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Institutionalization of health promotion in the South African health system

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG | WITS School of Public Health

PhD Thesis

Doctoral Programme in Public and Population Health

Institutionalization of health promotion in the South African health system

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A THESIS BY PUBLICATION

Submitted to the School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, in fulfillment of the requirements for the degree of

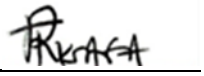
Doctor of Philosophy

JOHANNESBURG, SOUTH AFRICA

NOVEMBER 2020

DECLARATION

I, Rwafa Teurai declare that *"Institutionalization of health promotion in the South African health system"* is my own original work. Professors Jane Goudge, John Eyles and Nicola Christofides supervised the research and thesis writing. All citations, references, sources and borrowed ideas have been duly acknowledged. The thesis is being submitted for the degree of Doctor of Philosophy in the School of Public Health, at the University of the Witwatersrand, Johannesburg. It is written in a divided block format - approved by the Facility of Health Sciences with the results presented in the form of three discrete research manuscripts. All papers are reproduced with the copyright holders' permission on open access publishing. I confirm that I am listed at the first and lead author in the articles. None of the work has been submitted before to this or any other University or institution for any degree or examination.

Signature: 

Date: 9th day of November 2020

DEDICATION

To the younger version of myself

I could never had dreamt you could come this far!

ACKNOWLEDGEMENTS

"We are like dwarfs sitting on the shoulders of giants. We see more, and things that are more distant, than they did, not because our sight is superior or because we are taller than they, but because they raise us up, and by their great stature add to ours."

~ John of Salisbury ~

I could not have gotten to this stage of my academic life without the love, support and encouragement of the following giants in my life:

My supervisors and mentors: Jane Goudge, John Elyes and Nicola Christofides. I am overly appreciative of your unwavering support; guidance and patience in helping me complete this PhD, as well as bringing out the best in me. You stood with me through it all and helped me soldier-on. I am truly humbled by your patience; the road was certainly not easy.

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Loving husband: I would to give my heartfelt gratitude to my husband Ronald Ponela for the love, support and tolerance he rendered to me during the times I was highly stressed. He provided a home full of warmth and words of inspiration when I felt like quitting.

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To everyone who helped celebrate every milestone I achieved no matter how small it was, and all who managed to attend my presentations. If there is anyone, whose name I have missed and forgotten to specifically mention, I apologize, and thank you to you too.

Most importantly, I am most grateful to God. *Ebenezer,* thus far the Lord hath taken me!

OUTPUTS GENERATED FROM THE PHD

List of papers included as part of the thesis

This PhD thesis is based on three original research papers. For all the listed manuscripts, Teurai Rwafa was the principal investigator (PI) and conceptualised the study design, developed data collection tools, managed the research, including data collection cleaning, coding, analysis and writing of all manuscript drafts. All three papers are included in this thesis with the permission of co-authors (Appendices P-R) and were published or submitted to open access journals - where article material has been used, it has been appropriately referenced. The papers are referred to in the thesis write-up using their chapter numbers (4, 5 and 6 respectively). Their citations are as follows:

I. **Rwafa-Ponela, T.**, Christofides, N., Eyles, J., and Goudge, J. (2020) Health promotion capacity and institutional systems: An assessment of the South African Department of Health. *Health Promotion International.* https://doi.org/10.1093/heapro/daaa098

II. **Rwafa-Ponela, T.**, Goudge, J. and Christofides, N. Institutionalization of health promotion in the South African health system: A qualitative case study - *"The one who pays you has no name for you"*. *Manuscript under-review at BMJ Open Journal.*

III. **Rwafa-Ponela, T.**, Eyles, J., Christofides, N., and Goudge, J. (2020) Implementing without guidelines, learning at the coalface: a case study of health promoters in an era of community health workers in South Africa. *BMC Health Research Policy and Systems*. 18, 46. https://doi.org/10.1186/s12961-020-00561-5

List of additional papers complementary to the PhD

Galjour J., Schwarz T., Rusike I., Lomazzi M., Hoemeke L., Prytherch H., **Rwafa T.**, Nanyonga M., Ram R., Neupane S.. Tsasis P., Rumaney M., Akinmurele T., Ssemakula M., Nanda R., Mpinga EK. From "learning from the field" to driving change. *Manuscript under review at Journal of Public Health Policy*.

Goudge J., Thorogood M., De Kardt J., Malatji H., Babalola O., Tseng M., Watkins J., Muteba M., **Rwafa T**., Daviaud E., Levin J., Nxumalo N., Grifffiths F. (2020) Household coverage, quality and costs of care provided by CHW teams and the determining factors: findings from a mixed methods study in South Africa. *BMJ Open*: URL *https://bmjopen.bmj.com/content/10/8/e035578.full*

Tseng, Y., Griffiths, F., de Kadt, J., Nxumalo, N., **Rwafa, T.,** Malatji, H., Goudge, J. (2019) Integrating community health workers into the formal health system to improve performance: a qualitative study on the role of on-site supervision in the South African programme. BMJ Open: URL *https://bmjopen.bmj.com/content/bmjopen/9/2/e022186.full.pdf*

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The South African National Research Chair Initiative (SARChI) PhD Fellowship in Health Systems and Policy at the Wits Centre for Health Policy, funded by the South African National Research Foundation (NRF) from 2017 to 2020.

Conference Presentations

T. Rwafa-Ponela, J. Eyles, N. Christofides and J. Goudge: Poster Presentation - *Implementing without guidelines: Learning at the coalface - A case study of health promoters in an era of community health workers in South Africa.* Geneva Health Forum (GHF). Theme: Leaning from the field. Geneva, Switzerland: November 2020

T. Rwafa-Ponela, N. Christofides, J. Eyles and J. Goudge, J. Poster Presentation - *Health promotion capacity and institutional systems: An assessment of the South African Department of Health*. Geneva Health Forum (GHF). Theme: Leaning from the field. Geneva, Switzerland: November 2020

T. Rwafa-Ponela, N. Christofides, J. Eyles and J. Goudge, J. Oral Presentation - *Connecting the dots between Social and Behavioural Change Communication Capacity and Institutional Systems: A case study of the South African Department of Health*. International Social and Behaviour Change (SBCC) Summit. Theme: Connecting the dots of SBCC. Marrakech, Morocco: October 2020

T. Rwafa-Ponela, J. Eyles, N. Christofides and J. Goudge: Poster Presentation –*Implementing without guidelines: Learning at the coalface - A case study of health promoters in an era of community health workers in South Africa.* Association of Schools of Public Health (ASPHA) Conference. Theme: Universal Health Coverage. Kampala, Uganda: October 2019

T. Rwafa-Ponela, N. Christofides, J. Eyles and J. Goudge, J. **Awarded Best Oral Presentation**: *Health promotion capacity and institutional systems: A three-level assessment of the South African Department of Health*. Public Health Association of South Africa (PHASA) Conference. Theme: Health Systems and Policy. Cape Town, South Africa: September 2019

T. Rwafa-Ponela J. Goudge, J. Eyles and N. Christofides: Poster Presentation -*"They call us 'straat meit'; like you're always on the street. So you don't belong here, with us": Insider and Outsider views of health promotion practice within government* Public Health Association of South Africa (PHASA) Conference. Theme: Health Systems and Policy. Cape Town, South Africa: September 2019

T. Rwafa-Ponela, J. Eyles, N. Christofides and J. Goudge: **Awarded Second Best Oral Presentation**: *Implementing without guidelines: Learning at the coalface - A case study of health promoters in an era of community health workers in South Africa***.** Wits School of Public Health Research Day. Theme: Social and Behaviour Change Communication. Johannesburg, South Africa: August 2019

T. Rwafa-Ponela, N. Christofides, J. Eyles and J. Goudge Poster Presentation - *Health promotion capacity and institutional systems: An assessment across three-levels of the South African Department of Health*. Wits School of Public Health Research Day. Theme: Social and Behaviour Change Communication. Johannesburg, South Africa: August 2019

T. Rwafa, J. Goudge, N. Christofides, and J. Eyles: **Awarded Best Oral Presentation**: *Where are health promoters in PHC re-engineering? Working it on the ground: when the policy or process doesn't provide support.* Public Health Association of South Africa (PHASA) Conference**.** Theme: Health Systems Strengthening. Parys, South Africa: September 2018

T. Rwafa, J. Goudge, N. Christofides, and J. Eyles: **Oral Presentation**-*Where are health promoters in PHC re-engineering? Working it on the ground: when the policy or process doesn't provide support.* Wits Faculty of Health Sciences Research Day**.** Theme: Education Policy and Systems. Johannesburg, South Africa: September 2018

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2018: Public Health Association of South Africa (PHASA) Conference, Best Oral Presentation

ABSTRACT

Introduction: Despite global recognition of health promotion (HP) as a cost-effective way to improve population health, it is not highly regarded nor is it sufficiently institutionalized in many health systems, particularly in low and middle-income countries (LMICs). This diminishes its ability to deliver on public health promises, reducing the need for curative health care. In this regard, capacity of HP staff, as well as the institutions responsible for HP programming, is critical if the full potential of HP in the health system is to be reached. Given that, HP concepts are fundamental to the internationally renewed commitment on primary health care (PHC), it is worthwhile investigating how the role of HP is being ensured as part of the health system and not just subsumed into PHC. Ongoing efforts to strengthen health systems with the view to universal health coverage (UHC) should include measures to improve HP performance. Understanding how HP is institutionalized, within the Department of Health (DoH) at multiple levels (national, provincial and local/district), could inform efforts to strengthen functioning and integration within health systems, thus addressing implementation gaps. The aim of this doctoral (PhD) research was to investigate HP capacity, organization and implementation. The thesis focuses on how HP is institutionalized within the South African health system.

Methods: A case study approach was implemented using concurrent mixed methods [QUAL (quan)]. The methodological approach was applied to allow for a systems perspective on the *"what"* and the *"how"* of HP institutionalization in the South African DoH. Purposive sampling was used to select DoH settings and participants (both HP and non-HP staff) for

the study, from national, two out of nine provinces that had the highest number of HP staff, one district within each province, and two sub-districts within each selected district and 12 PHC-facilities in the selected sub-districts. Snowball sampling was used to recruit external HP stakeholders. Data was collected over a three-month period (November 2017 - February 2018) using a combination of data collection methods. Firstly, qualitative in-depth interviews (*n=37*) with HP managers, health promoters (HPPs), and facility-managers. Secondly, key informant interviews (*n=8*) with academia, research and non-governmental organization participants. Thirdly, one-day workshops (*n=5*) with DoH and HP managers, which used a quantitative capacity assessment tool and elicited in-depth discussions. Lastly, document reviews of the national HP policy and strategy (2015-2019), PHC revitalization implementation guidelines, as well as HP provincial and district level plans were completed. Qualitative data were analyzed using deductive and inductive content analysis using the aid of MAXQDA software. Descriptive statistics were used to analyze quantitative data using STATA 13 software. Mean capacity scores within and across different domains were calculated with standard deviations.

Findings: The study demonstrates limited collective capacity to prioritize, plan, deliver, monitor and evaluate HP activities among HP practitioners within the DoH, alongside inadequate institutional capacity to support an effective health promotive agenda, manifesting as systemic barriers against the organization and implementation of HP programming. Fundamental structural factors that impede integration of HP into the fabric of the South African health system include a robust curative-focused approach. This confines the strategic vision for HP within the DoH, further compounded by a limited understanding of the HP concept. There is lack of credibility in the HP programme among

those in positions of power at the DoH, which result in insufficient financial investment in HP activities. Programmes with greater resources such as HIV run parallel HP activities. As a result, HP practitioners and their leadership experience feelings of moral distress and an identity crisis within the health system. There is limited collective capacity among HP staff, resulting from inadequate training in HP and the lack of professional classification. As a result, the HP workforce generally feels powerless to change perceptions of low status ascribed to the field and the numerous challenges it faces. Additionally, data suggests inadequate vision and leadership to consider stakeholder coordination and multi-sectoral collaboration as part of the HP role, particularly at national DoH. Despite these results, the analyses show that health promoters have a critical role to play in PHC revitalization, such as provision of support and supervision to CHWs and other community-based initiatives. However, there is no mechanism for HP lessons from the field to be fed into the system to strengthen institutionalization of HP.

Conclusions: My PhD provides empirical evidence for the need to re-orient the structure of the South African health system to integrate HP, from the strategic level to the coalface. Given the current status quo, HP is unlikely to bring about any large-scale reductions in the high need for health care among the population, or win the scramble over resources with curative services. Leadership responsible for budget allocations make a limited budget available for HP at any level. The mechanisms for feedback from HP staff implementing activities on the ground are lacking. These factors among others would need to be addressed in order to strengthen institutionalization. Thus, HP will remain a Cinderella service as it is today, with limited meaningful commitment. In order to strengthen HP, strategic oversight from an entity such as an independent or semi-autonomous HP

Foundation that will support the HP agenda through prioritization, coordinate funding and contribute to evidence based health public policy, research, advocacy, multi-sectoral planning is required in South Africa.

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LIST OF ABBREVIATIONS AND ACRONYMS

CHWs	Community Health Workers
DHIS	District Health Information System
DoH	Department of Health
FGDs	Focus Group Discussion
HCIs	High Income Countries
HP	Health Promotion
HPDF	Health Promotion and Development Foundation
HPDFNet	Health Promotion and Development Foundation Network
HPFs	Health Promotion Foundations
HPPs	Health Promotion Practitioners
IDIs	In-depth Interviews
KIIs	Key Informant Interviews
LMICs	Low and Middle Income Countries
MoH	Ministry of Health
NDoH	National Department of Health
NGOs	Non-Governmental Organisations
NHI	National Health Insurance
PHC	Primary Health Care
PI	Principal Investigator
PhD	Doctor of Philosophy
SBCC	Social and Behaviour Change Communication

SD	Standard Deviation
SDGs	Social Development Goals
UHC	Universal Health Coverage
USAID	United States Agency International Development
Wits	University of the Witwatersrand
WBOTs	Ward Based Outreach Teams
WHO	World Health Organization

DEFINITION OF KEY CONCEPTS AND TERMS

In this thesis, meanings of key terms and concepts used throughout this work are briefly described and defined as follows:

Complex system	'complex' implies diversity - a wide variety of elements. A system is a set of connected or interdependent components or parts. Many diverse and autonomous components or parts (known as agents) are interrelated, interdependent, linked through a web of many (dense) interconnections, each operating from its own schema or local knowledge. These agents act based on local or surrounding knowledge and conditions and behave as a unified whole in learning from experience and in adjusting (not just reacting) to changes in the environment. An agent may be a person, or an organization, among many others (Begun et al., 2003).
Disease prevention	and health promotion are complementary. However, they are not identical concepts. Prevention is usually disease specific, a pathogenetic focus that is oriented towards avoiding risks (Kessler and Renggli, 2011).
Institutionalization	concept is frequently used to encompass various sets of meanings or interpretations. In this thesis, it is defined as activities, mechanisms and or processes by which structures, rules and routines become established as part-of every social reality. Therefore, it represents a core in sociological process in social sciences (Schneiberg and Soule, 2005). In organizations, institutionalization translates an organization's code of conduct, mission, policies, vision, and strategi plans into actionable guidelines applicable to the daily activities of it

employees. It aims at integrating fundamental values and objectives into the organization's culture and structure, thus `value infusion' ar `behavioural routinization' (Levitsky, 1998).

Infrastructure for health promotion is defined according to Nutbeam and WHO (1998) who state it as human and material resources, organizational and administrative structures, mandate, regulations and incentives, which facilitate organized HP implementation. Infrastructure for health promotion can be found not only in tangible resources and structures, but also through the extent of public and political awareness of health issues, and participation in action to address those issues (Nutbeam, 1998b).

Health has possible alternative definitions and interpretations (Levitsky, 1998). Over the course of human history, some definitions of health have been critiqued and contested, resulting in various re-visitations and expansions. In this thesis, health is considered as 'the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to cope with the interpersonal, social, biological and physical environments. Health is therefore a resource for everyday life, not the objective of living; it is a positive concept embracing social and personal resources as well as physical and psychological capacities' (Starfield, 2001).

Health promoters term is ambiguous and various definitions exist in literature. At times the term health promoter and health worker are used interchangeably (Le Roux, 2017). In this thesis, a health promoter was considered as a dedicated 'health worker who educates, motivates, and supports the members of the community in their pursuit of health' (Reinschmidt et al., 2006). Health workers are

trained personnel who are familiar with the health care system in order to educate, motivate and support the members of a community to select appropriate health related behaviours. Health promoters deal with positive health aspects in communities (Tengland, 2010), such as counselling, support and formation of communication links between the health sector and communities (Brownstein et al., 2011). Health promoter and HP practitioner (HPP) terms are used interchangeably in this thesis.

Health promotion is defined according to the Ottawa Charter of HP, which defines HP as 'the process of enabling people to increase control over, and to improve, their health. Therefore, HP is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being' (World Health Organization, 1986). It represents a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Participation is essential to sustain HP action (Nutbeam, 1998b). Sartorious elaborates on the definition of HP, adding that when high value is placed on health (not merely the absence of disease) it makes people undertake whatever is necessary to enhance health (Sartorius, 2006).

Health System is defined as according to the World Health Organization (WHO) definition, which states that it is 'the ensemble of all organizations, people and action whose primary intent is to promote, restore or maintain health' (World Health Organization, 2007b). Health systems encompass people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's

legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health (World Health Organization, 2000).

Primary Health Care is defined as the 'first level of care', which makes universal health coverage (UHC) accessible to all individuals and families in a community (as opposed to secondary and tertiary care which would normally be hospital-based with focus more on curative/palliative care) (World Health Organization, 1978). While, UHC was defined as 'all people can easily access the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship' (World Health Organization, 2005).

Social determinants of health are the conditions of daily life such as the social, physical and economic environments in which people are born, grow, live, learn, work, play, worship, and age and the wider set of forces and systems that impact on health, functioning, and quality-of-life outcomes and risks (World Health Organization and Commission on Social Determinants of Health, 2008)

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PREFACE

Undertaking this doctoral (PhD) journey has changed me in many ways I never thought possible. Through it, I have gained more insight about myself as an individual, as well as critical thinking capacity I never dreamt I would ever possess. This is my story, to every Black African child who feels less privileged. It is not about where you come from that matter, but where you end up. My academic drive began when I attended first grade, with no proper uniform. This made me realize that I came from a “different” background, compared with other children. Determined that my life was not going to be purposed by the socio-economic environment I grow up in, I made a choice to break new ground, not just for me, but also for my biological family, the family I married into, as well as generations to come.

Looking back, it’s a bit difficult to pinpoint when the desire to undertake a PhD began. For starters, I never knew what a PhD was, until later in life. I pretty much had to figure out a career path on my own. The model of schools I attended did not have opportunities for proper ‘career guidance’ neither were there role models close-by for me to emulate. However, time and chance happens to all. A turning point in my life was walking into one woman’s house years ago - Dr. Cynthia Chaibva’s, who inspired me. A big lovely portrait of her in a beautiful red gown hung in the middle of her living room. When I inquired what the graduation was for, she replied “PhD”. In puzzlement, I asked her to explain, that is when I learnt about life post a master’s degree.

