health education: ICT can be used in mental health promotion, health message posters, church platforms to campaign, and the municipality bill to distribute information. They focussed on existing infrastructure that can be used. This was reiterated with the photos of cellular phones and telecommunication.

Theme 4: Leaders should be knowledgeable about mental health with a platform to share

To transform mental health, the WHO (2022:xvii) proposed that leadership and governance are key role players in transforming mental health. The three types of political commitment required

to change mental health in a country is i) legislation and policies, ii) institutional commitment, and iii) financial commitment (World Health Organisation, 2022:xvii). In the South African context, policies, plans and laws related to mental health give citizens all the necessary rights, the implementation is lacking, also with respect to mental health promotion. The policy is curative in nature and lacks preventative measures. A participant mentioned that *“Leaders must be trained in mental health to support staff who have mental health issues”* and that there should be *“capacity building”*. Capacity building is a process of developing and strengthening the skills, predispositions, abilities, processes and resources that a community needs to survive, adapt, and thrive in a fast-changing world (United Nations, 2022). Participants felt it was important that mental health promotion should be conducted by a known person or team that can support mental health. It seems that the participants want the team to be recognised as ‘experts’ in mental health so that the community could contact them should they need help. This team must be able to help create awareness about mental health, identify when there are mental health concerns, create support groups and support for employers and staff places of work, and be responsible for assisting where mental health issues are identified. According to a study by Tamminen *et al.* (2022:6), leadership and management are prerequisites for collaboration and partnership success.

There was also an emphasis on the word “sharing” in mental health promotion. A participant (professional nurse) stated that *“in a support group, you can share your experience with others”* and then went on to say that it could *“provide emotional support”*. Peer support services in mental health care are about people using their own experiences to help each other. By sharing their knowledge, they can provide emotional support and create learning environments where awareness is raised (World Health Organisation, 2022:230).

Contextualising the results

The intersectoral team’s understanding of mental health promotion centres on the individual network sphere of the SEM, followed by the social and community networks of individuals’ relationships with others and social support. The current state of intersectoral collaboration on

mental health promotion in South Africa is reliant on primary health care resources and community participation to upscale mental health care and does not address the importance of mental health promotion to prevent mental health illnesses. The findings of this study reveal the understanding of the intersectoral team's pre-existing knowledge about mental health and health promotion. It is clear from the analysis that there is a comprehensive understanding of the dynamics required for an individual to be seen as a mentally healthy person. Knowledge about the intersectoral team's role, assistance, education, support, and advocacy for people at the community and societal levels in the Cape Agulhas sub-district in fostering and mentoring individuals to become mentally healthy, is lacking. A study on collaborative mental health care in South Africa stated that there should be a formalisation of the roles and functions of different stakeholders in mental health, education and improvement of leadership to make intersectoral collaboration work (Truter, 2022:9).

Conclusion

The results indicate that the intersectoral team in the Cape Agulhas sub-district tended to have fair knowledge of what inter- and intrapersonal dynamics are required for a mentally healthy person. The following attributes were mentioned: self-knowledge, having a purpose, participating in lifestyle-enriching activities, using senses, spending some time in spirituality, accepting positive and negative emotions and expressing it constructively, and functioning independently throughout their life course. It was clear, however, that the intersectoral team's knowledge of the social determinants of mental health and their role in addressing these to ensure mental health promotion as leaders in the community was lacking. All the photos that were gathered through photovoice confirm this statement. In a study done by Mokitimi et al. (2022:20) in the Western Cape on child and adolescent mental health services, they found that there was a lack of leadership, governance, public health campaigns, limited intersectoral collaboration and information systems, which correlates with the research finding in this study. What is unique,

though, is the lack of leadership training and education on the rural platform, which results in poor mental health promotion.

So what?

What is already known about mental health promotion in the Cape Agulhas sub-district?

The findings of this study present the intersectoral team's pre-existing understanding of mental health and mental health promotion. There is a comprehensive understanding of the dynamics required to create a mentally healthy person at the individual level of the SEM. Intersectoral team members tended to acknowledge mental health but negated mental illness. Regarding the resources for mental health promotion, the intersectoral team members focussed firstly on individual resources, followed by health facilities. The study emphasised an inclusive mental health system that is safe and non-discriminative of mentally ill community members. Implementing a mental health promotion programme requires training of the intersectoral team regarding their roles and functions of leadership in the community and the societal networks in mental health promotion in the Cape Agulhas sub-district.

What does this article add to already existing knowledge regarding mental health promotion?