I have always had an interest in health, but curative health to be precise. Sadly, growing up a health professional meant a doctor or a nurse. I fell in love with public health during my undergraduate training, when I graduated with a Bachelor of Science degree in Health

Education and Health Promotion. To further my new public health interest I enrolled for a Master of Public Health degree. For my master's research I analysed how male sexual dominance in intimate relationships increases vulnerability to HIV infection among the women. The research had a very strong base on societal norms as a determinant of health outcomes. It contributed to my deeper understanding on why it is important to understand societal vulnerabilities, which manifest as health inequities and social injustice; making me realize that many a time, ultimate health and well-being lie outside one's area of influence. Having grown up in a township this realization is something I closely identified with.

After migrating to South Africa, I wondered if the field of health promotion faced similar challenges as in my home country. I remember coming across the term 'health promoter' in one of the TB/HIV cross-border collaboration meetings I attended in Musina, Limpopo province, and probing what this type of professional was and what their roles were, as we did not have a cadre of HP foot-soldiers at the PHC facility level in my home country. I entered this research with an inquisitive mind, in the hope of understanding how HP is organized within the health system of another African, but middle-income setting.

In this thesis, I discuss a number of gaps in health promotion literature, and health systems and policy research. I address an important issue in the field of health promotion, which is capacity mapping at governmental levels in order to guide planning, implementation and evaluation of health promotion activities and gauge support of the broader institution for health promotion activities. I also address factors that influence the organization and implementation of health promotion within the South African health system. However, a curative-focused health system has hampered the institutionalization of health promotion. Coming from a health promotion background, I identified with the frustrations felt by most

health promotion practitioners during this study and the constant need to always be fighting for resources and recognition for the profession.

I also present results that examined the context of changing the approach of health promotion in primary healthcare in South Africa, using the case of the implementation of community health workers at primary levels. The most important thing about this type of study is that it provides qualitative evidence of high value for understanding barriers, facilitators and other crucial aspects for the implementation of health programmes and policies in contexts of evolution and the search for the consolidation of health systems that intend to strengthen the role of primary health care; given the factors related to the social determinants of health, especially in low-and middle income countries. My study shares information and insights that can help other health systems to reflect on their challenges and learn from the experience studied to consider this qualitative evidence in their decision-making processes. Although the contexts are different, the phenomena can always maintain verisimilitude, once their different constitutive elements are shared to some extent. In my opinion, this PhD study presents relevance and good general methodological quality.

Undertaking this research, I was interested in deepening my knowledge in health systems and policy. Given, that during my masters training, I majored in social and behaviour change communication. I wanted to merge my expertise in health promotion with health systems strengthening, because I had come to understand that trying to promote healthy behaviours without systems thinking and vice versa can be limiting in achieving better public health outcomes and population well-being. Therefore, I needed to learn and understand more about how health systems and policy issues operate and determine population health priorities, such that I would be better equipped to carry out rigorous research in the area.

Additionally, I now wear the qualitative research cap. I came onto the programme with quantitative methods knowledge only, but can now confidently say, 'I am a mixed methods researcher'. This journey allowed me to move away from my comfort-zone, learn new research methodologies and data analysis techniques.

Additionally, the journey has helped strengthen my character, both personally and as an academic. I vividly remember crying after a senior academic crushed my PhD proposal during one of our unit's project presentations. From that day, I vowed never to shed a tear on matters relating to my research work. Interestingly, I have always considered myself as shy and never liked being in front of an audience. During this PhD, I have learnt to brace-up presentations and perfect my public speaking skills. To my own surprise, I have won multiple best oral presentation awards. I have learnt to stand up for the research work I have done, as well as speak without being apologetic about the space I occupy. I am stronger now. Proudly, I can say I have learnt to adapt and use conceptual frameworks, something that sounded too abstract and complicated when I began this journey.

However, the unfortunate part about coming from a background were not many understand what you are doing or why you have chosen to do a degree-after-degree, was the inability to share my milestone achievements like publications with those I love the most, like my mother, who had no idea what a research publication was. All she earnestly waited for were the words graduation day, which is the only aspect that made sense to her. My sister complained that trying to read my so-called "work" gave her a headache. However, I am grateful to her for teaching me the value for spending most of my time in a community library.

Attaining a PhD qualification for me is not an end in itself by a means to an end in realizing my career path in public health. I plan to continue research in the field of health systems and policy relative to health promotion. There is a gap in low and middle-income countries in achieving health-promoting health systems compared to developed nations. My goal is to become a specialist in health systems strengthening and investigate improvements that can be made in order for health systems to become health promoting. The PhD has equipped me to play a better role in advocating and formulating such strategies that are relevant for the South African context and within other countries with related demographics, thereby I look forward to help strengthen the health system and other developing nations.

STRUCTURE OF THE THESIS

My PhD is by publication using a block format. The block format requires that there is a separate literature review and that the published papers make up the results chapters with the papers presented in their entirety. My PhD consists of eight chapters that are organized as follows:

Chapter 1: Background - introduces the background and study context, upon which my PhD is based. This chapter includes a research statement and position of the research, as well as provide the specific aims of the thesis.

Chapter 2: Literature Review - reviews relevant global, regional and local literature and other critical documents to contextualize health promotion in the thesis. The chapter begins with a definition of the concept of health promotion as well as introduces the overall conceptual framework used to guide the thesis.

Chapter 3: Methodology - describes the overall study design and methods that were applied in my PhD study in order to answer the research question; and provides justifications for the choices made.

Results Chapters: In *Chapters 4, 5 and 6,* I present the empirical results of the thesis in the form of the published papers or in the format that the paper was submitted to a journal for publication. The three papers are referred to in the thesis write-up by their chapter numbers. Results chapters are organized in such a way that allows for the interpretation of the overall thesis findings rather than being in a temporal order by publication date.

Chapter 7: Discussion - this chapter discusses the findings across the two published and one submitted paper in order to tell a single story.

Chapter 8: **Conclusion and recommendations** - provides the conclusions and recommendations drawn from all the components of the PhD. It summarises the current institutionalization of HP in the South African context, and how a health-promoting health system should be considered for greater health gains.

BACKGROUND

CHAPTER ONE

"But, solving problems of disease is not the same thing as creating health and happiness. Health and happiness are the expression of the manner in which the individual responds and adapts to the challenges that s/he meets in everyday life."

~ Rene Dubos ~

1. INTRODUCTION

This doctoral (PhD) thesis focuses on health promotion (HP) using a health systems' perspective. The thesis investigates some of the key issues relating to health-promoting heath systems within an African setting. *Chapter 1* introduces the background and context of the research conducted for this PhD. The chapter is organised into six sections. In the first section, I provide the overall research statement and position my PhD, which provides the impetus for this research. The chapter then describes the history and organization of HP in South Africa, including the development of its first national HP policy. In this chapter, I state the aims that the PhD research set out to answer, as well as provide the justification for carrying out this particular research.

1.1 Research statement

This PhD thesis investigates how HP is institutionalized within the South African Department of Health using a health systems lens. Given the complex nature of both HP and health systems research, my PhD crosses several disciplines including public health, health systems and social sciences. The thesis primarily draws on a combination of the World Health Organization's (WHO) System's Thinking for Health System Strengthening Model (World Health Organization, 2009e); and Brand and Aluttis's Country-level Framework for Public Health and Health Promotion Capacities (Brand and Aluttis, 2011). The research uses theories and conceptual frameworks from various disciplines including: a management theory, Lewin's three-step model of organizational change (Cummings et al., 2016); Giddens' sociological structuration theory (Giddens, 1989) and a capacity assessment tool

that was developed on the ground in Malawi for a United States Agency for International Development's (USAID) project (Jana et al., 2018). The research is positioned at the intersection between HP and health systems, in the wider context of health systems strengthening and revitalization of primary health care (PHC), as illustrated on *Figure 1*.

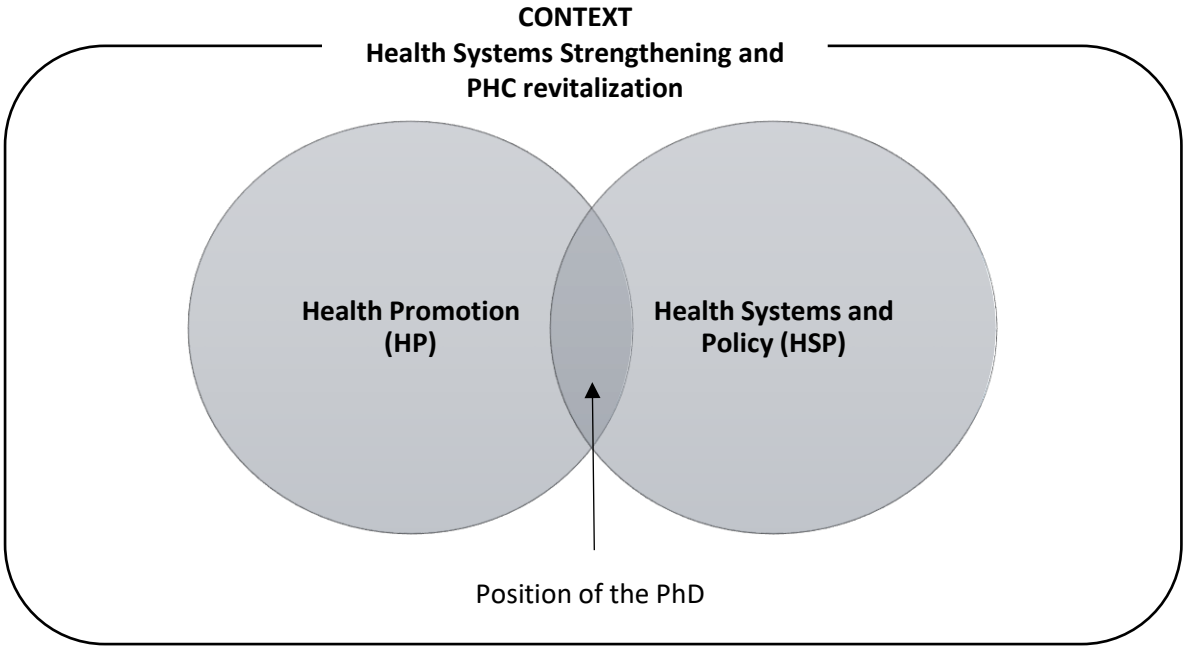


Figure 1: Position of the PhD, adapted (Martin, 2016)

1.2 Background to the study

While curative and rehabilitative health services are critical to every health system, they are not sufficient to accomplish optimal health gains (World Health Organization, 2018). Promoting health and preventing disease is essential within countries for the reduction of the global burden of disease, especially in low and middle-income settings (World Health Organization, 2003). Low-and-middle income countries (LMICs) carry the greatest burden of disease, specifically infectious diseases, an increasing burden of non-communicable

diseases, high levels of maternal and child mortality and morbidity, as well as violence and injuries (Bygbjerg, 2012, Remais et al., 2013, Thienemann et al., 2019). In 2016, the Ninth Global Conference on HP recognized promoting health as essential in achieving sustainable development goals (SDGs) (World Health Organization, 2017b). In this regard, it is important to ensure that efforts to strengthen health systems and efforts to improve health service performance, do not neglect HP programmes and their related activities that address the social determinants of health.

Many factors that influence people's health lie outside the health system, such as poverty, education, infrastructure, and the broader social and political environment (Mondiale, 2007). HP draws on a holistic view of health, and the complex interplay between individual, organizational and environmental factors (Nutbeam, 1998b). This approach is also known as the socio-ecological model of health. In this regard, HP is defined by the Ottawa Charter for HP as the process of enabling people to increase control over and to improve their health (World Health Organization, 1986). Since HP seeks to ensure that all populations can have healthy lives and to maximize their full potential (World Health Organization, 1986), it has a critical role to play in improving population health and wellbeing. The mechanisms for improving population health include reinforcing efforts that strengthen health systems and improve public health performance (European Commission, 2019, Kumar and Preetha, 2012).

In its 2008 report '*Primary Health Care, Now More than Ever*', WHO stated that health systems have a better likelihood of improving population health when HP is embedded within PHC approaches (World Health Organization, 2008). Health workers, particularly

those at PHC levels, have an important role in nurturing and enabling HP (World Health Organization, 2009c). South Africa like many other countries has been implementing a complex set of reforms to strengthen PHC and realize universal health coverage (UHC) (World Health Organization and UNICEF, 2018). While it is essential to strengthen the health system, it is also critical to increase the integration of HP within the fabric of the health system. In this context, HP programmes and interventions can be a vehicle to achieve the recent global PHC revitalization surge, and the proposed National Health Insurance (Department of Health, 2019). This provides an opportunity for rethinking the role and function of HP within the health system (Freeman et al., 2020). Yet it is unclear, if HP is being operationalized within the new context of PHC-focused universal health care revitalization.

Despite PHC approaches emphasizing the importance of HP (World Health Organization, 2007b, World Health Organization, 2008), and international acknowledgement that promotive and preventive health strategies have important roles to play in reducing burden of diseases within health systems through addressing key individual, social, behavioural and other determinants of health (Baum and Fisher, 2014, Ziglio et al., 2011), HP seems neglected. For example, the field of HP is characterised by insufficient investment and a low status, which disable it from delivering on its promise, particularly in LMICs (Kumar and Preetha, 2012, Coe and de Beyer, 2014, Murray et al., 2013, Sanders et al., 2008). In order to effectively map a way forward for the future role of HP within revitalized health systems and the increasing importance to strengthen health systems' health-promoting role; HP needs to be fully integrated into the fabric of health systems. Before that can be done, there is need to first understand how HP is currently organized,

supported and implemented, particularly within government institutions - who are the custodians of the health of the population.

While globally there has been previous research on PHC revitalization and health systems strengthening, few have specifically focused on HP-oriented health systems. Furthermore, given the internationally renewed focus on PHC and universal health coverage over the past decade (World Health Organization, 2008), it is important to build on previous work on health system strengthening, and expand the body of scholarly knowledge on the phenomenon of contemporary integrated health-promoting health systems. Therefore, the purpose of my PhD research was to examine '*how HP is institutionalized within the South African health system*'.

1.3 What is health promotion?

1.3.1 The concept of health promotion

In 1986, WHO's Ottawa Charter for HP provided the predominant conceptual framework for the global recognition of professional HP practice (World Health Organization, 1986). The Charter defines HP based upon a socio-ecological model of health (*definition provided on Section 1.2)*. HP is premised on addressing social and environmental determinants of health. When high value is placed on health (not merely the absence of disease) it motivates people to undertake whatever is necessary to enhance health (Sartorius, 2006). According to the Ottawa Charter, HP encompasses five action areas (building healthy public policy; creating supportive environments for health; strengthening community action for health; developing

personal skills, and re-orienting health services) (World Health Organization, 1986). Definitions for each are provided on *Table 1*. Therefore, a HP practitioner is considered to be person who works to promote health and reduce health inequities using the five action areas described by the Ottawa Charter (International Union for Health Promotion and Education, 2016).

The Charter also highlighted three basic strategies to advance HP: *advocate* for health; *enable* all people to achieve their full potential; and *mediate* between different societal interests in pursuit of health (World Health Organization, 1986). Since, HP is directed towards action on the determinants of health (World Health Organization, 2009c), it is not just the responsibility of the health sector alone, but 'goes beyond healthy life-styles to well-being' (World Health Organization, 1986). As such, multi-sectoral partnerships are crucial for HP (World Health Organization, 2009c, World Health Organization, 1978). Multi-sectoral partnerships for HP means collaborations between different actors and departments within and outside government, such as civil society, for-profit private organizations, as well as citizens and communities, when designing and implementing healthy public policies and practices to improve health outcomes in a way that is more effective, efficient or sustainable (Nutbeam, 1998b, World Health Organization, 2018). Further details are provided on *Section 2.5.7*.

1.4 Study context: The South African situation

HP is more relevant in South Africa now than ever. Given the current quadruple burden of disease faced in the country (Coovadia et al., 2009), there is a need for the implementation

of an effective HP-focused health system (Kumar and Preetha, 2012). The challenge is that HP within the Department of Health (DoH) may not be sufficiently institutionalized so that would effectively improve population health and significantly reduce health expenditure over the coming years. For example, the recent 2019 National Health Insurance (NHI) Bill on health services and financing system makes reference to HP (Department of Health, 2019), but lacks clarity on how it will be embedded within the South African health system to ensure sustainable reduction of health care needs (Freeman et al., 2020). In this context, it is essential to strengthen the health system's health-promoting role through making sure that HP is a strong part of it. For this to occur, there is need to better understand how HP is organized, practiced and capacities available for its support and implementation, particularly within the DoH structures.

1.4.1 A snapshot of the historical evolution of the health system in South Africa

Substantial progress in developing the South African health system have been made since independence in 1994 (James et al., 2018). South Africa is characterised by the devastating effects of huge health inequities, rooted in a historically political landscape of a divided and discriminatory society based on race and gender (Delobelle, 2013, Coovadia et al., 2009, Rispel, 2018). For example, pre-1994 under the apartheid government, the health status of the largely black African population was compromised due to systematic limitations in health access and massive exclusions to any quality healthcare (Coovadia et al., 2009, Delobelle, 2013). Post-1994, numerous attempts have been made to reform the healthcare and public health system (Conmy, 2018). PHC provides a foundation for reforming the fragmented health system in South Africa and the main drivers for change were to

readdress health inequities among the population (Rispel, 2018, Coovadia et al., 2009). Key moments for reforming the health system in the country include the decentralization of health services, integrated care services, as well as recent big health sector reforms, such and PHC revitalization and the National Health Insurance towards achieving universal health coverage (Blaauw et al., 2004, Barron et al., 2010, Department of Health, 2019, Sanders and Chopra, 2001).

1.4.2 HP in the South African context

1.4.2.1 The history of HP

In South Africa, the existence of designated HP personnel within the DoH, commonly known as health promoters or HP practitioners (HPPs) has a long history. HP foot soldiers were originally introduced during the country's apartheid era, as health advisors in the 1970s and 80s. They were recruited without formal professional training, specific qualifications or degrees. These health workers needed to know the community well, as well as speak a number of local languages. Family planning advisors provided door-to-door reproductive education and promotion of family planning to women (Department of Health, 2001). Initially, only women were recruited to work in the programme; later on the government needed to focus on men's programmes and men were brought in (Rwafa, 2017). Since 1990, their scope of practice expanded to include the delivery of health education on a range of health topics in clinic facilities and communities (Coulson, 2000). At this time, their job classification changed to health promoters, making South Africa similar to countries like Australia with dedicated HP staff (Sunderland et al., 2015). However, during the re-categorising of family planning advisors to health promoters, the DoH did not provide any systematic training. The recent national community health worker

(CHW) programme as part of the strategy to revitalize PHC, known as 're-engineering of PHC' (rPHC) has followed a similar recruitment pattern (Tseng et al., 2019).