Mental health promotion involves the social determinants of health and the intersectoral members' shortcomings. The knowledge regarding their intersectoral team's role(s), assistance, education, and advocacy for people at the community and societal networks level in the Cape Agulhas sub-district is lacking. This is vital to foster mental health promotion.

What are the implications for mental health promotion in the Cape Agulhas sub-district?

We should transform mental health promotion policy in South Africa from a curative to a promotive approach that focuses more on the intersectoral team and develops mental health promotion leadership. Leadership and societal factors are central to addressing rural communities' lack of mental health promotion. Intersectoral teams must be trained before mental health promotion programmes can be implemented.

Limitations of the study

COVID-19 delayed the research as the social isolation protocols had to be considered, resulting in a change in the data collection method. The initial qualitative semi-structured interview technique was replaced with an online asynchronous data collection technique that required some creative changes. Therefore, photovoice was included as a method to ensure that the data would be rich and multidimensional. Permission to conduct the research was complex due to the multi-layered permission of the intersectoral team angle of the study, which required approval from the Department of Social Development, Department of Health and Department of Education, as well as non-profit organisations. The online data collection method where the participants had two weeks to respond to the posted questions, resulted in fragmental responses to the questions as participants partially completed the online asynchronous interview, and some did not complete it at all. This could be due to the delayed responses causing a decrease in focus and maintaining their attention over the period.

Recommendations

We recommend that future educational focus points be addressed. Before a mental health promotion programme is planned, an intersectoral team training programme in mental health promotion is recommended, which should include:

- The basics of social determinants that influence mental health,
- The intersectoral team's role and function in the community regarding mental health promotion and
- The meaning of mental health promotion and how it differs from mental illness
- Establishing mental health promotion leadership to monitor and sustain mental health promotion

Future research should focus on the role and function of the intersectoral team members in mental health promotion and how to create a sustainable mental health promotion plan.

Statistics regarding mental health in South Africa are poor and the last large-scale population-based study of common mental disorders was done in 2009 (Stein Dan *et al.*, 2009:339). Statistics is fragmented between medical funds and public psychiatric institutions. The key determinants of public health regarding mental health are mainly focussed on institutionalisation and inpatient care. Statistics regarding outpatients are not standardised and not evaluated appropriately to derive at scientific conclusions.

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The authors wish to acknowledge the intersectoral team in the Cape Agulhas sub-district for participating in this study despite pressures like COVID-19, municipal elections and year-end pressures during 2021.

Author's contribution

M.H. conducted the study in fulfilment of requirements for the degree MSCs in Health Science within AUTheR. Professors I.M.K. and P.B. supervised the study from the conception of ideas to its completion.

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Data availability

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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CHAPTER 3 EVALUATION, LIMITATIONS AND RECOMMENDATIONS OF THE RESEARCH

3.1 Introduction

The researcher intended to explore and describe an Cape Agulhas intersectoral team's existing knowledge about mental health, mental health promotion and the already existing resources that can be used in mental health promotion so that recommendations can be made regarding a mental health promotion programme in the Cape Agulhas sub-district of the Western Cape. This led to the research questions on the intersectoral team members' knowledge of mental health, how mental health promotion is perceived, and what existing resources in the community can be identified to help with mental health promotion.

3.2 Evaluation of the research

The research problem was meaningful and significant as this study explored the intersectoral team's understanding of mental health promotion in the Cape Agulhas sub-district. According to the World Health Organization, mental health is considered a person's ability to connect, function, cope and thrive in their communities (World Health Organisation, 2022:11). Mental health promotion needs an intersectoral approach. This approach is crucial in identifying the different social determinants of mental health for interventions to be implemented. Such interventions are needed to reduce mental-health-associated risks and improve a person's resilience (World Health Organisation, 2022:148). An intersectoral collaborative approach to addressing 'wicked problems' has been recognised since the early 2000s. In the Western Cape, there are many training sessions and talk about the "whole of society" approach, focussing on an intersectoral approach addressing the economic, social, and environmental pillars of the 2030 Agenda. The 2030 Agenda for Sustainable Development was launched by a UN Summit in New York on 25–27 September 2015 and aimed at ending poverty in all its forms, which forms part of the social determinants of mental health (United Nations, 2015:3).

The economic, social, and environmental pillars of the 2030 Agenda include the social determinants affecting mental health since social inequalities are associated with a higher risk of mental disorders and specific communities are at higher risk due to exposure and susceptibility to unfavourable social, economic, and environmental circumstances, interrelated with gender throughout their life cycle (World Health Organisation & Calouste Gulbenkian Foundation, 2014:9). According to the 2011 census, the Cape Agulhas had 14 630 economically active people

(employed or unemployed but looking for work), of which 13,8% were unemployed (Statistics South Africa, 2011). These statistics are outdated, and we are awaiting the new data of the census held in 2022 as the picture may have changed due to coastal emigration to rural areas as well as COVID-19, which had a direct influence on the economic profile of the community.