Over the past years, commitment to HP in the South African context has been witnessed in several initiatives. *Figure 2* highlights key developments for HP within the DoH over the past two decades. In 1997, the White Paper on the Transformation of Health Services (Department of Health, 1997) emphasized the role of HP and health education was to 'assist people to gain and maintain good health through promoting a combination of educational and environmental supports, which influence people's actions and living conditions' (Wills and Rudolph, 2010). Since 2011, the rPHC or PHC strategy to revitalize PHC in South Africa highlighted HP and disease prevention as essential elements of community-based approaches for health (Subedar, 2012).

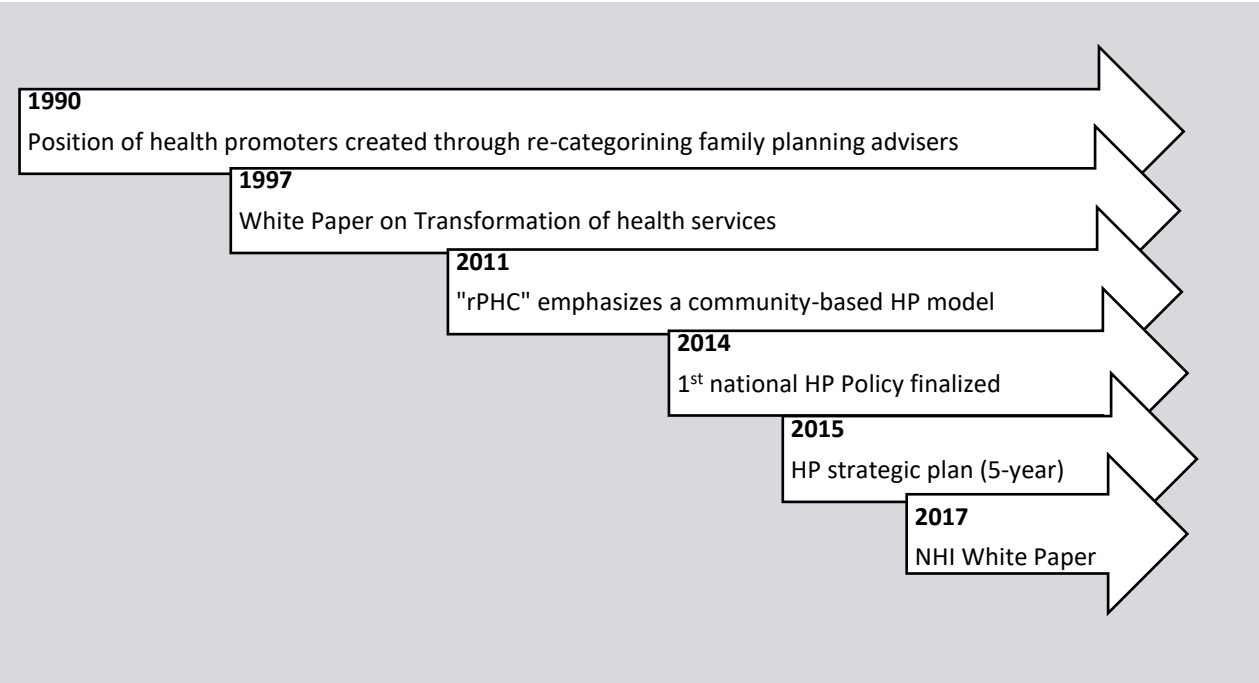


Figure 2: Key developments for HP within the South African DoH

In 2014, South Africa published its first national HP policy and a strategic plan (2015-2019). It was based on a number of international and regional declarations including the Ottawa Charter (Department of Health, 2014). The policy was in draft for more than two decades due to lack of political will. Its publication reaffirms the commitment of the DoH to promote the health of South Africans. The HP policy states that its successful implementation depends on a variety of initiatives: such as establishment of HP norms and standards of operating procedures, adequate financing, and a clear plan to build health promoters' capacity (Department of Health, 2014). Yet, it remains unclear whether national and provincial DoH have been dedicating sufficient resources and capacity in HP to achieve the goals set out in the strategic plan (2015-2019), whose period is now over. *Table 1* provides examples of what South Africa has achieved with respect of some of the action areas of the Ottawa Charter for HP.

Table 1: Some examples of what South Africa has done to achieve action areas of the Ottawa Charter

Ottawa Charter Action Areas	Definition of the pillar	South African HP Policy and Strategy (2015-2019)	Examples from the South African context
Healthy Public Policy	**Definition** Healthy public policy covers a combination of diverse but complementary measures and approaches such as legislation, taxation, fiscal incentives and disincentives, policy analysis and review, and organizational change (World Health Organization, 2014a)	- Advocate for healthy public policies to achieve health outcomes - Assess and identify health promotion gaps in existing policies. - Advocate and lobby for policies that focus on creating environments that are conducive for promoting health. - Consult with stakeholders to prioritize health promotion actions within policies. - Develop a strategy to prevent and manage obesity in SA. - Develop implement and monitor tobacco regulations	- *Tobacco Products Control Act (83 0f 1993)* - *Bill of Rights* - *Choice on Termination of Pregnancy Act (Act 92 of 1996)* - *The Domestic Violence Act (116 of 1998)*
Creating Supportive Environments	**Definition** Supportive environments cover the physical, social, economic, and political environment. This is what is envisaged by the "settings" approach (World Health Organization, 1986).	- Create enabling environments that promotes healthy behavioural practices. - Facilitate the creation of healthy environments for children: e.g. co-ordinate inter-sectoral action for the promotion of hand washing, personal hygiene practices, healthy eating options and personal safety. - Promote smoke- free environments - Promote child- friendly environments to prevent home, institutional and community level accidents and injuries. - School Health: Promote the healthy lifestyle package for learners - Communities: Facilitate and promote the establishment of community based support groups on breastfeeding, physical activity, and chronic diseases of lifestyles - Lobby and advocate for creation of environments to promote physical activity. - Health Facilities: Promote and ensure availability of IEC material within health facilities	- *Health Promoting Schools Initiative* - The National Adolescent *Friendly Clinic* Initiative (NAFCI) - *Water Services Act*

		- Develop and implement guidelines on activities to be implemented on health promotion within health facilities.	
Strengthening Community Action: community participation	**Definition** Community participation is a social process whereby groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs (World Health Organization, 1992).	- Empower local communities on health promotion approaches that facilitate strengthened community action and ownership. - Strengthen partnerships with community structures and civil society - Strengthen linkages with existing community forums. - Establish community forums. - Promote community participation in health campaigns	- *District Health Management Team* - *The Valley Trust (NGO-led)* - *Radio Zibonele (Community-led)* - *Clinic Committees* - *Hospital Boards* - *The Healthiest Company Index* (2010), sectors outside government
Developing Personal Skills	**Definition** Skills that can promote an individual's health include those pertaining to identifying, selecting and applying healthy options in daily life (World Health Organization, 1986).	- Improve health literacy - Develop and disseminate appropriate key IEC messages and materials, including for people with disabilities. Intensify social marketing of priority health programmes (e.g., diabetes, hypertension, TB screening, HCT, early ANC booking and care - Promote male involvement in maternal and childcare health and development. - Promote healthy lifestyle practices on the five pillars: nutrition, physical activity, tobacco control and prevention of substance abuse (including alcohol and tobacco) and safer sexual practices	- *Life-skills project at schools* - *The ADAPT, Section 21 NGO project* - NGO health promoting projects: e.g. *One Man Can campaign*- Sonke Gender Justice, Soul City's *OneLove Campaign (NGO-led)* - "Arrive alive" campaign - "Slap it on" campaign on paraffin safety
Re-orienting Health Services	**Definition** Moving from emphasis of provision of curative services to focusing on health outcomes (Nutbeam, 1991).	- Support PHC outreach teams to implement health promotion programmes. - Develop package of service delivery of health promotion services - Develop tools to assess and promote community mobilization	- *White Paper for the Transformation of the Health Services in South Africa* - *White paper and Bill on the National Health Insurance* - *Re-engineering of PHC* (ward-based outreach teams and CHWs)

1.4.2.2 Organization of HP in South Africa

1.4.2.2.1 HP structures within Department of Health

At the national DoH (NDoH), a HP directorate is located within the Social Services Cluster under PHC (Onya, 2007). Due to this structure, it is therefore viewed as a programme. This means that HP does not operate at the highest level of the hierarchy in the national DoH. Each of the nine provincial DoH have HP coordinators (*Figure 3*); however staffing varies at district level.

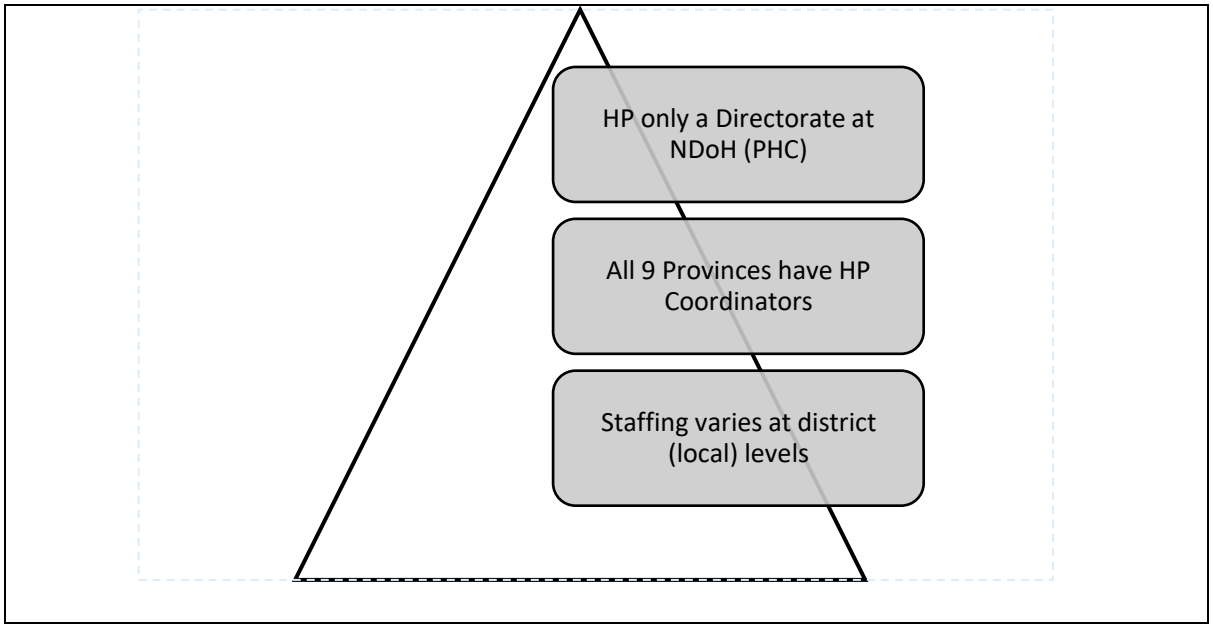
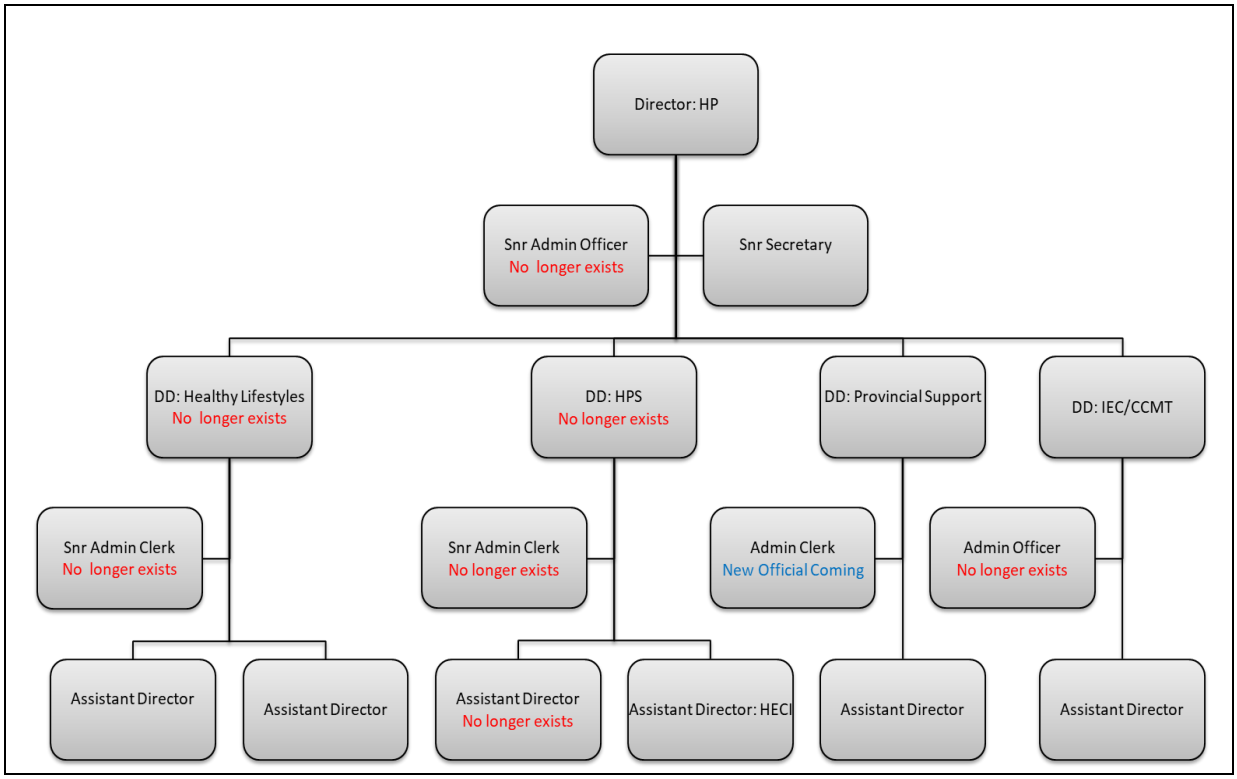


Figure 3: **South African DoH HP structure**

HP activities within the HP directorate cover policymaking, e.g. tobacco control regulation, at national level, while at the local level activities focus on individuals and community-based programmes. The mandate of the national HP directorate is to offer technical and strategic support, while provinces, particularly local levels (health districts or municipalities) implement activities (Department of Health, 2014). At PHC, health promoters mostly focus on HIV and AIDS, tuberculosis (TB), integrated management of

childhood illnesses, expanded programme of immunisation, breastfeeding, antenatal care, hand washing, substance abuse, physical activity and outbreaks. HP activities are also carried out by different cadres of health workers from other clusters within the DoH, such as HIV and TB, maternal and child health, and non-communicable diseases. Furthermore, DoH communications staff who sit outside of HP have a mandate for the design and development of all information, education and communication (IEC) material as well as media-related activities and public relations. *Figure 4* shows the organogram of the HP directorate at national level.



[1]DD- Deputy Director, [2]AD – Assistant Director, [4]HPS –Health Promotion Schools, [5]IEC-, Information, Education and Communication, [6]CCMT-Comprehensive Care, Management & Treatment, [7]HECI- Healthy Environments for Children Initiative

Figure 4: HP Directorate organogram at national DoH, Source Personal Communication from the national HP directorate, 2017

Each province has its own HP structure and organogram. In 1999, Gauteng province was reported to have the largest HP sub-directorate or division (*approximately 300*) (Coulson, 1999), and is estimated to have maintained these high levels. Some provinces have either one HP staff e.g. KwaZulu Natal and Limpopo Provinces, while others have few staff responsible for HP, for example, Northern Cape (Onya, 2007). *Table 2* describes an estimated number and characteristics of the dedicated HP staff within DoH for the national HP directorate and the provinces in 2017. Where there are no HP cadres, a variety of other categories of health workers are utilized to achieve HP goals, such as environmental health officers and or CHWs (Moodley, 2013). However, variations exist in job titles and job levels for HP personnel, e.g. salary levels range from 2-13 (most HP practitioners are at levels 6-7) (Rwafa, 2017). Furthermore, the government human resources system does not define HP professional categories, even for the national level workforce. Mpumalanga and Free State provinces are an exception as they have registered HP staff on their Human Resources PERSAL employment system as “HP practitioners”. In all other provinces, they are registered in different wings of the DoH, e.g. administrators, service auxiliary workers, communications or HP coordinators etc. The majority of staff in HP posts have no specific HP qualifications.

Table 2: Estimated number and characteristics of dedicated HP staff within DoH for national directorate and provinces, Source: Personal communication with the national DoH, 2017

SETTING	PERSONNEL	STAFFING COMMENTS
National HP Directorate	9	- National managers are as follows: 1D[1], 3DDs[2] (DD HP, DD Admin and DD Communications), 5AD[3] to give direction to the provinces and the different programmes - 11% with a HP qualification - Salary levels 11-13
Eastern Cape (EC)	187	- Have a director post, DD, AD at some districts - 2 people at province, 11 district, 54 sub-district, 120 PHC facility level - 81% with a HP qualification - Health promoters from Level 2-3 = floor cleaners
Free State (FS)	22	- Provincial manager is a DD - 2 at Province, 20 at Districts - Majority of staff have a HP qualification - HP practitioners are on the HR Pearsall - Manager as salary Level 7
Gauteng (GP)	209	- 3 people at province, each running their own programmes - 8 district, 75 sub-district, the remainder at PHC - West Rand had the highest proportion of cadres, followed by Tshwane, Sedibeng, Johannesburg, and Ekurhuleni - 91% with Grade 12 (matric) - Managers at salary Level 10, and health promoters at salary Levels 6 -7
Limpopo (LP)	1	- Provincial manager is an AD– - Has a degree in HP - Salary Level 10
KwaZulu Natal (KZN)	1	- Provincial manager at DD post - Works with 5 district managers to execute his duties - Salary Level 12
Mpumalanga (MP)	102	- Provincial manager is at director level - 5 provincial managers, 93 at Facility Centres and 3 at district - Almost half of the cadres are based at Ehlanzeni district - MP took staff for a HP course, but are not accredited at QCT - 90% hold a HP certificate, - All called HP practitioners under the HR Pearsall
Northern Cape (NC)	7	- Provincial manager is a director - 4 at Province and 3 and district - 75% with in a HP qualification - Salary levels range from Level 13, to 8 and 7
Western Cape (WC)	87	- Metro City has 8 placements - 81 at PHC level - Salary Levels at 6 and above
North West (NW)	102	- 3 people at province - 33 sub-district and 64 at PHC

		- Dr. Kenneth Kaunda district has 31% of health promoters, then Bojanala district - None have HP qualifications - Most HPPs at salary Level 3 and a few in Level 6
Total	**727**	

[1.] D = Director, [2.] DD = Deputy Director, [3.] AD = Assistant Director

In South Africa, the organization and implementation of HP, particularly within the DoH, faces a myriad of challenges. Firstly, most published literature on HP is ten or more years old. Secondly, HP also lacks formal documentation of activities that occur on the ground (Coulson, 1999). Such information gaps leave us less informed about what is happening in terms of HP in the country, including *who is doing what, what works and why*. More than a decade ago, infrastructure to support HP in South Africa was reported to be weak (Onya, 2007). For example, at the time of this PhD study there were no guidelines from national DoH on setting minimum standards for HP, including organograms, the ratio of health promoters to the population they serve and harmonizing of training. As a result, the Department of Public Services (DPSA) was not able to register HP professionals and establish a national qualifications framework (NQF) levels for the field (Rwafa, 2017). As a result, some provinces do not have a HP structure at local level and use other cadres to run HP activities. While provinces run a HP programme, there are disparities in staff qualifications and competencies. Registration of health promoters with the Health Practitioners' Council of South Africa (HPCSA) has not occurred despite some efforts. This would assist in setting standards of practice e.g. service delivery, competencies and scope. Health promoters want to register with HPCSA to attain a benefit for scarce skills on occupational specific dispensation classification (OSD) (Rwafa, 2017). Therefore, some provinces have cadres with a HP qualification while others have a mixture of qualifications among cadres.