The theoretical framework consisted of Stokols' social-ecological approach to health promotion, which was also used in the National Health Promotion Policy and Strategy of South Africa. This made the data analysis of this research more relatable and easier to understand.

3.2.1 Self-reflection

As a health care worker in the Cape Agulhas sub-district working at a public hospital, I have experienced the fragmented public mental health system that ostracises the mentally ill and places the responsibility of the mentally ill patient on the Department of Health. This perception is reflected in the community and leads to the curative revolving door of mental health patients with minimal intersectoral team assistance or community support, which increases the burden on the community and has far-reaching consequences for our already overburdened health system. Furthermore, COVID-19 increased the burden of mental health issues in the community. The lack of attention to mental health promotion and knowledge of mental health and mental health promotion will hamper any mental health promotion programme in the community.

Intersectoral collaboration in Cape Agulhas is still in its infancy, as many obstacles remain. Barriers to effective intersectoral collaboration in South Africa include resource shortages; a lack of support and trust between stakeholders; poor information, communication and referral systems; inadequate education and training; low prioritisation; power dynamics; and a problem of delineating roles (Truter, 2022:8). In the Cape Agulhas sub-district, there is a lack of human resources. One of my observations is that the same people represent different NGOs on several forums. I also observed a shortage of young adults represented on these forums. This leads to burnout and a lack of innovation and drives in the intersectoral team as the community representation is only realised sometimes. Furthermore, collaboration is a continuous process that requires effort and perseverance and must be constantly maintained (Butcher & Gilchrist, 2020:9).

3.2.2 Making sense of the data and what was found

The findings of this study present the understanding of the intersectoral team's pre-existing knowledge regarding mental health and health promotion. It was evident from the analysis that there is a comprehensive understanding of what dynamics are required in the individual sphere

of the SEM for someone to be seen as a mentally healthy person. As stated previously, intersectoral collaboration is still in its infancy in South Africa. Although there are some discussions in the Cape Agulhas sub-district, it is still siloed and one-sided. Intersectoral collaboration on mental health promotion in South Africa relies on PHC resources and community participation to upscale mental health care and does not address the importance of mental health promotion's role in preventing mental illnesses. The importance of the role and function of the intersectoral team role in mental health promotion Cape Agulhas community is not foregrounded. A study on collaborative mental health care in South Africa stated that there should be a formalisation of the roles and functions of different stakeholders in mental health, education and improvement of leadership to make intersectoral collaboration work (Truter, 2022:9).

3.2.3 Integration of the theoretical assumptions into the social-ecological model of Stokols

The social-ecological theory was used to develop the research question and guide the analysis and interpretation of the data. The reason for this choice was to establish links with the health promotion policy and strategy of South Africa, but also to emphasise the importance that social determinants have for mental health. This is better explained at the hand of the SEM and explains the interrelated aspect of personal and environmental factors in mental health illness and mental health promotion.