1.4.2.3 Dedicated HP practitioners within the DoH

Historically, as mentioned earlier there has been grossly inadequate training of staff deployed into HP positions in South Africa (Onya, 2007, Coulson et al., 1998, Wills and Rudolph, 2010). The result is that their skills and educational qualifications differ (Coulson, 2000). Various institutions in the country offer HP related training. Since 1999, Walter Sisulu University in the Eastern Cape offers undergraduate and post-graduate courses for HP professionals (Douglas, 2010). However, the challenge is that the national HP directorate views these qualifications as HIV specialist courses; developed for non-governmental organization (NGOs) due to funds available for HIV in the country (Rwafa, 2017). Other institutions like the University of the Witwatersrand and University of Cape Town focus on postgraduate qualifications within public health that focus on social and behaviour change instead and the Universities of Pretoria and Limpopo offer a track in HP. The University of Kwa-Zulu Natal offers a Master's degree in HP within the Psychology Department rather than public health. There are also colleges like Tabetso FET College where HP courses exist, but learners are not available (Rwafa, 2017). The majority of staff in HP posts have no adequate HP qualifications (Onya, 2007, Coulson et al., 1998, Wills and Rudolph, 2010). The slow development in training has resulted in a HP capacity gap (Coulson, 2000). Substantial disparities also exist in terms of HP service delivery, such as lack of uniformity of roles, responsibilities and uncoordinated activities (Department of Health, 2014, Onya, 2007, Coulson, 2000). Thus, HP activities are often done haphazardly and the situation varies from one province to the next.

Research conducted some years ago reported that there are very few working HP structures or local systems at the provincial level (where implementation happens) in

South Africa (Department of Health, 2014, Onya, 2007, Coulson, 2000). A decade ago, Mpumalanga Province was regarded as having the best HP model, and was described as having stronger HP practice than other provinces (Onya, 2007). Most of its health promoters were up-skilled through a two-year diploma in HP at the University of Limpopo initiated by the provincial HP coordinator at the time with support from the provincial human resources department (Rwafa, 2017). However, this qualification is not accredited and some HP practitioners did not receive their certificates. Mpumalanga has an established career structure for HP practitioners (Onya, 2007, Coulson, 2000). Eastern Cape Province recruits mostly HP cadres with a HP qualification from Walter Sisulu University, which offers a three-year undergraduate degree. The practitioners have an opportunity to rise to a Deputy Director's post (Onya, 2007). This has added onto the variations in HP structures, job titles and job levels.

1.4.2.4 Health promotion among civil society

A strong civil society which includes non-governmental organizations that conduct HP activities also exists in South Africa (Department of Health, 2014, Onya, 2007). NGOs like the Soul City Institute, LoveLife, and other community based organizations (CBOs), as well as academic institutions have been very active with regard to HP implementation in South Africa (Department of Health, 2014, Onya, 2007) (*see Table 1 for some of the campaigns carried out by NGOs)*. Soul City also supported the social and behaviour change communication (SBCC) field of specialisation on the Master of Public Health at the University of the Witwatersrand (Christofides et al., 2013). Health promotion is an important activity in other non- health sectors, including NGOs. *Figure 5* shows a representation of the full scope of HP practice in South Africa.

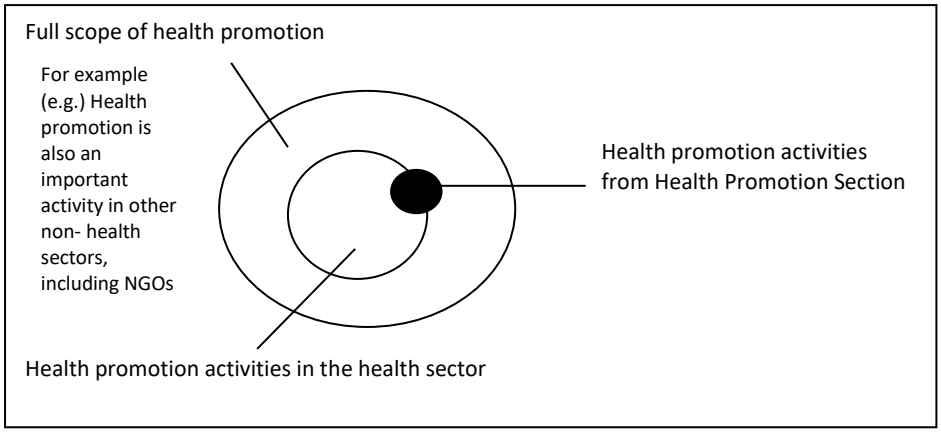


Figure 6: Diagrammatic representation of the full scope HP, Adapted (Ntayiya, 1998)

1.4.2.5 Proposals to establish a HP and Development Foundation

In considering the future of HP in the country, one proposal that has been explored is the establishment of an independent HP and Development Foundation (HPDF). In 2012, a broad alliance of HP civil society and academia, called the HP and Development Foundation Network (HPDFNet) presented a motivation to the South African Minister of Health and the Inter-Ministerial Committee on Substance Abuse, advocating for the establishment of an independent HP and Development Foundation (Perez et al., 2013). This was alongside movement on the National Health Insurance and the South African National Health Commission (Health Promotion and Development Foundation, 2018). If these ongoing discussions with policy makers are successful, South Africa could be on the verge of taking the lead in demonstrating the feasibility of HP Foundations (HPFs) in an African setting (Munodawafa, 2011). It is envisaged that if established, the HP and Development Foundation in South Africa would be an independent organization. Its roles could include: managing and coordinating funds for HP across sectors; ensuring adequate and sustainable financing arrangements; increasing awareness about health gains; producing HP evidence,

creating demand for HP, ensuring broad participation and commitment, and providing an effective HP stewardship (Munodawafa, 2011). The stakeholder voice for public health and HP in South African has mainly been through the HPDFNet, which is a single entity that has been calling for HP in the country. However, efforts of this group have been limited over the past decade due to limited funding and competing demands of members. There have been moments of pushing the agenda for HP when funds were available to hold meetings which have been followed by years of inactivity (Health Promotion and Development Foundation, 2018).

Establishment of such an independent Foundation outside government is currently unlikely, as Treasury is against collection of hypothecated tax, including for HP activities (Health Promotion and Development Foundation, 2018). To address social determinants of health and multi-sectoral collaboration, the National Health Insurance White Paper proposed setting-up a South African National Health Commission within the DoH to oversee intersectoral activities for HP (Department of Health, 2017a, Department of Health, 2017b). Progress towards the establishment of a National Health Commission has been slow (Freeman et al., 2020). The proposed model was meant to be made up of a variety of stakeholders and chaired by the Deputy President of the Republic of South Africa (Department of Health, 2017b). However, at the time of the study civil society was lobbying against such a HP and Development Foundation structure to be located within the DoH or government. They were advocating for an autonomous or semi-autonomous entity (Health Promotion and Development Foundation, 2018). Furthermore, the recent 2019 National Health Insurance fund omits financing of HP activities and focuses on curative services instead (Freeman et al., 2020, Department of Health, 2019).

1.5 Justification for the study

There is an undeniable need for HP research in Africa (Anugwom, 2020). For example, there is the dearth of recent research on the topic of HP in South Africa. My PhD thesis investigates the issue of achieving effective health-promoting health systems. Internationally, there is a renewed commitment to focus on PHC, improving health systems performance and achieving universal health coverage, commonly known as PHC-led universal health care (World Health Organization, 2008, World Health Organization, 2009e, World Health Organization and UNICEF, 2018). Given that HP concepts are fundamental to PHC and health system strengthening (Coe and de Beyer, 2014), it is worthwhile to explore if the role of the HP programme and its activities are acknowledged as part of the PHC-led universal health coverage. Since 2011, various health system-strengthening initiatives have been initiated in South Africa, including the recent National Health Insurance (Department of Health, 2019), which mentions HP, but does not provide emphasis to it or describe models for its financing (Freeman et al., 2020). In light of re-engineering PHC focus and the National Health Insurance, the question is whether HP can play an advocacy role in the South African context.

There is international acknowledgment that investment in HP and evidence-based HP programming and disease prevention can reduce the burden of disease on the country's health system (Coe and de Beyer, 2014), this includes making the National Health Insurance feasible (Freeman et al., 2020). In this background, HP programming can be a vehicle to drive PHC revitalization and achieving the 2030 sustainable development goals (SDGs) (United Nations, 2015, World Health Organization and UNICEF, 2018). Thus, my PhD

research is timely, given the current efforts to improve health system performance in South Africa. In order to effectively map a way forward for the future role of HP in the South African health system, the starting point is to understand how HP is institutionalized in terms of its: (a) current capacity, (b) organization, and (c) programme delivery, including who has power over resources for its implementation and strategic direction. In 2014, South Africa developed its first national HP Policy (Department of Health, 2014). Nonetheless, questions remain on how much the HP policy is guiding organization and practice, particularly within the DoH. A broader systems perspective for HP is required, to effectively bridge gaps in capacity to promote health. By so doing, my PhD contributes to scholarly literature by assisting to position the health-promoting role of the health system so as to close current implementation gaps (World Health Organization, 2009d). In changing the policy environment and PHC revitalization efforts, more empirical evidence using systems thinking on how HP is organized and implemented is needed, especially in sub-Saharan Africa and other LMICs.

Given a quadruple burden of disease in South Africa, there is need to figure out how to promote health and prevent disease to increase population health gains. This includes identifying what the challenges are and making appropriate recommendations on how the current DoH HP programme can be restructured to allow more effective functioning. Therefore, results from this PhD study may be used to advocate for a more focused HP agenda in the South African health system, to meet health system strengthening goals and universal health care.

1.6 Overall research question

My PhD sought to answer the main research question: '*how is HP institutionalized in the South African health system?*'

The word *institutionalized* was used in this thesis as an umbrella verb covering the following research questions:

- 'What collective and institutional systems capacity is available to deliver and support HP implementation within the DoH?'
- 'What structural and agency factors impede the organization and implementation of HP within the DoH system?'
- 'How is HP practiced among health promoters, particularly within the context of PHC revitalization and the introduction of CHWs in South Africa?'

1.7 Aims of the research

The overall aim of the thesis was to examine how HP is institutionalized within the South African health system.

1.7.1 Specific objectives

The specific objectives of the PhD study were to:

1. Assess collective and institutional systems capacity to deliver and support HP implementation across three-levels of the South African DoH.

2. Explore structure and agency factors that hinder the organization and implementation of HP within the South African health system.
3. Analyze how health promoters practice HP in the context of PHC revitalization and the introduction of CHWs in two South African provinces.

CHAPTER TWO

“That is part of the beauty of all literature. You discover that your longings are universal longings, that you're not lonely and isolated from anyone. You belong.”

~ F. Scott Fitzgerald ~

2. LITERATURE REVIEW

This chapter reviews relevant literature and explains how I position myself as a researcher in relation to other researchers and previous HP and health systems and policy studies conducted. The chapter begins with describing the concept of HP and its global evolution as a field. The literature review positions HP in the broader health systems context and highlights its significance in efforts to strengthen performance, particularly within PHC revitalization efforts. This chapter further provides a description of HP as a disciple, as well as its status and investment in it by various governments. It discusses global, regional and national implications of HP organization and implementation. This is followed by the introduction of the theoretical background that underpins the research. Domains of the conceptual framework are used to organize the literature review. In the chapter, I identify themes, debates and gaps in literature and demonstrate how my PhD addresses the identified gaps in literature and contributions towards international HP and health systems strengthening debates.

2.1 Focus and scope of the PhD

Health Policy and Systems Research (HPSR) seeks to understand how people organize themselves to achieve collective health goals (World Health Organization, 2012). It is concerned with a wide range of research questions – e.g., financing to governance - and investigates issues surrounding health service implementation and delivery, using various methodologies (Gilson, 2012a, World Health Organization, 2012, Le et al., 2014). My PhD

specifically focuses on the organization and implementation of HP, as well as capacity to deliver and support its activities within government structures.

Institutionalization is the infusion of values and routinization of practices (Levitsky, 1998). In this PhD, I assumed that HP institutionalization within the health system might occur if the following happen in a health system. Firstly, if every health worker meaningfully engaged in HP activities (Johansson et al., 2010, Geense et al., 2013, Raphael, 2008). Secondly, for implementation of HP activities, availability of sufficiently skilled HP cadres is required (Battel-Kirk et al., 2009, Dempsey et al., 2011). These cadres need to be well-resourced to carry out HP activities independently (Barry and Battel-Kirk, 2011, Battel-Kirk et al., 2015), and provide advice and support for strategy development. Thirdly, these HP practitioners should be able to create and sustain multi-sectoral collaborations for HP (Corbin and Mittelmark, 2008, Corbin et al., 2018), at all levels of the health system and support other health workers and programmes to implement HP activities. These health system changes all require strengthening of the HP agenda at a broader strategic policy level (European Commission, 2019).

2.2 The evolution of the HP concept over time

2.2.1 The global evolution of HP

The nature of HP practice has been shaped by numerous historical eras, key documents, commissions and international conferences (Raingruber, 2017). *Table 3* displays a timeline of some key HP milestones. The Alma-Ata declaration on PHC was the first formal

acknowledgment of the importance of multi-sectoral partnerships for health (World Health Organization, 1978). The spirit of Alma-Ata was carried forward in the Ottawa Charter, which discussed building 'healthy public policy' as a key action area for HP (World Health Organization, 2009c), leading to the Health in All Policies initiative (World Health Organization, 2014a). This approach emphasizes multi-sectoral collaboration. The emergence of the term HP, and its subsequent development as a discipline led to a new perspective and approach to health (Davies, 2013). WHO recently expanded the definition of HP to actions directed towards: social and political processes; strengthening skills and individual capabilities; changing social and environmental conditions to alleviate their impact on public and individual health, multi-sectoral collaboration and Health in All Policies (World Health Organization, 2013). As previously stated, HP is a multi-sectoral set of activities that should occur in various settings, such as schools, workplaces, cities and local communities and staff working within the health system organize only a part.

Table 3: Timeline of some key HP milestones, Adapted (World Health Organization, 2009b, Raingruber, 2017)

1948	Establishment of the World Health Organization
1951	The International Union for Health Promotion and Education
1974	The Lalonde Report
1977	Global Strategy for Health for All by the Year 2000
1978	International Conference on Primary Health Care, Alma-Ata
1979	Healthy People Report
1986	Achieving Health for All: The Epp Report
1986	International Conference on Health Promotion, Ottawa Charter
1988	Adelaide Recommendations on Healthy Public Policy
1991	Sundsvall Statement on Supportive Environments for Health

1997	Jakarta Declaration on leading Health Promotion into the 21st Century
2000	The 5th Global Ministerial Conference, Mexico
2005	Bangkok Charter for Health Promotion in a Globalized World
2009	The Nairobi Call to Action on Health and Development
2012	WHO-AFRO's Strategy for Health Promotion in the African Region
2013	The Helsinki Statement on Health in All Policies
2016	Shanghai 9th Global Conference on Health Promotion "Health Promotion in the Sustainable Development Goals

While the practice of HP has evolved over time, WHO continues to drive the international HP agenda, as evidenced by the various commissions and commitments (*Table 3*). However, some organizations and institutions have opted for the development of disciplines parallel to HP, including health communication, communication for development and social and behaviour change communication. Health communication is the development, dissemination and evaluation of health information communicated to and from target audiences (de Wit et al., 2011). Communication for development emphasizes dialogue and participation, where communities participate in decisions that affect their health and development (Lennie and Tacchi, 2011). Social and behaviour change communication highlights understanding health behaviour and policies using a socio-ecological lens to design interventions that address interpersonal relations and policy, social norms, and values that shape the environment which people live and work in (Christofides et al., 2013). While there is a significant overlap between the different conceptualisations, some practitioners' argue that they are not synonymous and prefer to be identified by one or the other. Implications of the various understandings of what HP is, may include the background and HP qualifications, as well as experiences of practitioners hired in social mobilization or health communication posts which affects HP training and opportunities or categorization of

such practitioners under the umbrella term 'HP' as they may not be viewed as HP practitioners per se.

2.3 Link between health systems strengthening and HP

The scope of health systems includes both the pathogenic (health care) and the salutogenic (HP) approaches to health (Au, 2017). As described in *Chapter 1*, the notion of promoting health is supported by WHO's expanded definition of health systems, which describes it as the organization of people, institutions, actions and resources for the primary purposes of *promoting*, restoring, and maintaining the health of target populations (World Health Organization, 2007b). This definition emphasizes HP as an essential component of health systems, as it moves away from focusing on populations at risk of developing disease, to population level systems and environments that shape the development of good health (World Health Organization, 1986, European Commission, 2019). Furthermore, in 2018 WHO provided a simpler definition of PHC to facilitate the coordination of future PHC efforts and guide implementation as a whole-of-society approach aiming to ensure the highest possible level of health and well-being that focuses on people´s needs, along a continuum from HP and disease prevention to curative and rehabilitative care, and as close as possible to people's everyday environments (World Health Organization, 2018). The link between health systems strengthening and HP is described in more detail under *Section 2.4*, theoretical background of the thesis.

Health systems strengthening is a term used in global health to mean improving the health system of a country (World Health Organization, 2009e). One of the five key tracks of the

Nairobi Call to Action for closing the implementation gaps in HP, urged country members to strengthen health systems, asserting that, for sustainability HP must be embedded within health systems and integrated in all functions and at all levels in order to improve performance (World Health Organization, 2009c). This HP Call to Action was a follow on of the WHO 2008 internationally renewed focus on PHC as a key strategy for improving health outcomes and strengthening health systems (World Health Organization, 2008). As mentioned earlier, PHC revitalization is one of the mechanisms to emphasize preventive and promotive health in the public health agenda (Jha, 2013). Despite the recognition of HP programming as part of PHC reforms, there is a wide consensus that closing the HP implementation gap by reframing, repositioning and renewing efforts to strengthen health systems' HP role has not yet been accomplished (Wise and Nutbeam, 2007). Furthermore, in many countries progress towards Ottawa Charter's re-orienting or strengthening health services to promote health is lethargic (Ziglio et al., 2011). Thus, the purpose of my PhD was to gauge how HP is positioned within the South African health system, particularly given local developments in health system strengthening.