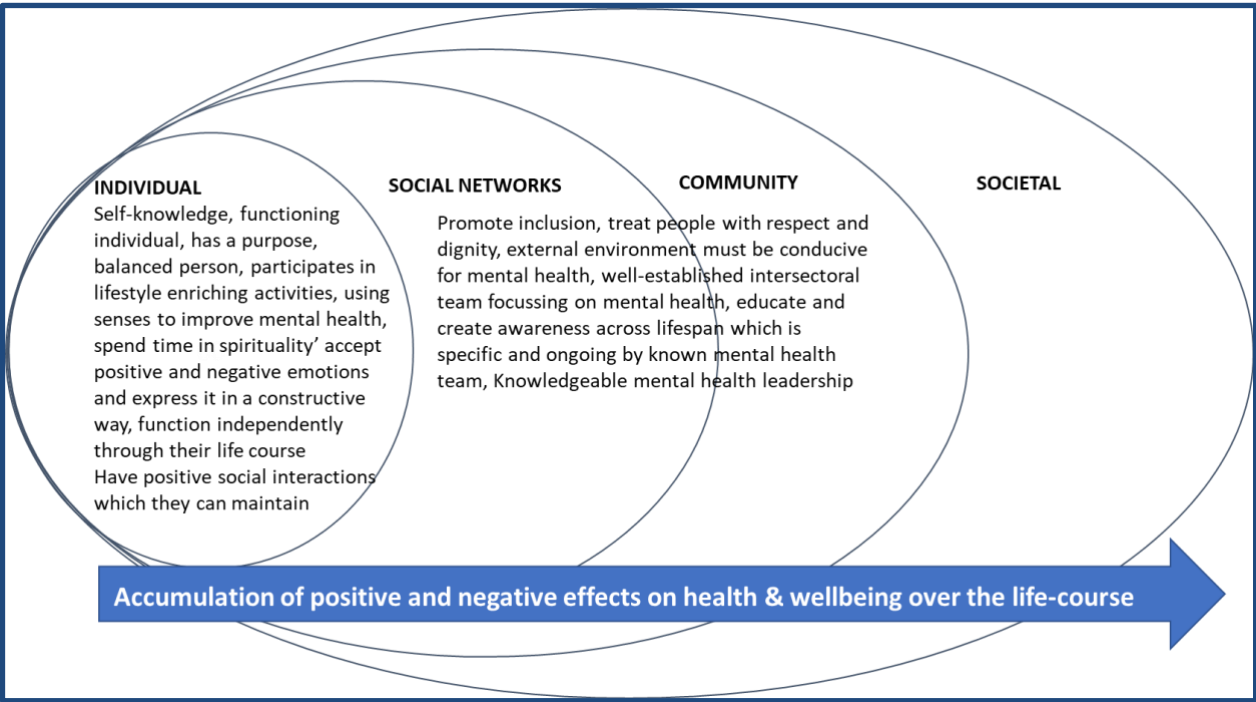


Figure 3 Integration of theoretical assumptions into SEM of Stokols

In accordance with the analysis of mental health promotion and mental health, it was clear that the intersectoral team's knowledge mostly coincides with and is concentrated on individual factors or characteristics that can influence mental health and mental health promotion. It includes aspects of the individual relating to their biology, like age, sex, hereditary factors, lifestyle factors, skills, knowledge, motivation, spirituality, and attitude. The social-ecological model is in constant interrelationship with the external environment, including social networks and the community.

To realise the potential of mental health promotion, the intersectoral team members must recognise their interdependence and be informed about their role in the bigger picture. Although the community members must be inspired to take personal control and to be educated on their responsibility regarding their own mental health, the same can be said regarding the intersectoral team and their role and function in the process. The sphere of the social networks and community in the SEM must be revisited to provide knowledge and information that will empower the intersectoral team in a resource-restricted rural area.

Thus, in marrying the SEM spheres, the individual community is vital in caring for their mental health, decisions, and lifestyles. Therefore, to promote self-care, the empowerment of an individual is crucial, encouraging care, coping and utilising available resources. For this, they need education and empowerment to use existing resources in their environment.

3.2.4 Limitations

COVID-19 affected the data collection method as social isolation had to be considered, resulting in a change in the data collection method. The initial qualitative semi-structured interview technique as data collection was replaced with an online asynchronous data collection technique, which required some creative changes. Changes were also made to the consent process to ensure that social distancing and infection prevention processes were adhered to. The inclusion of photovoice as a method ensured that data would be rich and multidimensional. This data collection method was different and required some creative changes to the research. Data collection was hampered by calendars that did not always match among the different departments and entities. For example, the municipality and ward councillors were busy with the 2021 South African municipal elections, which required preparation and campaigning. The Department of Education was busy preparing their students for exams at different times. The researcher had to delay certain departments' data collection so that she could accommodate their calendars. Even with the delay some participants didn't answer the questions and snowball sampling was done for additional participants. Data was analysed as answers were received. The coder and co-coder informed that data saturation was reached at 16 participants and snowball sampling was stopped.

Permission to conduct the research was complex as permission was multi-layered due to the study's intersectoral team angle, which required approval from the Department of Health, Department of Education, and the Department of Social Development in the Western Cape, as well as NGOs. After provincial permission had to be granted, permission had to be obtained from the district. Each department had their own ethics committees with processes, as did each NGO.

The online data collection method, where the participants had two weeks to respond to the posted questions resulted in fragmented responses to the questions as participants partially completed the questionnaire and some did not complete it at all. This could also be ascribed to calendar clashes and the timeframes could have caused a decrease in focus and motivation, maintaining their attention over the period. The participants were asked not to take photographs of people's faces so that they would not be recognisable. There were however pictures of faces although covered with a mask as well as hands. The researcher contacted the participants, who gave permission that the photos may be used.