2.4 Theoretical background to the research

Connections are often made when conducting research and interpreting findings (Peters, 2014). My PhD was informed by a system's thinking for a health-promoting health system theory. I adapted and combined two theoretical frameworks, one that refers to health systems strengthening and the other to HP capacities: (a) System's Thinking for Health System Strengthening Model (World Health Organization, 2009e), and (b) Country-level Framework for Public Health and Health Promotion Capacities (Brand and Aluttis, 2011). The

rationale for selecting and combining the two theories was because neither was adequate to meet all my PhD objectives on its own. While both theories considered different domains that make-up the organization of an effective system, there were overlaps between some domains, such as governance, workforce, information, and financing (Aluttis et al., 2014, World Health Organization, 2009e). Finally, both have strengths, for example the health system-strengthening framework emphasizes interconnectedness of system building blocks (World Health Organization, 2009e), versus the cause-and-effect relationship highlighted in the domains of the public health and HP capacities model. However, the former considers multi-sectoral collaboration, organizational structure, context and capacity, components that were significant to HP and the PhD (Brand and Aluttis, 2011), but missing in the health system-strengthening framework.

2.4.1 Theoretical foundations

2.4.1.1 Foundation 1: Systems thinking

Health systems are complex (World Health Organization, 2009e). Since, HP organization operates within a health system, and is made up of health system building blocks such as: finance, workforce, resources, information systems and organizational teams and partnerships (World Health Organization, 2007b). The building blocks are connected and work together as a system through governance, policy and strategy frameworks (Agarwal et al., 2009, World Health Organization, 2009e). The multi-level and multi-dimensional nature of HP practice points to the importance of systems thinking and the ability to adapt and act according to context (Lin et al., 2009a). These contextual layers of HP influence its organization and implementation. Therefore, HP capacity, structure and practice in a health system is determined by how well the contextual layers support an effective HP agenda.

Infrastructure for HP is defined as human and material resources, organizational and administrative structures, mandate, regulations and incentives required for implementation (Nutbeam, 1998b). Rules and resources, which make up the social structure of a system can be regarded as the software and hardware (intangible and tangible assets or factors respectively) of that system (Gilson, 2012b). Therefore, infrastructure for HP can be found not only in tangible resources and structures, but also through intangible aspects like organizational norms and values (Nutbeam, 1998b).

2.4.1.2 Foundation 2: Public health and HP capacities

Seven dimensions have been postulated to constitute effective public health and HP organization, specifically organizational structures, partnerships, financial resources, workforce, knowledge development, leadership, governance, and context. According to this model, HP capacities are a combination of available infrastructures, resources and people's competencies to achieve desired public health goals (Aluttis et al., 2014). These are determined by the organizational, human, financial and other resources that enable actions to be taken by responsible authorities to improve health and reduce health inequalities (Brand and Aluttis, 2013). The capacities relate more to inputs of the health system, than outputs (World Health Organization, 2016). Capacity for HP may be defined as performance capabilities to deliver HP, including knowledge, skills, commitment, structures, systems and leadership to effective HP programmes (Lin et al., 2009a). It therefore suggests that HP capacity is needed at national, regional, and local levels. Capacity building for HP needs to address not only individual domains of the model in the HP system but also ultimately, how well the health system functions as a whole in promoting health. Attention is therefore needed on how to strengthen links between infrastructure, capacity and performance (Lin

et al., 2009a). Smith and colleagues, argue that HP needs to be afforded visibility and status at the highest level of government and at the highest tiers of Ministries of Health, evidenced by governance, allocation of resources, and effective policies and programmes that feed into the whole health system (Smith et al., 2009).

2.4.2 PhD Conceptual framework: Health-promoting health systems

WHO's (2007) definition of health systems strengthening emphasizes interactions between the health system building blocks that achieve equitable and sustainable development (World Health Organization, 2007b). The interconnections of the health system can be viewed as the functions and roles played by each of the building blocks (Mondiale, 2007). A previously mentioned, HP actions closely align to health system strengthening efforts. International evidence shows that HP approaches can help achieve global health gains if brought into the mainstream of public health policy making and practice (Agarwal et al., 2009). Making health systems function better requires comprehensive changes in health policies, organizational structures, multiple relationships, behaviour change and effective use of resources (Chee et al., 2013, Adam and de Savigny, 2012). In this regard, integrated health-promoting health systems can help assist efforts to improve population health. A HP lens within health systems denotes a systematic approach of HP principles and practices to be adopted within health policies, programmes and across health systems (Agarwal et al., 2009). A systemic approach refers to bringing together theoretical, practical, and methodological approaches, to understand phenomena that is recognized as complex, and poses challenges to delineations of wholeness, internal and external interactions, structures, and or regulations that characterize a system (Garbolino et al., 2019). Integrating HP within health systems reinforces efforts to reform PHC (Agarwal et al., 2009, World

Health Organization, 2008). Therefore, health systems need to change the way they think and approach HP organization and implementation. In this regard, there is need to ensure that health provision includes the following ten key concepts (*Figure 6*): (a) people-centred approaches; (b) leadership and governance; (c) organizational structures; (d) financing and resources; (e) workforce; (f) capacity; (g) evidence development; (h) service delivery; (i) multi-sectoral collaboration; and (j) a country specific context; in order to make health systems sufficiently health-promotive. *Table 4* shows definitions of the key relevant concepts of the 'adapted' theory used to guide this PhD.

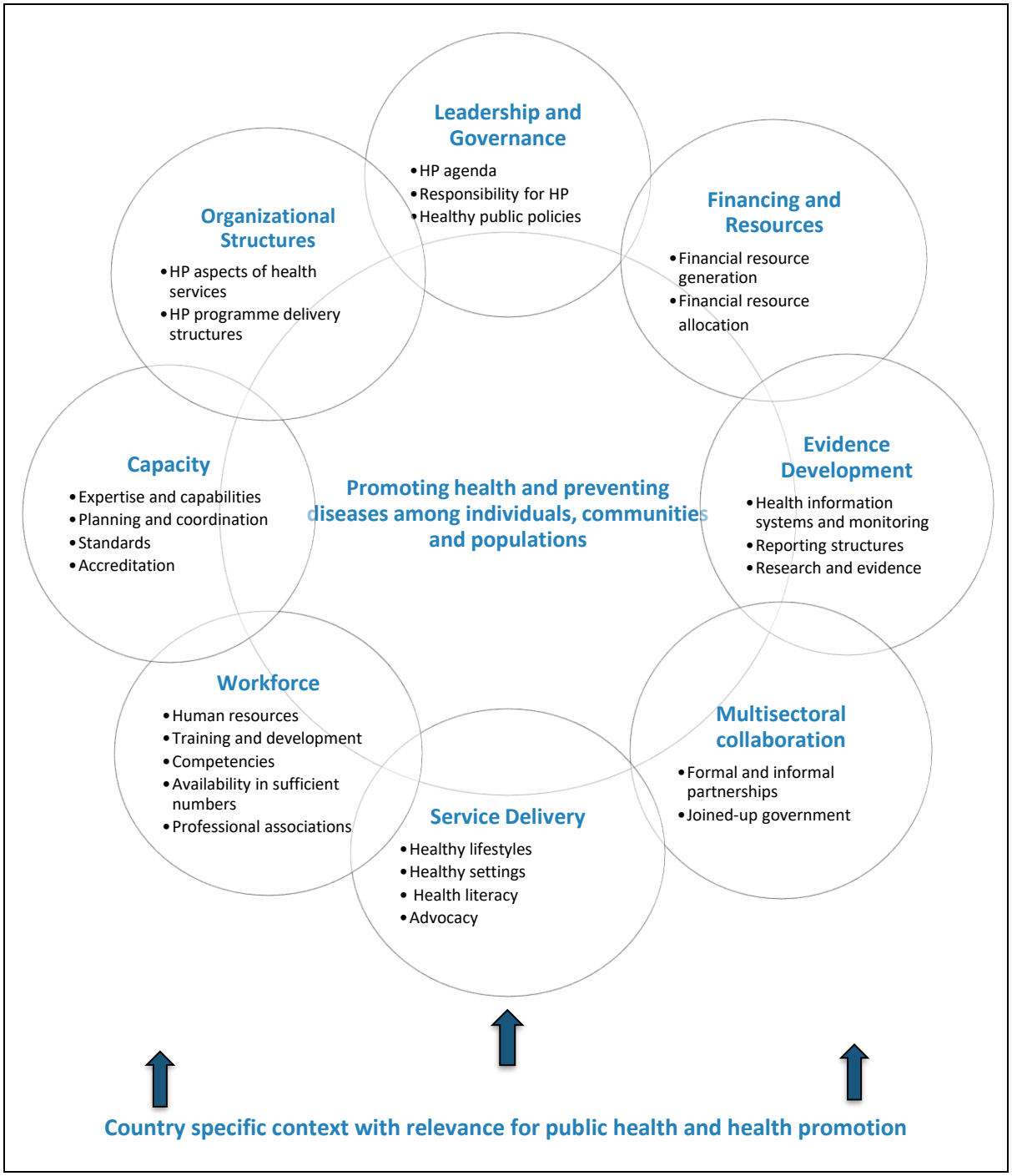


Figure 7: A framework for integrated health-promoting health systems, Adapted (Aluttis et al., 2014, World Health Organization, 2009e)

Table 4: Descriptions of concepts and constructs of the framework

CONSTRUCT	DESCRIPTION
1. People-focused	Approaches that promote health and prevent disease among individuals, communities and populations, based on people's needs, expectations and participation
2. Leadership and governance	The ability and willingness of governments to improve HP by developing and implementing effective healthy public policies and by expressing qualities in leadership and strategic thinking that supports a HP agenda
3. Organizational structure	The infrastructural ability of the health system to contribute to HP goals, evidenced by HP aspects of the organization's health services and delivery of programmes
4. Financing and resources	Generation of funds, allocation and provision of financial and other resources necessary to carry out HP activities
5. Workforce	Qualified human resources for HP with sufficient skills and knowledge. This also includes the availability of training
6. Capacity	Performance capabilities to deliver effective HP programmes. This requires a combination of available infrastructures, resources and people's competencies to achieve desired public health goals
7. Evidence development	Knowledge base that provides evidence and information on the health of the population and that supports evidence-based health policy and interventions at all levels
8. Programme delivery	HP activities and interventions at individual, community and population levels that address determinants of health, advocacy for health and promotion of healthy settings
9. Multi-sectoral collaboration	Formulation of informal and formal networks within and between organizations for effective HP practice. These are collaborations within government and outside government among various stakeholders for health
10. Country specific context with relevance to public health and HP	The political context and other characteristics of a country that may have influence on healthy public policies and capacity building efforts relevant to public health and HP

Adapted (Aluttis et al., 2014, World Health Organization, 2009e)

2.5 Critical conditions needed to develop health-promoting health systems

Greater investment in HP has been shown to have the potential to significantly improve health outcomes and reduce need for health care (Kumar and Preetha, 2012, Coe and de Beyer, 2014, Murray et al., 2013). However, the level of infrastructure and capacity to support and deliver HP varies considerably across countries (Carter et al., 2012). For example, the concept of HP is not well understood by HP health workers (Howat et al., 2003a). Consequently, there is a limited credibility of the infrastructure, resources, knowledge and skills required to translate HP into effective and sustainable efforts (European Commission, 2019). This is evidenced by the presence of significant HP capacity, organization and implementation gaps across many countries, especially in terms of mainstreaming HP within health services (Agarwal et al., 2009). Additionally, there is limited investment in developing necessary HP systems required for substantive health progress and gains to be achieved (Vathesatogkit et al., 2011, Tangcharoensathien et al., 2008, Schang et al., 2012, Coe and de Beyer, 2014). This gap in HP organization and implementation and lack of investment is more evident in LMICs. Fully institutionalizing HP within health systems requires a significant shift in focus; from illness to health through, multi-sectoral collaborations and integrating HP activities within health service provision (European Commission, 2019). In order to achieve this, critical conditions are required to develop health-promoting health systems. According to literature reviewed, this includes the following key conditions:

2.5.1 People-centred approach

According to the Ottawa Charter (*Section 2.2*), HP implies that health is produced through the dynamic relationship between people and their environments (World Health Organization, 1986, Nutbeam, 1998b, Kickbusch, 2003). Individuals and groups are not able to achieve their full potential and well-being unless they are able to take control of those things that determine their health (World Health Organization, 1986). While, social determinants are considered central to health and at the same time people are recognized as social actors who can effect that change (Kickbusch, 2003). In its Health for All strategy, WHO proposed a shift from health inputs to health outcomes, with governments being held accountable for the health of populations they serve, and not just for the health services provided (World Health Organization, 1981). However, globally in many countries progress towards this goal has not yet been attained (World Health Organization, 2008). Principles of HP practice are based on working with people and enabling health (World Health Organization, 1986). The expression 'nothing about us without us' was first created by disability advocates to convey the idea that no policy should be reached without full participation of representatives of all stakeholders (Charlton, 1998). Communities seeking broader participation with the health system have recently adopted it (Paul, 2016). People have an essential role to play as active citizens and participants in the creation of their health and well-being (World Health Organization, 2018).

2.5.2 Leadership and governance

It is a well-known fact that governments have a responsibility towards health system stewardship (World Health Organization, 2000). Leadership and management is critical in ensuring that countries achieve health gains (Costello et al., 2018). In health systems

strengthening, leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability (World Health Organization, 2007b). Countries with the greatest health gains are those whose leaders are committed to policies that improve social, economic, and environmental determinants of health, while at the same time tailor HP, disease prevention, and treatment programmes that overcome specific bottlenecks within health systems and across sectors (Bishai et al., 2016). Therefore, leadership capacity development is required for better health systems and improved outcomes (Agyepong et al., 2018). For this progress to be realized there is need for HP political will at strategic levels. Technical capacity is necessary to provide sustainable HP funds, coordination of multi-sectoral collaboration, research, training and advancing recognition of the need for a dedicated HP workforce, and investing in the development of organizational capacity as well as implementation of HP structures at national and local levels (European Commission, 2019). However, relevant empirical evidence on research about leadership from LMICs within the health sector remains scanty (Gilson and Agyepong, 2018).

2.5.3 Organization of HP, a dedicated HP workforce and programme delivery

There is wide consensus that HP suffers from an identity crisis (Howat et al., 2003a). In many countries HP faces challenges including lack of clarity about associated roles, lines of accountability and gaps in competency, skills and training (Wills and Rudolph, 2010). The field denotes a conceptual space rather than a clear professional policy or institutional domain; and it is a space of debate, uncertainty and ambiguity, because HP appears to be embedded in many activities (Cribb, 1993). Specifically, first, lines of its operationalization

remain blurred, and its professional practice varies globally (Carter et al., 2012). Second, many health workers, professional groups, community-based workers and volunteers perform selected HP roles as part of their primary responsibilities (World Health Organization, 1981). Third, the HP workforce is made up of interdisciplinary professionals (Barry and Battel-Kirk, 2011). Last, the term HP is used inconsistently such that the role of the HP workforce in the health system becomes unclear (Howat et al., 2003a, Ntayiya, 1998).

No ideal HP structure was found within the literature, meaning various models of HP institutionalization exist in different contexts. Some are integrated within Ministries of Health while others are stand-alone authorities that operate within and outside of government. However, HP's implementation gap is more prevalent in LMICs, where it is faced with limited infrastructure and capacity challenges (Lin et al., 2009a). A 'health promoter' may be loosely used to indicate anyone working to promote health. Linguistic confusion such as this is a disadvantage for HP. The term health promoter may be considered ambiguous, as various definitions exist in literature. Some scholars use the term health promoter and health worker interchangeably (Le Roux, 2017). Health workers are trained personnel who are familiar with the health care system in order to educate, motivate and support the members of a community to select appropriate health related behaviours. Therefore, every health worker is expected to perform HP activities. Ideally, health promoters deal with positive health aspects in communities (Tengland, 2010), such as counselling, support and act as communication links between health sectors and communities they serve (Brownstein et al., 2011).

2.5.3.1 How health promotion is organized within different contexts

2.5.3.1.1 High income countries

HP is organized differently in different contexts. In order to ensure the maintenance and enhancement of HP in a complex and changing system with interrelated and interacting stakeholders, some industrialized countries have initiated formal educational, professional and policy infrastructure for HP (Melville et al., 2006a, Howat et al., 2001, Coe and de Beyer, 2014). According to Smith and collegues (Smith et al., 2009) Australia has a highly skilled HP workforce, commonly equipped with a undergraduate and/or postgraduate qualification in HP, public health or health sciences. Its HP workforce may be grouped into: designated HP practitioners; health professionals whose role include HP; and people in other sectors whose roles include promoting health as well as levels of specialization (Howat et al., 2001, Shilton et al., 2008). Other high-income countries such as the United States, Canada, New Zealand and Israel have developed competency levels that define the practice of the workforce at different levels and this includes envisaging future needs for their designated HP personnel (Melville et al., 2006a, Howat et al., 2001, Barry et al., 2009). The link between HP roles and qualifications is not common in LMICs.

2.5.3.1.2 Low-and-middle income countries

Some LMICs have also established HP programmes/ structures as well as developed and implemented HP policies, although implementation and organization varies like elsewhere. Most models of how HP is organized are integrated within government structures. For example, countries such as Brazil, Botswana, Eritrea, Kenya, Malawi, Zimbabwe and Nigeria all integrate HP professionals into their Ministry of Health (MoH), at various levels (Malta et al., 2016, Ramos et al., 2014, Tapera and Sekis Moseki, 2018, Ministry of Health, 2017,

Ministry of Health, 2013, Mzembe and Chirwa, 2012, Chideme-Maradzika, 2000, Federal Ministry of Health, 2005). Whereas, Sudan only has small-scale HPP programmes and isolated posts (Elsubai, 2007). Others such as Liberia, Brazil, Malawi and Nigeria have also developed HP policies and or strategies, like South Africa (Ministry of Health and Social Welfare, 2009, Kind and Ferreira-Neto, 2013, Mzembe and Chirwa, 2012, Federal Ministry of Health, 2005, Department of Health, 2014). From this literature review, we realize that there is some evidence on how HP is organized and somewhat implemented in many countries. However, factors that facilitate and/ hinder the organization and implementation of HP within health systems have not being adequately addressed.

2.5.4 Financing of health promotion

Scholars acknowledge that HP is a complex system operating in a resource constrained multifaceted environment (Hattingh and Janks, 2012, Carter et al., 2011, Johansson et al., 2010). As mentioned earlier in *Section 1.2* and *1.4* (*Chapter 1*), despite international consensus of HP as a cost-effective way to reduce burden of diseases and improve population health (Bayarsaikhan and Muiser, 2007, Melville et al., 2006a), global evidence shows relatively low investment in HP compared with curative services (Vathesatogkit et al., 2011, Tangcharoensathien et al., 2008, Schang et al., 2012, Coe and de Beyer, 2014). In particular, HP activities in LMICs are usually funded by national governments through conventional budget allocation for facility-based activities such as antenatal care and immunization (Tangcharoensathien et al., 2008). A 2008 global assessment estimated that only 2.9% of the total health expenditure across 120 countries (1999-2003) was spent on HP and disease prevention activities (Tangcharoensathien et al., 2008).