3.3 Recommendations for an intersectoral mental health promotion programme

We recommend that future educational focus points be addressed. Before a mental health promotion programme is planned, we recommend an intersectoral team training programme in mental health promotion which includes:

Table 5 Recommendation for an intersectoral mental health promotion programme

Recommendation	Explanation
Develop a mental health promotion policy that guides mental health promotion.	Currently, there are two separate policies: one for the National Health Promotion Policy and Strategy and the National Mental Health Policy Framework and Strategic Plan. However, there is no existing policy that exclusively focuses on mental health promotion. Sometimes a top-down approach is needed to address wicked problems at grassroot level.
Educate the intersectoral team on social determinants that influence mental health.	Education about social determinants can include the identification of context specific

Recommendation	Explanation
	social determinants prevalent in the Cape Agulhas sub-district that should be addressed.
Educate the intersectoral team on their role and function in the community with respect to mental health promotion.	This includes formalising their roles, relationships regarding mental health promotion
Educate the intersectoral team about what mental health promotion is and how it differs from mental illness.	There should be theoretical and practical approaches to mental health promotion and intersectoral focus points to re-enforce mental health promotion in the community
Establish mental health promotion leadership to monitor and sustain mental health promotion.	According to Truter (2022:9), leadership should be improved to ensure buy in, monitor and sustain intersectoral collaboration.
Future research could focus on the role and function of the intersectoral team members in mental health promotion and how to create a sustainable mental health promotion plan.	Intersectoral team members was unable to explain their role and function in mental health promotion, which also indicate that they are not aware of their role and function in other intersectoral teams.
The monitoring and evaluation of people with mental illness should be upscaled. Statistics should include screening of patients and reporting of people with possible mental illnesses. Statistics on mental health in South Africa is poor and the last large-scale population-based study of common mental disorders was done in 2009 (Stein Dan <i>et al.</i> , 2009:339).	Statistics is fragmented between medical funds and public psychiatric institutions. The key determinants of public health regarding mental health are mostly focussed on institutionalisation and in-patient care. Statistics regarding outpatients are not standardised and not evaluated appropriately to derive to scientific conclusions.

3.4 Summary

This section aimed to evaluate what this study found, and it indicated that Cape Agulhas is not ready for intersectoral collaboration for a mental health promotion programme. Gaps with respect to mental health and mental health promotion education, as well as the role and function of the intersectoral team's role and function could be identified.

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ANNEXURES 1 NORTH-WEST UNIVERSITY HREC



Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 086 016 9698
Web: <http://www.nwu.ac.za/>

North-West University Health Research Ethics
Committee (NWU-HREC)

Tel: 018 299-1206
Email: Ethics-HRECA@nwu.ac.za (for human
studies)

11 June 2021

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 11/06/2021, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general and specific 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: Intersectoral team members' understanding of and recommendations for a mental health promotion programme in a rural sub-district, Western Cape Province																													
Principal Investigator/Study Supervisor/Researcher: Prof IM Kruger																													
Student: M Hattingh - 10716238																													
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Application Type: Single study	Risk: <table border="1"><tr><td>Minimal</td></tr></table>	Minimal																											
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Commencement date: 11/06/2021																													
Expiry date: 30/06/2022																													
Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of an annual monitoring report and the concomitant issuing of a letter of continuation. A monitoring report is due at the end of June annually until completion.																													

General conditions:
<i>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:</i>
<ul style="list-style-type: none">• <i>The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:</i><ul style="list-style-type: none">- <i>Annually on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and</i>- <i>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.</i>• <i>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 principal investigator/study supervisor/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.</i>• <i>Annually a number of studies may be randomly selected for active monitoring.</i>• <i>The date of approval indicates the first date that the study may be started.</i>• <i>In the interest of ethical responsibility, the NWU-HREC reserves the right to:</i><ul style="list-style-type: none">- <i>request access to any information or data at any time during the course or after completion of the study;</i>

ANNEXURE 2 WESTERN CAPE DEPARTMENT OF HEALTH HREC



Western Cape
Government

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
Tel: +27 21 485 0868; Fax: +27 21 485 6258
5th Floor, Market Tower House, 2 Kierkegaard Street, Cape Town, 8001
www.westerncape.gov.za

REFERENCE: WC_202011_032
ENQUIRIES: Dr Sabela Petros

Private Bag X6001
Polchefstroom
South Africa
2520

For attention: Ms Michelle Horningh, Prof Petra Bester

Re: Intersectoral team members' understanding of and recommendations for a mental health promotion programme in a rural sub-district, Western Cape Province

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.