Furthermore, Watabe *et al* (2016) pointed out that discussions on health financing reforms for achieving universal health care are predominantly curative, omitting HP programmes and prevention of disease (Watabe et al., 2016). Ensuring sustainable HP financing is an important task for countries and should be comprehensively integrated into national financing strategies towards achieving PHC reforms and universal health coverage (Bayarsaikhan and Nakamura, 2015, Watabe et al., 2016). Limited financial and technical resources persistently hinder efforts to strengthen HP actions at the individual, family and community levels (Munodawafa, 2011). The result is HP delivery systems that are mainly information giving/awareness creation compared to an emphasis on enabling and reinforcing factors, which is ideal.

2.5.4.1 Health Promotion Foundations (HPFs)

In order to effectively drive the HP agenda both within the health sector and other sectors, some countries such as Australia, Switzerland, Hungary, Korea, Malaysia and Thailand established organizations called HP Foundations (Bayarsaikhan, 2008, Bayarsaikhan and Nakamura, 2015, Prakongsai et al., 2007, Tangcharoensathien et al., 2008, Schang et al., 2012). These are statutory authorities endowed with providing long-term and recurrent public resources for promoting health, through managing and coordinating funds collected through mechanisms such as excise tax on tobacco, alcohol or any other substances that are harmful to health (Mouy and Barr, 2006). They are usually autonomous, but work across all levels of government and across many disciplines and sectors to support government priorities and contribute to evidence based public policy, research, advocacy intersectoral planning and policy implementation in collaboration with government, academia and civil society (Vathesatogkit et al., 2011). In such contexts, HP Foundations

play the role of change agent or catalyst (Mouy and Barr, 2006), spearheading multi-sectoral collaboration and driving the Health in All Policies approach to help achieve sustainable development goals (United Nations, 2015, World Health Organization, 2014a).

2.5.5 Capacity to support and implement effective HP programmes

As described in *Section 2.4*, capacity is significant in health system strengthening efforts (World Health Organization, 2007b). In organizational HP research, HP capacity is a central concept that is used to describe the abilities of individuals, organizations, and communities to promote health (Rod, 2015). HP organization and support has the potential to advocate, mediate and enable individuals, institutions and communities to have more control over their health and well-being decisions as well as ensuring an enabling and supportive environment (World Health Organization, 1986, Fortune et al., 2018). Different countries have different capacities to support, implement and organize HP (Lin and Fawkes, 2005).

Capacity of dedicated HP staff, as well as the institutions responsible for HP (both government and NGOs), is critical if HP potential is to be fully realized. Capacity assessments may help organisations plan, strategize, and make decisions on future capacity building and health system strengthening initiatives (Lê et al., 2014). This means HP capacity is a useful way of thinking about how to strengthen HP work (Bell Woodard et al., 2004). Thus, capacity for HP is influenced by the effectiveness of some domains on the health-promoting health systems framework, such as supportive country-specific contexts, leadership, skilled workforce, and resources (*Figure 6*). On the other hand, one of the main challenges identified when assessing HP capacity is how to count the 'HP workforce', given that many different professionals perform HP related activities (Mittelmark et al., 2006) – *Section 2.5.3*,

and may not be necessarily be called HP staff in those posts. In order to strengthen HP capacity, it is critical to map the current capacity for HP that exists among HP practitioners and institutions with the mandate of providing HP activities so that gaps are identified and progress to close them may be monitored (Dixey, 2013, Fehlker, 2012).

In the early 2000s, WHO introduced a global initiative to map country-level capacity for HP. The aim of the initiative was to find out what infrastructure exists in different countries to plan, implement, coordinate and evaluate HP efforts (World Health Organization, 2010). Capacity assessments represent the status of capacity in a system or organization (Mahmood, 2015). Capacity of HP staff, as well as the institutions responsible for HP programming and activities, is critical if the full potential of HP in the health system is to be reached. Data from HP capacity assessments can be used to advocate for infrastructure and strengthening of health-promoting health systems (Mittelmark et al., 2005, Wise and Nutbeam, 2007).

Capacity strengthening efforts can only be made if HP practitioners, researchers and policy-makers are aware of what HP capacities exist and what needs to be strengthened. Some regions like the Western Pacific (Lin and Fawkes, 2005), the Eastern Mediterranean (World Health Organization, 2010), and the European Union (Mittelmark et al., 2005) and some individual countries particularly, Canada (Ebbesen et al., 2004), Korea (Nam and Engelhardt, 2007) and Peru (Cosme Chavez et al., 2017), have undertaken the initiative of mapping their local HP capacities. The HP Strategy for the WHO African Region identified the need to sustain institutional HP capacity at national, regional and local levels (World Health Organization, 2013). In Malawi, capacity in HP was recently assessed, which found a low

capacity to plan, implement and evaluate HP interventions, and a fairly-strong institutional capacity to lead and co-ordinate HP activities at both national and district levels (Jana et al., 2018). However, limited research exists on the status of what HP capacities exist in the rest of the African region.

2.5.6 Building an evidence-base for HP practice

Evidence in HP interventions is complex due to the multidimensional nature of the field. Evidence plays a vital role in any field, particularly strengthening health systems, through informing healthy public policies and decision making for practice, including HP (Bryant, 2002, Rychetnik and Wise, 2004). Within health-promoting health systems, evidence-based HP practice may be considered as the development, implementation, and evaluation of effective HP programmes and policies in public health through application of principles of scientific reasoning, including systematic use of data, health information systems and appropriate use of behavioural science theories to inform HP programming and public health intervention planning (Brownson et al., 2017).

The challenge is that within the health system, concepts of what is considered or constitutes an evidence-base may vary among different actors and professional groups when comparing clinical spaces with community or population level data (Rychetnik and Wise, 2004). Generally, generation of health evidence, is commonly biased towards the use of disease specific statistics to allocate resources and track population health changes within the health system (Bryant, 2002, Au, 2017). This type of broad-based evidence-based approach frequently omits aspects such as social determinants of health, as it is more inclined to illness than promotive and preventive health. As a result, strategies of interventions

developed are mainly based on tackling risk factors and *not* social determinants of health (Au, 2017); thus have little impact of population health and well-being.

Systematic development of a HP specific evidence-base is required in order for health systems to promote health. Some scholars have proposed that in order to overcome the hurdle in the generation of HP evidence, use of mixed methods is required, in order to evaluate the effectiveness of HP programmes. Quantitative data on changes in outcome measures should be collected, while qualitative data is used to capture context and processes related to implementation of such activities (Wong, 2002). Specifically, Speller and colleagues proposed four tracks needed by HP programmers to generate data and develop evidence-based HP practice, systematic review of research and data collection, developing and disseminating evidence-based guidance; developing capacity to deliver effective evidence-based practice, and learning from effective practice (Speller et al., 2005). Once these are put in a place within a health-promoting health system, evidence-based HP practice may be developed. However, despite progress being made in building evidence for HP practice globally, questions remain about its use in priority setting for activities and interventions (Rychetnik and Wise, 2004).

2.5.7 Multi-sectoral collaboration for HP

As mentioned earlier, the health and well-being of people and populations is as a result of the primary interaction between social, behavioural, economic, environmental, and other determinants of health factors, which generally lie outside the immediate influence of the health sector (Blas et al., 2016). In this same regard, the responsibility for promoting health does not lie in the health sector alone (World Health Organization, 1986). As described

earlier, achievement of social and health equity requires coordinated and collaborative multi-sectoral action among various stakeholders as social injustice continues to affect mortality and morbidity on a large scale (World Health Organization and Commission on Social Determinants of Health, 2008, World Health Organization, 2011). Efforts to ensure multi-sectoral collaboration have been undertaken globally in high, middle as well as lower income countries in advocating "Heath in All Policies". The was the focus of the WHO Helsinki global conference on HP in 2013 (World Health Organization, 2014a).

Although a number of countries have engaged with addressing social determinants of health, there has not yet been widespread policy uptake to improve conditions of daily living, tackle the inequitable distribution of power, money, and resources, and monitor both inequities and the impact of policies to address them (Rasanathan, 2018). This is because actors working in isolation cannot confront health challenges successfully. In many instances, co-ordination remains difficult and many collaborations fade before their goals are unmet (Corbin and Mittelmark, 2008). Research that identifies factors that drive or hinder co-ordination and multi-sectoral collaboration for health is required, to strengthen health-promoting health systems. To refocus the findings of the Commission of Social Determinants of Health, recommendations that include broadening multi-sectoral collaboration bases through engaging with the wider health sector, such as vertical health programmes and other sectors have been put forward (Rasanathan, 2018).

2.5.8 Country specific context

Scholars have long debated the role of county specific contexts in explaining behaviour of organizations like health systems and management practices of people who work in them

(Cheng, 2014). A country's context affects what happens in its health system, and what can be done within it, as decisions taken, particularly at political strategic level strongly impact on health (World Health Organization, 2009a). Therefore, the context within which health policy is developed is critical (Walt and Gilson, 1994); as change does not occur in a vacuum, but responds to a complex set of stimuli and factors in the system (Collins et al., 1999). These contextual factors may be: situational, structural, cultural or environmental (Leichter, 1979). An organization's contextual environment is the set of 'actors', interest groups or stakeholders, who are affected directly or indirectly by the organization's work and have control over it (Voiculet et al., 2010). Some aspects of organizational behaviour (e.g., governance issues) are more susceptible to influences from a country's cultural and political systems (Child, 1981). In this regard, there is need to increase investigations of the influence of country context on the health system (Cheng, 2014), as an understanding of factors that influence the structure and who has power over resources, helps explain why some issues are on the health agenda than others (Collins et al., 1999).

2.5.8.1 PHC re-engineering: a reform to strengthen PHC in the South African study context

In the last decade, as has happened in other countries, South Africa has implemented various health system-strengthening initiatives to ensure a PHC-led reform that enables archiving universal health coverage. The 'PHC re-engineering' or 're-engineering of PHC' (as is commonly known in South Africa) initiative to revitalize PHC, deploys ward-based outreach teams (WBOTs) of CHWs and focuses on the integrated school health programme as part of its strategies to strengthen PHC (Pillay and Barron, 2011, Subedar, 2012). HP and disease prevention principles are mentioned as essential elements of all home visits and other community based activities including the school health programme (Subedar, 2012).

The role of each ward-based outreach team is to offer an integrated health service at community level to households and individuals within its catchment area (Subedar, 2012, Barron et al., 2010). The responsibility of the implementation of the school health programme falls under a school-based support team (Department of Health, 2012). According to the PHC re-engineering implementation guidelines, ward-based outreach teams should ideally comprise a nurse who is the team leader, six CHWs, as well as an environmental health officer and a health promoter per sub-district (Subedar, 2012). *Figure 7* shows the ideal composition of the PHC outreach teams.

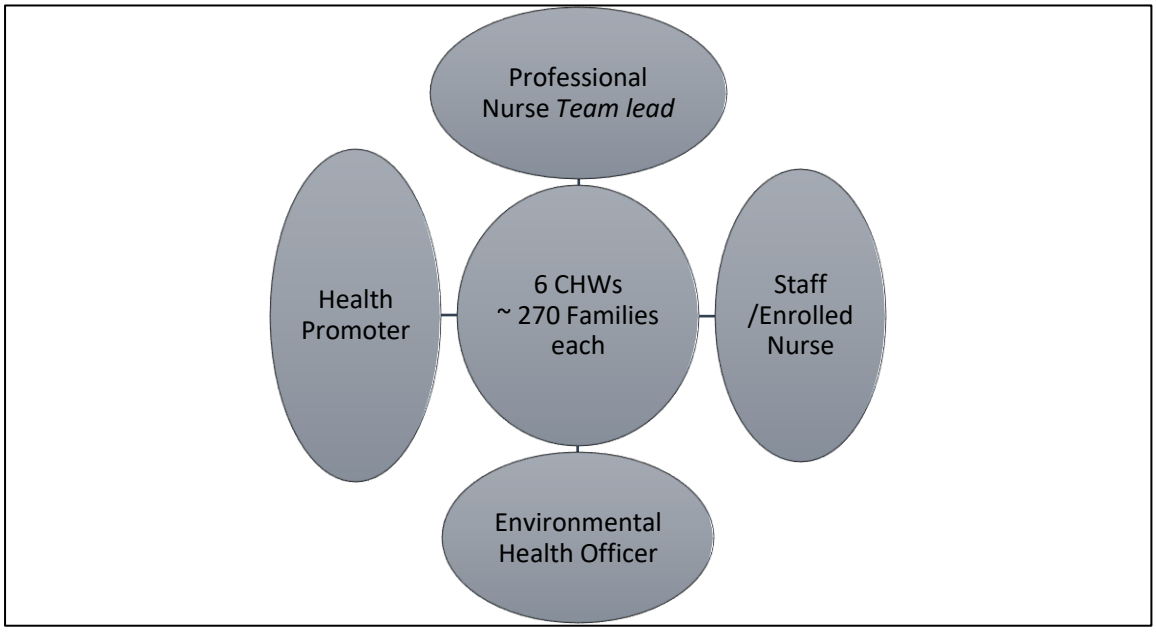


Figure 8: Ideal composition of community ward-based outreach teams, Adapted (Subedar, 2012)

Within ward-based outreach teams, health promoters are expected to assist and support CHWs by providing health information and mentorship (Subedar, 2012). However, the proportions of ward-based outreach teams far outweigh the number of health promoters at PHC levels. Health promoters are also meant to be part of the school-based support

team; their role in this aspect is to deliver health education and HP components on full or part time basis. Within the School Health Programme, health education and HP may be provided by other cadres like CHWs, NGOs or community based organizations (Department of Health, 2012).

2.6 Gaps in literature

Literature has demonstrated that despite investments in HP in some contexts and the global emphasis to mainstream it into public health policy making and practice (Agarwal et al., 2009), it has not yet been fully integrated into all health systems. Historical background shows that currently most countries, particularly developing ones remain curative-focused. This pushes HP to the edges (Coe and de Beyer, 2014). When HP is an integral part of health systems, it helps drive the HP agenda through shaping national health public policies including taxation, strengthening multi-sectoral collaboration, receiving a sustainable allocation of resources, investment in HP research, and inclusion in health service delivery. While, countries differ in their capacity for HP (Lin et al., 2009b), relatively little is known about how HP is organized and implemented, particularly in African health systems (Govender, 2005). This research seeks to answer some of the identified gaps. A summary of identified gaps in literature is shown on *Table 5*. My PhD particularly focuses on answering mainly three of the identified gaps: what is the capacity for HP within the DoH, how HP is institutionalized within the health system and what the role of HP practitioners in PHC revitalization is in South Africa.

To the best of my knowledge, only one African HP capacity assessment has been published (Jana et al., 2018). This means that there is limited evidence of HP capacity mapping in African settings. As discussed earlier, HP capacity is an important issue to address in efforts to strengthen health systems (European Commission, 2019). To strengthen HP capacity, it is important to determine existing capacities first, so as to identify gaps (Dixey, 2013, Fehlker, 2012) and to better understand the context specific issues in order to plan and implement effective capacity strengthening initiatives (van Herwerden et al., 2018). A lack of baseline information of HP capacities may limit opportunities to close gaps. Before my PhD, mapping of HP capacities had not yet been systematically conducted in South Africa and *Objective 1* (*Chapter 4*) of the thesis aims to fill this gap, using a HP capacity assessment tool adapted from Malawi (Jana et al., 2018).

Furthermore, as previously highlighted despite consensus on the critical role of HP in health system strengthening, its integration within the fabric of health systems has not yet been fully established (Wise and Nutbeam, 2007). In many countries, progress towards Ottawa Charter's re-orienting health services to strengthen their HP role has been slow (Ziglio et al., 2011). Reasons behind this are not so evident. This means there is dearth in research on investigating factors that impede the organization and implementation of HP within the health system. It is critical to understand the key barriers to the institutionalization of HP. In the same context, factors that facilitate its organization and implementation are also important, as well as the role of agency given power dynamics. *Objective 2* (*Chapter 5)* of the thesis aims to fill this gap, using Giddens's structuration theory and conducts an in-depth exploration of structural and agency factors that hinder the institutionalization of HP with the DoH system in South Africa.

The current wave of revitalization of PHC, in the context of a push for universal health coverage, has provided an impetus to broaden research and an evidence-base for PHC reforms. PHC revitalization offers mechanisms to emphasize HP (Jha, 2013). However, the majority of LMICs concentrating on PHC reforms have paid more particular attention to CHWs (Tseng et al., 2019, Seutloali et al., 2018, Zulliger et al., 2014, Ozano et al., 2018). This means there is limited research on PHC revitalization focusing on the dedicated HP workforce at coalface. The two studies identified which have looked at the question are from a high-income context (Lovell and Neuwelt, 2011, Jolley et al., 2014). This shows that little is known about the role of HP practitioners in the context of the introduction of CHWs and PHC reforms, especially in Africa. In this regard, the potential contribution of the HP workforce in the success of PHC reforms is missed. *Objective 3* (*Chapter 6*) of the thesis aims to fill this gap, using Lewin's three step organizational change model to take an in-depth exploration at how health promoters and CHWs or ward-based outreach teams are working together on the ground if at all, in the context of a PHC reform.

Nevertheless, the questions to ask include, how does HP remain relevant in such a complex changing system? How is it implemented at district level within the PHC revitalization context? What role do health promoters actually play within this broader sense of goals? By taking an organizational approach, guided by a health-promoting health systems model, my PhD seeks to address some of these questions that have not been previously answered.

Table 5: Summary of implementation and research gaps relative to each construct of the health-promoting health systems framework, Adapted (Munyewende, 2016)

Dimension of the framework	What is known in literature?	What is the implementation and research gap?
People-centred focus	People are recognized as social actors who can effect creation of their health and well-being	In many countries, progress towards the Health for All strategy has not yet been an option, highlighting an implementation gap
Leadership and governance	Countries with the greatest health gains are those whose leaders are committed to determinants of health and tailor HP and disease prevention	Relevant empirical evidence on research about leadership from LMICs remains scanty
Financing and resources	Global evidence shows relatively low investment in HP compared with curative services	Limited African-based studies on why health system budgets and financing systematically omit HP
Capacity	Different countries have different capacities to promote health and deliver HP	Limited scholarly literature on capacities available to support and deliver HP in LMICs
Organizational structure	Various models (integrated vs. stand-alone) of HP organizational structure exist in different countries	Limited empirical evidence on factors that influence the organization and implementation of HP structures across levels of the health system
Workforce	Globally there are gaps in competency levels, skills and training of the dedicated HP workforce	Lack of advancement in the recognition of the need for a dedicated HP workforce at country level
Service delivery	In many countries HP faces challenges such as lack of clarity about associated roles and lines of accountability	Lines of HP operationalization remain blurred, and its professional practice varies globally
Evidence-base development for HP practice	Evidence plays a vital role in health public policy planning processes and decision making for HP practice	Questions remain about the use of evidence in priority setting for HP practice, particularly in African settings
Multi-sectoral collaboration	Collaborations between different actors within and outside government are central to HP activities	Limited research that identifies facilitators and barriers to co-ordination and multi-sectoral collaboration for HP to strengthen implementation
Country-level context	A country's context influences what happens in its health system, and what can be done within it	Dearth of empirical studies on the role of HP practitioners in PHC revitalization and health system strengthening initiatives

CHAPTER THREE

"Research is an organized method for keeping you reasonably dissatisfied with what you have."

~ Charles Kettering ~

3. RESEARCH METHODOLOGY

This chapter provides an account of how the PhD research was conducted and why decisions were made in order to meet the study's overall aim and objectives. The chapter discusses the research methodology and methods applied in this PhD. This comprises the research design and rationale, study settings included in the research and reasons for selection, populations of interest and sampling procedures used to recruit participants into the study. The chapters explain how I collected data, introduce the data collection instruments I used and sources of information, and how I analyzed the data and triangulated it across various sources. My roles as a PhD candidate in the research process end the chapter. The aims of my PhD are outlined in *Chapter 1, Section 1.6*.

3.1 Research philosophy

Research is influenced by a researchers' own understanding of what reality and knowledge is (Gilson, 2012a). A research philosophy is a system of beliefs and assumptions about the way in which data about a phenomena is collected, analyzed and used to develop new knowledge (Saunders et al., 2009). I conducted this PhD research using a relativist research paradigm, to create new knowledge and richer understandings of social reality on how HP is institutionalized within the South African health system (Mack, 2010, Saunders et al., 2009, Gilson, 2012a). Given that health systems are complex, I used multiple perspectives and drew on the experiences of study participants and their narratives to triangulate and verify my own interpretations and conclusions about how HP is organized and implemented in the

South African DoH (Gilson, 2012a, Saunders et al., 2009). The study of phenomena in their natural environment allowed me to understand people's subjective views and interpretations of their experiences, practices and shared meanings of reality, which is key to an interpretivist's philosophy (Gilson, 2012a, Saunders et al., 2009). A health-promoting health systems conceptual framework was used to guide the research. Both inductive and deductive thematic and content analysis were used to infer data generated by the PhD study.

3.2 Researcher characteristics and reflexivity

I conducted this research for my PhD and was the principal investigator (PI) of the study. I am African from Zimbabwe, which may have influenced the way that research participants viewed me. Not being a South African by birth meant that to some extent I was able to position myself as an outsider with a naïve interest in understanding HP within the context of the South African health system. Prior to this PhD, I worked as a HP officer in Zimbabwe and have qualifications in HP. In addition, I have postgraduate training in social and behaviour change communication. Given this background, I assumed the role of an 'outsider researcher' in the context of the South African DoH. Yet, as a professional who worked in HP, I used to find myself having to defend my profession, which meant that I was also an 'insider researcher'. When collecting data, I found that I could relate to many of the experiences and challenges that participants shared. When analysing the data I was aware that in some instances I readily accepted the framing offered by participants and needed consciously engage a critical mind.

I did not know most of the study participants, particularly those from the DoH prior to my interactions with them during the research process, except for three of the external HP stakeholders with whom I had worked in the past. Knowing that I had a HP qualification made HP practitioners feel more open to me. My background also enabled me to engage with external HP stakeholders at a higher level. In the same regard, I could not help but feel that some facility managers thought I was on a fault-finding mission, sent by the national DoH and were very much in a "defensive mode". My ability to understand some local South African languages, although I could not completely respond, made facility-based health promoters comfortable with me. As a researcher affiliated with the University of the Witwatersrand (Wits - a big academic institution), some health promoters could not help but view me as a solution to their many HP field challenges. Some were grateful for an opportunity to share their experiences and reflect on the dynamics within the DoH, as since they had begun practising HP in the 1990s, no researcher had ever come to conduct research on their roles and experiences. Hence, they were very welcoming and embraced my presence, and treated me with respect. Funnily enough, many thought I was a doctor already and referred to me or introduced me to their colleagues as such. As a Black female, I was aware how most health promoters at grassroots' level were Black females too, and that more males occupied managerial positions in the HP programme.

Conducting this research, I often related to the challenges and frustrations highlighted by the HP staff. My training in HP and health education, as well as my previous experience in the field of social and behaviour change communication influenced my interpretation and understanding of the results. I had to remind myself constantly that this research was not about me, but how HP was institutionalized in South Africa. Yet, my past commissions

assisted in igniting my interest to study further, how HP is organized and implemented, even when I was fully aware that the field of HP is a complex issue to tackle.

3.3 Study settings

Taking into account a whole system view, my PhD study was conducted across multiple levels to achieve maximum variation: (a) the national DoH, (b) two of the nine provinces, referred to as Province A and Province B in the thesis, (c) two districts, selected from each of the two included provinces (District A and District B respectively), and (d) seven HP civil society organizations. Geographically, Province A and Province B share a border. Province A is mainly a rural setting, while Province B is mostly urban. Administratively, Province A is divided into three district municipalities, whilst Province B is divided into five. District A comprised of five local municipalities, whereas District B had three. According to the District Health Barometer (2017/2018), which provides an overview of the delivery of PHC in South Africa (Massyn et al., 2019), comparison of some health indicators for the two districts selected at the time of this study were as follows (*Table 6*):

Table 6: Comparison of selected health indicators in the two recruited districts, Source (Massyn et al., 2019)

HEALTH INDICATOR	NATIONAL	DISTRICT A	DISTRICT B
< 5 malnutrition	7.4	9.4	2.9
Immunization <1	77.0%	94.8%	82.4%
Contraceptive use	59.8%	74.6%	89.1%
Cancer screening	61.2%	90.4%	64.8%
TB cure rate	81.7%	88.9%	82.2%
ANC 1st visit	66.6%	79.5%	68.7%
HIV testing	23.0%	27.0%	27.6%

3.3.1 Justification for choice of study settings

Study settings included in this study were purposively selected for a number of reasons, described below. Purposive sampling is a technique used to deliberately select informants into a study, based on qualities they possess (Tongco, 2007). The researcher decides what needs to be known, and sets out to find participants who can and are willing to provide the information they seek, based on their knowledge or experience (Bernard, 2017).

National: the national DoH and particularly the HP directorate was included due to its role as custodians of HP in the country at the time of study, including their responsibility in providing overall policy and HP technical support to lower levels (province and district). External HP stakeholders were included in the study to allow for a non-DoH voice. However, eligibility criteria required civil society representatives to be part of an alliance called the South African HP and Development Network.

Provinces: selection criteria were based on both provinces having a high number of HP staff and stable HP structures at local grassroots/ PHC facility levels (districts, sub-districts and clinics). For example, according to preliminary interviews and reports conducted with the HP directorate at national DoH, Province A was considered as having one of best HP models in South Africa, while, Province B was reported to have one of largest HP workforces in the country. In addition, inclusion of each of the two provinces permitted a rural-urban mix within the case study methodology.

Districts: District A and District B were also selected on the basis of having the highest dedicated HP staff in their respective provinces as well as in terms of better HP

performance, as reported by the HP directorate. This approach increased the chances of finding a health promoter at PHC level. Sub-districts thereof were chosen due to their geographical proximity to the district health offices and logistical purposes. Whereas, PHC clinics selection was based on the availability of a health promoter working in that clinic at the time data collection occurred.

3.4 Study design

The PhD applied a case study research design, using concurrent mixed methods [QUAL (quan)] approach. In my PhD, the unit of analysis was the HP programme at different levels of the South African health system, which represented the 'case'. The strength of case studies is that they are a valuable way to investigate the world around us. They provide researchers with the ability to describe, explore or explain relationships that exist in reality and often in a single organization (Rowley, 2002). The design allowed investigation of a complex contemporary issue like HP within its real-life context, given that the boundaries between phenomenon and context where not clearly evident (Yin, 1994, Crowe et al., 2011). In this study, the case of interest was to: (a) describe "*what"* HP is, (b) analyse "*how"* it is organized (Schneider and Nxumalo, 2017), and (c) analyze the reasons or explanations for how HP is viewed and *"why"* it is organised and implemented in the way that it is within the DoH. In addition, use of a case study approach allowed for a whole system view, which enabled in-depth understanding of the consequences or results of the *"what"* and the *"how"* on the functioning and institutionalization of HP. A combination of four complementary data collection methods (in-depth and key informant interviews, workshops and document reviews) were carried out, to meet each research objective and triangulated

(Guion, 2002). Results *Chapters 4, 5 and 6* describe the detailed methodology for each of the corresponding papers included in the thesis.

3.4.1 Rationale for a case study approach

A case study approach was chosen, as it was appropriate to meet the aim of this PhD research, which was to understand both, what the status of HP is in the South African DoH (*what is happening*) and how HP is institutionalized within the health system (*in what ways it is happening*) (Sosulski and Lawrence, 2008). Concurrent collection of both qualitative and quantitative data, particularly during workshops allowed for a combination of numerical measurement and in-depth exploration of data for the PhD research study. This strategy enhanced interpretation of findings (Zhang and Creswell, 2013, Johnson et al., 2007, Leech and Onwuegbuzie, 2009). The approach allowed for collection of in-depth and multi-faceted information to fulfil the overall aim of the thesis (Crowe et al., 2011, Zhang and Creswell, 2013). The case study methodology was selected because it allows topics to be studied in their context-specific settings, while attempting to interpret the phenomena of interest as it unfolds in terms of the meanings it brings from various individuals (Patton, 2005). In my PhD, the object of phenomena was HP capacity, structure and practice in the DoH, South Africa (Yüksel and Yıldırım, 2015). *Figure 8* shows the framework of how the research questions and combination of theories and tools align to meet the overall PhD goal.

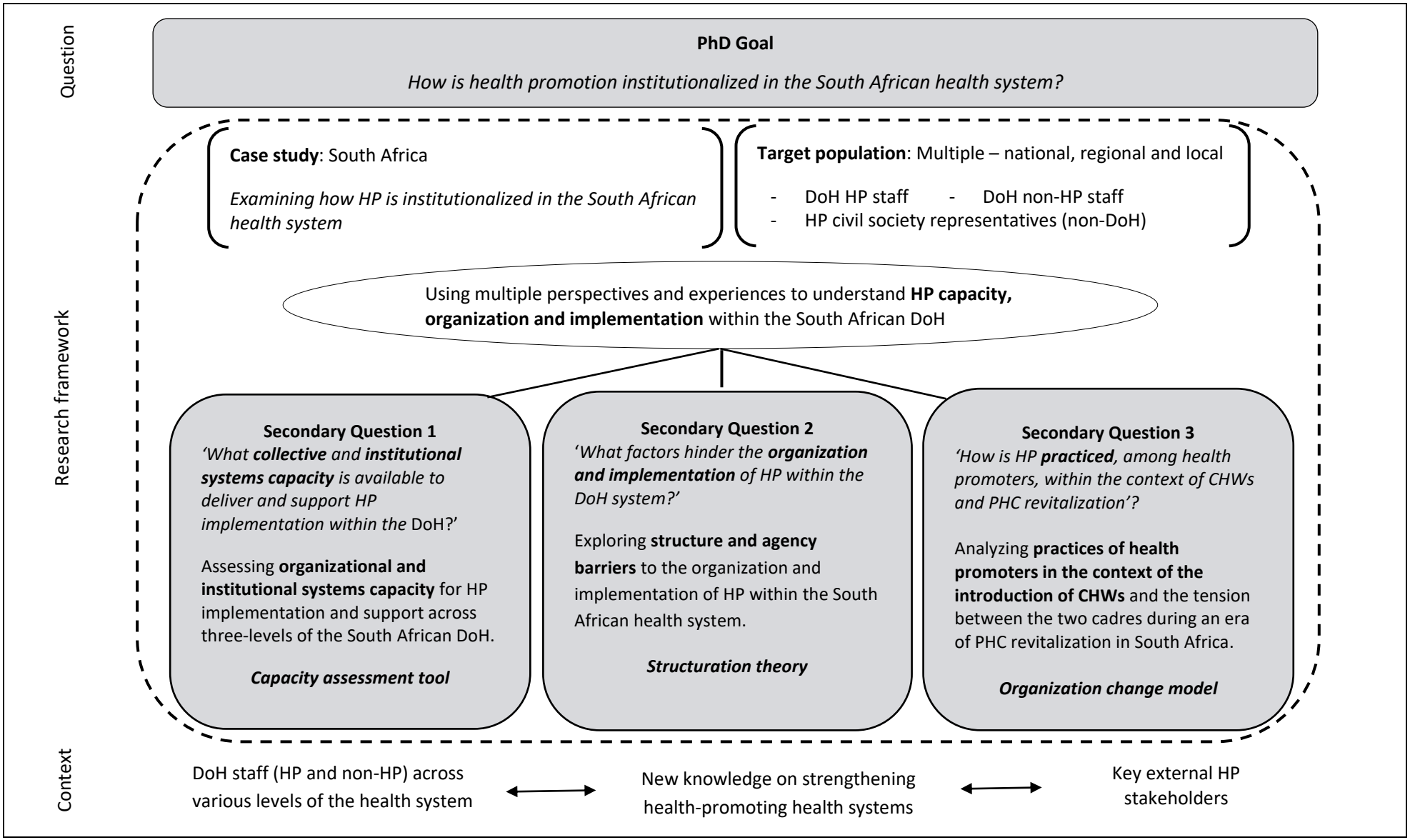


Figure 9: PhD Research Framework, Adapted (Martin, 2016)

3.5 Study population

Study participants were HP information-rich DoH (both HP and non-HP staff) and non-DoH or external HP stakeholders. The populations of interest were: (a) national DoH managers, (b) HP staff working for the DoH at national, provincial and district level, (c) non-HP staff working for the DoH, at national and facility level, and (d) a nationwide HP civil society representatives during the time of study (2017-2018), recruited from various non-governmental organizations, research and academic institutions.

3.5.1 Description of study participants

Study participants recruited for in-depth interviews were asked to complete a socio-demographic form, *n=49*. Their demographic characteristics are shown on *Table 13* and *Table 17* in Chapters 5 and 6 respectively. Of these, more than half were DoH HP staff (*n=27*, 55%) and almost a third were non-HP staff within DoH (*n=15*, 31%) and some HP external stakeholder representatives (*n=7*, 14%). Most of the participants were aged 45 years or older (*n=35*, 71%). Younger participants were difficult to find, with no participant under 25 years of age. The majority of study participants were female (*n=37/49*, 76%). Most participants were Black African (*n=39*, 80%). In addition, White (*n=7*, 14%), Indian (*n=2*, 4%) and Coloured (*n=1*, 2%) participants were also recruited into the study. Most key HP stakeholders were White (*n=6/7*, 75%), with post-graduate qualifications. Generally, the majority of participants had a diploma certificate or higher (*Table 13*), *n=40* (82%). Only one participant (HP practitioner) had some level of high-school qualification. Nearly half of the participants worked at the PHC level (*n=25*, 51%). Most had worked in their current job location for more than six years (*n=38*, 81%), with the same job title for more than six years

(*n=36*, 77%). Only five (10%) of the HP staff participants identified themselves as health promoters.

3.6 Sampling, sample size and sampling procedures

Purposive sampling was used to recruit DoH participants into the study. The sampling technique allowed for the deliberate identification and selection of knowledgeable and available participants to provide HP information as well as increasing maximum variation of study participants who represented all various levels of the health system (Patton, 1990). As the PhD candidate and PI, I approached and recruited the study participants through face-to-face, telephonic and email invitations. Fifty-six participants were recruited for this PhD study (*Figure 9*).

In qualitative research we strive for data saturation to be reached to ensures that enough data has been collected to answer research questions (Patton, 1990). However, in this study, there were limited numbers of staff at the different levels and so all were interviewed. In addition, snowball or chain sampling was used to recruit key HP actors (mostly external HP civil society stakeholders). This approach involved locating external HP information-rich participants (Patton, 1990), who in turn recommended a chain of other stakeholders for selection into the study (Rwafa-Ponela et al., nd). External HP stakeholders were included in the study to represent a non-DoH of voice in the data as their views of HP within the DoH as outsiders.

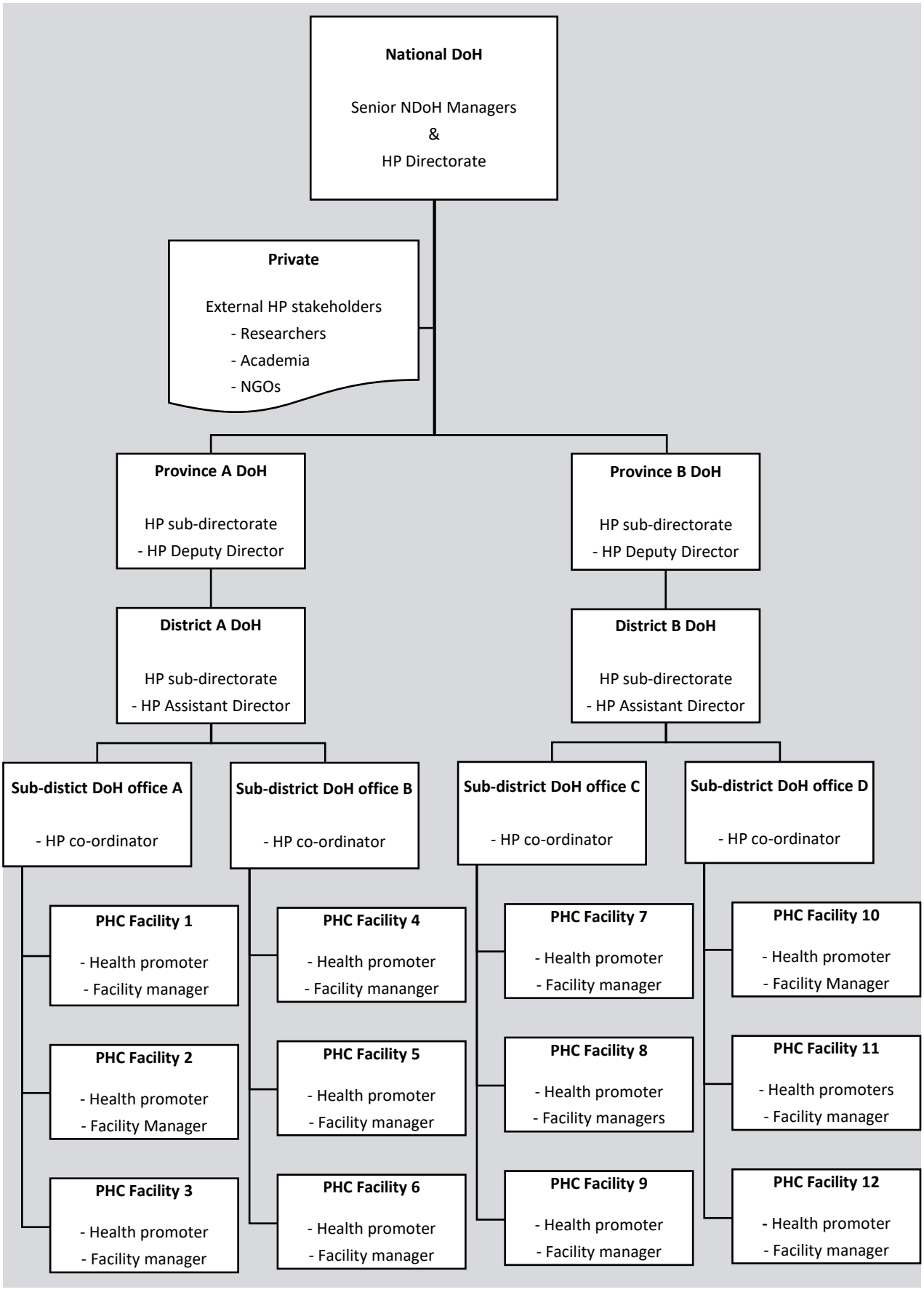


Figure 10: Sampling algorithm of study sites and recruitment strategy of participants

3.7 Overview of steps taken during the case study

The study consisted of different levels of analysis: national, provincial, and district and how they are connected *(Table 7)*. The first component involved conducting in-depth interviews with DoH staff at national, two provincial and two district (including sub-district and facility) levels. The second component was conducting key informant interviews with external HP stakeholders from national civil society organizations. The third component consisted of carrying-out capacity assessments among DoH HP staff at national, two provincial and two district levels. While, the fourth component consisted of conducting document reviews. Triangulation of data across a variety of the data sources enabled integration of findings as the final component.