Please contact **Ronell Zondo (028 214 5804)** to assist you with any further enquiries in accessing the following sites:

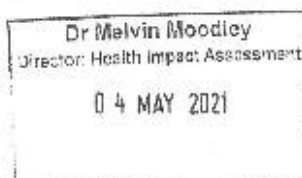
**BREDASDORP CLINIC
OTTO DU PLESSIS HOSPITAL
CAPE AGULHAS SUB DISTRICT**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing content to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely


DR M MOODLEY
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE:
CC



ANNEXURE 3 WESTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT HREC



Research, Population and Knowledge Management

48 Queen Victoria Street, Cape Town, 8000

Reference: 12/1/2/4

Enquiries: Clinton Daniels/Petro Brink

Tel: 021 483 8658/483 4512

Ms M. Hattingh

Private Bag X10

Bredasdorp

7280

Dear Ms Hattingh

RE: APPROVAL TO UNDERTAKE RESEARCH IN THE WESTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT

1. Your request for ethical approval to undertake research in respect of *'Intersectoral team members' understanding of and recommendations for a mental health promotion programme in a rural sub-district, Western Cape Province'* refers.
2. Kindly note that your request was found to meet the ethical requirements of the Department's Research Ethics Policy, subject to the conditions stipulated below.
 - That the Secretariat of the Research Ethics Committee be informed in writing of any changes made to your proposal after approval has been granted and be given the opportunity to respond to these changes.
 - That ethical standards and practices as contained in the Department's Research Ethics Policy be maintained throughout the research study, in particular that informed consent (written or recorded) be obtained from participants.
 - The confidentiality and anonymity of participants, who agree to participate in the research, should be maintained throughout the research process and should not be named in your research dissertation or any other publications that may emanate from your research.
 - The Department should have the opportunity to respond to the findings of the research. In view of this, the final draft of the research dissertation or products compiled by members of the research team should be sent to the Secretariat of the REC for comment before further dissemination.
 - That the Department be informed of any publications and presentations (at conferences and otherwise) of the research findings. This should be done in writing to the Secretariat of the REC.

ANNEXURE 4 WESTERN CAPE DEPARTMENT OF EDUCATION HREC



Directorate: Research

Audrey.wyngaard@westerncape.gov.za
tel: +27 021 467 9272
Fax: 0865902282
Private Bag x9114, Cape Town, 8000
wced.wcape.gov.za

REFERENCE: 20210205-845
ENQUIRIES: Dr A T Wyngaard

Ms Michelle Hattingh
Private Bag X10
Bredasdorp
7280

Dear Ms Michelle Hattingh

RESEARCH PROPOSAL: INTERSECTORAL TEAM MEMBERS' UNDERSTANDING OF AND RECOMMENDATIONS FOR A MENTAL HEALTH PROMOTION PROGRAMME IN A RURAL SUB-DISTRICT, WESTERN CAPE PROVINCE

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **01 March 2021 till 30 September 2021**.
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:
**The Director: Research Services
Western Cape Education Department
Private Bag X9114
CAPE TOWN
8000**

We wish you success in your research.

Kind regards,
Signed: Dr Audrey T Wyngaard
Directorate: Research
DATE: 05 February 2021

Lower Parliament Street, Cape Town, 8001
tel: +27 21 467 9272 fax: 0865902282
Safe Schools: 0800 45 46 47

Private Bag X9114, Cape Town, 8000
Employment and salary enquiries: 0861 92 33 22
www.westerncape.gov.za

ANNEXURE 5 EXAMPLE OF INFORMED CONSENT



Private Bag X1290, Potchefstroom
South Africa 2520
Tel: +2718 299-1111/2222
Fax: +2718 299-4910
Web: <http://www.nwu.ac.za>

NWU- Date:
HREC 2021.06.1
Approval 1 15:30:44
+02'00'

NWU-HREC Stamp

INFORMED CONSENT FOR WILLING PARTICIPANTS IN SEMI-STRUCTURED, INDIVIDUAL INTERVIEWS:

TITLE OF THE RESEARCH STUDY: Intersectoral team members' understanding of and recommendations for a mental health promotion programme in a rural sub-district, Western Cape Province

ETHICS REFERENCE NUMBERS: NWU-00477-20-A1

PRINCIPAL INVESTIGATOR: Prof L Kruger & Prof P Bester

POST GRADUATE STUDENT: Ms M Hattingh

ADDRESS: North-West University
Building F7B, Room 117
Private Bag X6001
Potchefstroom
2522

CONTACT NUMBER: 082 335 0571

You are being invited to take part in a **research study** that is required for a Master's degree in Transdisciplinary Health Promotion. Please take some time to read through the information, which will explain the details of this research. Please ask the researcher or the 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 pleased with the content and understand what this research is about and how you might be involved. 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.

Due to the current COVID-19 pandemic regulations and the Alert level in place in South Africa, it is crucial to keep you safe. Therefore, the research informed consent will be obtained online. You and a witness on your side on the smartphone and the researcher with a witness on the other side. After the research consent was signed a photo of the signatures needs to be sent to the researcher's smart phone as evidence that the participation is voluntary. The original signed document will be put in an envelope which will be fetched at a predetermined place and time of your choice, abiding by regulations of social distancing. You are one of 26 other participants and we want to keep you safe. Your opinion is valuable for this research.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00477-20-A1)** 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?

- This study will be conducted in the Cape Agulhas sub-district
- We want to hear what your understanding is of mental health promotion and how we can address this in the community. The researcher will ask guiding questions that will help you answer the questions to the best of your ability.
- The questions can be answered in three ways namely text messaging, with audio voice or writing/ typing it. The written or typed answer will be sent by taking a clear picture of the document and sending it to the research assistant
- There will also be a question in which you need to take one to three photographs from your smartphone that must be sent to the research assistant. This will be guided with clear instructions

Why have you been invited to participate?

- You have been invited to be part of this research because you are a teacher/ spiritual leader/ community leader /professional nurse/ health worker/ psychologist/ social worker/ non-professional working in the Cape Agulhas Sub-district.
- You are an active member of an entity or organisation which render a service for at least one year in the community
- You have a smartphone with WhatsApp
- You are confident in expressing yourself on paper, in text messages or on voicemail on WhatsApp
- You are interested in mental health promotion and be the person colleagues and community members turn to in difficult times
- You are older than 18 years and therefore can give voluntary consent
- You are able to communicate effectively in Afrikaans or English
- You have been involved with the community for more than a year and can share your knowledge about this

What will be expected of you?

- An appointment will be made with you and a witness with a definite date and time where delayed consent will be signed online during a WhatsApp video call with the researcher and a witness
- The consent will be signed simultaneously
- The completed consent form, will then be photographed with the visible signature indicating that you consent to participate in the study and sent it to the researcher on WhatsApp
- The researcher will discuss with you a time and place where the original form in an envelope will be fetched
- Make at least sixty minutes of your time available to answer the interview questions in a way which suites you either by text messaging, voice recording or by writing / typing and taking a photo
- You can answer these questions over a period of weeks
- Recognition of receiving the questions and instructions must be indicated on WhatsApp with text or emoji.
- Take photos and share these photos with the research assistant during the interview.

Texting/ audio/ typed/ written answers:

- Text messages must be clear
- Emojis can be used when you want to portray emotion but should not replace any words
- When using audio voice, you should ensure your own privacy. Ensure that you are in a private place and that background noises is minimal so that the audio is clear
- Written/typed answers must be destroyed after the researcher indicated that the photo was clear and she is able to read the answers

Photograph

- Avoid taking pictures of people and people' faces as this will require written consent - you may want to take pictures of any unidentified structures like feet or hands, but this will also require consent
- Objects will be more permissible
- Please ensure your safety before taking the photograph
- Please ensure that the photo is clear
- Do not download pictures from other sources as this need special permission and cannot be used

Will you gain anything from taking part in this research?

- The researcher will provide you with WhatsApp data to reimburse any data used during the two weeks
- There are no other direct benefits for you to participate in this research. The information provided during the interviews can assist the researcher make recommendations to promote mental health in the community
- Your contribution will be appreciated and assist the researcher to make recommendations towards mental health promotion programs in the sub-district

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

- There might be some risks involved for you when you decide to be part of the research.

You might feel unsure about the questions	When you feel you are unsure you can contact the research assistant, which will either phone or text you to explain. Use your own interpretation in your own words
You might feel the answer is wrong and not what the researcher wants	All information gathered is relevant and are valuable in giving the researcher different viewpoints. There are no right or wrong answers. That makes research interesting. The questions asked will lead you to answer within the context of the research
You are concerned that the information given will identify you as one of the participants	All participants will be identified in the research with false names. Identifiable markers like place, names will be removed as far as possible, so that it is unidentifiable. The results will be discussed in one pool of data and will not be directly linked to you.

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

- You will be linked with a false name on the researcher assistant's WhatsApp during the research and will therefore, stay anonymous. This false name will be used in the documentation as well
- WhatsApp has 'end to end' encryption which ensure that any third party will be unable to see what is discussed. The researcher assistant's smartphone has a security code with the phone needs to be opened. Her laptop is password protected as well as the file where text messages will be saved. Security on her electronics is up to date and will ensure that no one can access it.
- Your privacy will be protected. Identifying markers like places and people will be excluded unless it will be needed to make sense of the researcher in which case the researcher will contact you and get consent to include it in the research.

- Consent to do the research must be approved by the Health Research Ethics Council of the University and the Department of Health which is strict about protecting you during this research.
- Your results will be kept confidential by ensuring that the research assistant, researcher and research supervisors sign a confidentiality agreement. Voice recordings and transcripts of the interviews will be password protected on the research supervisor's computer and hard copies will be kept in a locked cabinet in her office, on the Potchefstroom Campus of the University. Data will be stored for 5 (five) years.

What will happen with the findings or samples?

- The findings of this study will only be used for this research and any future research that require the anonymised information should apply for approval by the Committee of the Faculty of Health Sciences on the Potchefstroom Campus (HREC)

How will you know about the results of this research?

- You will receive a summarised report on the research finding and on request feedback will be given to your management with you in attendance. The findings of the study will be used to publish an article

Will you be paid to take part in this study and are there any costs for you?

- You will receive a one gig WhatsApp data bundle to reimburse any data used during the course of the two week
- No other payment will be made during the course of the research. There will thus be no costs involved for you, except the time you spent in answering the questions.

Is there anything else that you should know or do?

- You can contact Ms M Hattingh at 028-424 2652 if you have any further questions or have any problems
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 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 the participant

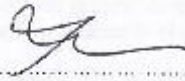
By signing below, I, [REDACTED] agree to take part in the research study titled: 'intersectoral team members' understanding of and recommendations for a mental health promotion programme in a rural sub-district, Western Cape Province'

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 pressurised 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) Bredasdorp on (date) 30/09 2022
and time 15h00



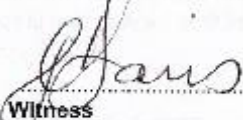
Signature of participant

Declaration by the witness of the participant

I (name) [REDACTED] declare that:

- 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) Bredasdorp on (date) 30 Sept. 2021
and time 15h00



Witness

Signature of person obtaining consent

Declaration by the researcher

I (name) Nicole Hobson declare that:

- The information in this document was explained to me by [REDACTED]

- He/she did/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) Breda on (date) 30 Sept 2021
 and time 16h00

.....
 Signature of researcher

Declaration by researcher's witness

I (name) [redacted] declare that:

- The information in this document was explained to [redacted], who I trained for this purpose.
- He/she did use an interpreter
- The informed consent was obtained by an independent person.

Signed at (place) Breda on (date) 30 Sept 2021
 and time 16h00

.....
 Signature of witness

General de Wet 2019: 133 (Mandatory Health Research) 10715220
 7/1/2019 9:11:10

ANNEXURE 6 TURNITIN CERTIFICATE

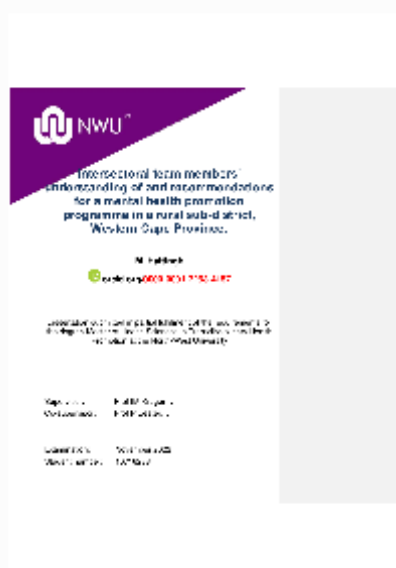


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ANNEXURE 7 LANGUAGE EDITING



31 Kirk Street, Haenertsburg, 0730
cumlaudelanguage@gmail.com

Christien Terblanche
SAIT accredited
078 250 8101

Michele Venter
SAIT accredited
083 327 9601

Elizanne Terblanche
PhD (Lang)
059 211 5218

DECLARATION OF LANGUAGE EDITING

I, Christien Terblanche, hereby declare that I edited the text titled:

**Intersectoral team members' understanding of and recommendations
for a mental health promotion programme in a rural sub-district,
Western Cape Province**

for **Michele Hattingh** for the purpose of submission as a postgraduate
study for examination. Suggestions were indicated in track changes and
application was left to the author. The language editor did not view a final
version.

Regards,

A handwritten signature in black ink that reads 'Christien Terblanche'.

CME Terblanche

Cum Laude Language Practitioners (CC)

South African Translators Institute accr nr: 1001066

Full member of the Professional Editors Guild