Table 7: Methods used in the PhD study

Methods	What was done?	Data collection instruments
In-depth Interviews ***(Component 1)***	The first method focused on describing perspectives and experiences of the roles of health promoters in the context of the introduction of CHWs and examining the tension between the two cadres during an era of a PHC reform in South Africa, using in-depth interviews (IDIs) with DoH HP staff and non-HP, specifically facility managers.	Interview guides ▪ *see Appendix L* ▪ *see Appendix M*
Key Informant Interviews ***(Component 2)***	The second method examined HP in the South African DoH from the perspective of external non-DoH HP stakeholders, using key informant interviews (KIIs) to collect HP data. This phase focused on understanding what civil society is doing in order to push the HP agenda within the South African government and their views on how HP is being implemented within the DoH.	Interview guide ▪ *see Appendix N*
Workshops ***(Component 3)***	The third method that was used to assess organizational capacity and institutional systems to implement HP across three-levels of the South African DoH, using workshops which consisted of rich discussions. HP capacity assessment tools (HP CAT) were administered at each level to	HP capacity assessment tool ▪ *see Appendix O*

	participants of five sites (national, two provinces and two districts) which required participants to reach a consensus score on different aspects of capacity. Workshops generated both qualitative and quantitative data.	
Document reviews ***(Component 4)***	The forth method included a review of documents, particularly the national HP policy and strategy (2015-2019) (Department of Health, 2014), and the PHC-re-engineering implementation guidelines (2011) to contextualise the study (Subedar, 2012). In addition, copies of available relevant documents such as HP job descriptions, reports and action plans were sought and reviewed in order to verify the self-reported scores in the capacity assessments.	Thematic content analysis
Thesis discussion	The final component involved triangulation of the multiple sources of data and methods.	Integration of PhD findings

3.8 Data collection

Data were gathered from multiple sources, across multiple levels and at various time points over a period of three-months (November 2017 to February 2018). Multiple methods and data sources were used to collect data to meet the research question 'how is HP is institutionalized within the South African health system', as outlined on *Figure 9*. Participants were recruited to participate in the study according to the population of interest recruitment strategy outlined on *Figure 10*. All DoH interviews were conducted face-to-face. Key informant interviews with external stakeholder varied, depending on the location and flexibility of the participant. This resulted in a mixture of face-to-face and telephonic interviews through different electronic platforms such as WhatsApp calls and Skype being utilized.

All participants were provided with written full information about the research and its aims *(Appendix F).* Written consent was sort from each participant prior to collection of any data

(Appendix G & H), including seeking permission to record interviews and workshops respectively *(Appendix I & J)*. The principal investigator (PI) collected the study data through interviews, workshops and document reviews. In some instances there was need to return for follow-up visits. These were arranged during the data collection period with the specific participants. All interviews and workshops were audio recorded. Research activities were based on empirical materials, such as interview data, questionnaires and documents reviews. Some of the multiple data collection approaches overlapped to meet each objective of the PhD (*Chapters 4, 5 and 6*). Furthermore, existing data particularly national South African documents like the HP policy (Department of Health, 2014) and the PHC re-engineering implementation guidelines (Subedar, 2012) were sourced from the internet and analyzed for this study. These were selected based on their relevance to the research.

3.8.1 Qualitative data sources

3.8.1.1 Qualitative interviews

Semi-structured interview guides were developed in English for the study. These covered six broad topics, as described in more detail on *Section 5.2.5* in *Chapter 5*. Interviews were conducted across each health system level (in-depth interviews) and among external stakeholders (key informant interviews). Probing was employed for elaboration, in order to elicit in-depth narratives and descriptions of topics and questions posed. Non-verbal cues of participants and contextual aspects on the interviews were also recorded through note taking during the data collection process. An overview of the research objectives and data collected are shown on *Table 7*. In addition, to the in-depth interviews using a semi-structured guide with open, non-directive questions, workshop deliberations allowed

further rich qualitative data to be collected and analysed for the PhD. This approach is described in more detail on *Section 3.8.3.1* below.

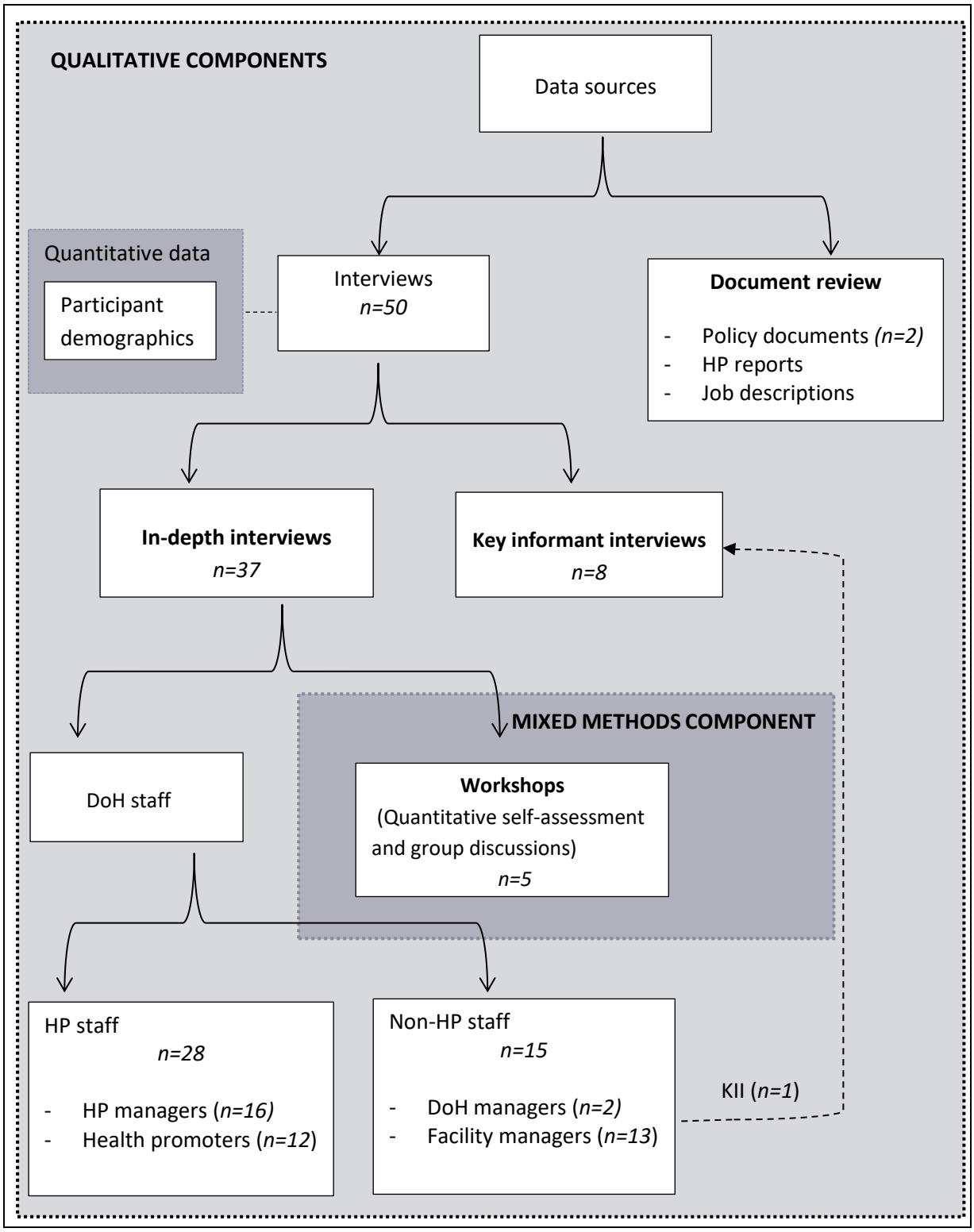


Figure 11: PhD data sources

3.8.2 Quantitative data sources

The HP capacity assessment questionnaire was used to generate both qualitative and quantitative data for the study, together with the participant socio-demographic characteristics form. The PhD considered that quantitative data would usefully supplement the data obtained from qualitative components of the study for the thesis (Morley, 2014), consequently, extending the empirical knowledge generated by this PhD for HP strengthening in South Africa.

3.8.2.1 Socio-demographic variables and measurements

During individual interviews, participants were requested to complete a short-questionnaire measuring socio-demographic characteristics in order to be able to describe the study sample *(Appendix K)*. The variables considered and their measurements as well as categories used are describe on *Table 8*.

Table 8: Socio-demographic characteristic variables and measurements

Variable	Measurement	Categories
Age group in years	Participants' age was categorized using a five-level outcome	<25, 25-34, 35- 44, 45-54 and 55+
Sex	Sexual classification variable was measured using two outcomes	Female vs. Male
Race	Participants' race was measured using five outcomes	Black, White, Indian, Coloured and Other (racial categories that required specifying)
Level of education	Level of education was measured using a seven-level outcome	None, Some primary, Some secondary, Matric/high school, Certificate, Diploma, Bachelor's degree
Job location	Participants' current job location was categorized into six outcomes	National, Province, District, Sub-district, PHC facility and Other (requiring one to specify)
Years working at current location	This variable was measured using a five-level outcome	< 1 year, 1-2 years, 3-4 years, 5-6 years and >6years
Years working at current job title	years at current job title was categorized using five outcomes	< 1 year, 1-2 years, 3-4 years, 5-6 years and >6years

Previous job title before current	Participants' previous job titles were measured using five outcomes	None, CHW/Caregiver, HIV counsellor, HP manager and Other titles (that required participants to specify)

3.8.3 Source of mixed methods data

3.8.3.1 HP capacity assessment questionnaire

The HP capacity assessment tool was administered in the form of one-day workshops at national, two provincial and two district levels. In 2016, the tool was adapted for use in Malawi (Mzembe and Chirwa, 2012, Jana et al., 2018). The tool was initially developed by the United States Agency International Development under the Health Communication Capacity Collaborative Project, as part of its capacity strengthening work in social and behaviour change communication among HP practitioners in Malawi (Jana et al., 2018). The questionnaire was designed to assist Ministries of Health to assess their own technical social and behaviour change communication capacity, ability to effectively coordinate and implement HP activities and the state of institutional systems to support their HP work. The questionnaire was adapted for the HP context in South Africa and a modified version was used for the different levels of the health system. Each item was scored using a four-point Likert scale *(Appendices O)*. There was no need for sample size calculation. However, a minimum of three participants representing each study site had to be present in order for collective capacity assessments to be conducted. More details about the tool and workshops are provided on *Chapter 4*. Consensus scores for each study site were recorded as well as discussions among workshop participants and justifications behind settling for a particular score. The strength of the workshops is that they allowed the study to generate concurrent quantitative and qualitative data. The two approaches were combined for complementary purposes (Ivankova et al., 2006). Cronbach's alphas were used to assess

internal consistency for all scores in each domain (*Table 9*). The scales' reliability coefficients were between α= 0.68 – 0.92.

Table 9: Cronbach alpha's of the core domain scales

Core Domain	Scale	Maximum score	Co-efficient (α)
Institutional systems	twenty-one item scale	84	0.89
Plan and design	twenty-two item scale	88	0.90
Implement and monitor	twelve item scale	48	0.92
Evaluate, scale and sustain	seven item scale	28	0.68

3.9 Data processing methods and data analysis

A system's view was used to understand how HP is institutionalized within the South African DoH. *Table 10* provides as summary of the overall PhD research methodology. The study uses de-identified narratives and illustrative quotes of the textural descriptions provided by participants to report on data (Anderson, 2007, Creswell and Creswell, 2017). Data were analysed through an iterative process, as per each study objective (Lee E et al., 2010). Findings of my PhD were summarised into themes that emerged from patterns within the data, reflecting participants' key issues and views (Smith and Firth, 2011).

Table 10: Summary of methods used to achieve each objective to meet the overall aim of the PhD

Study Objective	Research question	Study setting	Participants and sources of data	Data collection and tools	Data analysis
Multiple case study *OBJECTIVE I*	What capacities are available to implement and support HP within the DoH?	National DoH Two Provincial DoH Two District Municipal Health Offices	National HP Directorate *(n=6)* Provincial HP and senior DoH managers *(n=6)* District and sub-district HP managers *(n=16)*	Capacity assessment questionnaires among HP managers, *n=5* Documents (e.g. operational plans, job descriptions) Workshop notes	Thematic analysis Descriptive statistics, means and standard deviations of scores QUAL and quant data
Qualitative case study *OBJECTIVE II*	How has structure and agency factors impeded the organization and implementation of HP in the South African health system?	National DoH Two Provincial DoH Two District Municipal Health Offices HP civil society representatives	NDoH senior managers *(n=2)* HP Directorate staff *(n=6)* Provincial HP and senior managers *(n=3)* District and sub-district HP managers *(n=18)* External HP stakeholders *(n=7)*	In-depth interviews (individual and group), *n=37* Workshops, *n=5* Key informant interviews, *n=8* Field notes	Deductive thematic analysis Triangulation of interview data and workshop data QUAL data
Qualitative case study *OBJECTIVE III*	What is the effect of the CHW programme among health promoters' practice and to what extent are the two cadres working together?	Two provinces (Province A and Province B)	NDoH senior manager (*n=1)* HP Directorate staff *(n=5)* Provincial, district and sub-district HP coordinators *(n=9)* Facility managers *(n=12)* Health Promoters *(n=11)*	In-depth interviews (individual and group), *n=37* Policy documents review, *n=2* Field notes	Deductive and inductive thematic content analysis QUAL data

3.9.1 Qualitative data analysis

Two independent companies transcribed the audio-recorded files verbatim. The transcribed data was checked against its original recording to ensure accuracy by an independent transcriber. Based on interview topic guides, topic codes were identified and supplemented with inductive codes, which emerged from a deep reading of the transcripts. Reviewing documents involved isolating relevant texts, which was read and coded. A combination of manual and MAXQDA software was used to code text segments and prepare data into categories and themes for analysis through a reiterative process that combined content and thematic analysis (*Chapters 4, 5 and 6*). Thirty-one categories and 105 codes emerged from the data. Codebooks for each manuscript was generated, including definition of codes. To ensure quality control, supervisors of the PhD produced their own separate codebooks and comparisons made were possible. Similarities and differences between the responses of various study participants were explored. Conceptual frameworks for each research component also guided the exploration of occurring themes and other patterns in the data. Member checking to verify accuracy of interpretations was performed through meetings with some of the participants. Triangulation across all data sources enabled integration of findings for the PhD thesis. From this, appropriate recommendations as per each research component towards strengthening the role of HP within the South African health system for policy-makers, HP implementers and further research are proposed.

3.9.2 Quantitative data analysis

Data from HP capacity assessment tools and the participant socio-demographic forms were populated onto Microsoft Excel spreadsheets, imported and analysed using the statistical package STATA 13 (StataCorp, 2014). Univariate descriptive statistics were conducted to

describe the data. Proportions and frequencies were used to describe the study sample by their socio-demographic characteristics. Capacity scores for each HP domain scale were created through summing up individual sub-domain scores and dividing them with the total number of items under each domain. These were represented as means with standard deviations. Overall scores for the core domains were also calculated and are described in more detail in *Chapter 4*.

3.10 Techniques to enhance trustworthiness

Various strategies have been established to examine trustworthiness of research processes. Techniques employed by the researcher to ensure trustworthiness of the research findings included:

- *Credibility* - triangulation of data across various sources, multiple methods used to collect data and using mixed methods. This included the semi-structured in-depth interview techniques employed during the data collection process.
- *Transferability* – recruiting multiple participants and multiple levels of HP staff representatives to increase maximum variability of data collected.
- *Dependability* - code-to-code procedures were conducted through keeping a record of the audit trail of the codes that emerged from the overall thesis, as well as making sure that more than one research team member cross-checked the data analysis process.
- *Confirmability* - reporting back to study participants findings that emerged from the research and providing them with an opportunity to disagree with the findings.

3.11 Ethical considerations

The PhD research was approved by the University of Witwatersrand's Human Research Ethics Committee (HREC Medical), clearance number M170654 (*Appendix A*). Permission to conduct the research was provided by the national DoH (*Appendix B*), the two provinces (*Appendix C & D* respectively) and one of the district health offices (*Appendix E*). The other reported that permission by the province was sufficient to conduct the study at district level. In addition, written permission to collect data was obtained from each of the twelve PHC clinics recruited for the study. Individual participation in the study was voluntary and participants were informed that they could withdraw from the research at any point they wished to do so. All participants were provided with detailed written information about the study. This was supplemented by verbally explaining the aims of the research and giving participants opportunities to ask questions and seek clarifications on any areas of concern. They then made a choice whether to participate in the study or not. This was done through providing written informed consent, as well as consent to be audio-recorded. The research ensured confidentiality and anonymity of study participants by using unique study codes instead of participants' names and identifiers to indicate the type and level where participants were based. The two provinces selected for the study and their respective districts have been anonymised, with the thesis using pseudonyms. Information gathered from the study and quotes used is not directly attributed to any particular individual. Audio-files obtained during the study and transcripts are kept in the PI's password protected computer, and hardcopy material and questionnaires stored in a locked cupboard in her office. All data will be stored for a period of up to two years after completion of data analysis as per Wits University ethics regulations.

3.12 Role of the PhD candidate during the research process

My role as the PhD candidate and PI of the research involved actively participating is the various elements of the research process, listed below:

- *Research proposal*: Initially, I developed a concept note for this research, which I used to apply for admission at the Wits School of Public Health's interdisciplinary PhD programme. I refined the concept through consultations with supervisors and literature review. I presented the proposal among a group of peer PhD fellows and senior academics. I prepared the final PhD research proposal draft, which I submitted for review and defended at a meeting chaired by the Wits Faculty of Health Sciences research committee, who approved the protocol.
- *Data collection tools*: I developed the semi-structured interview guides, piloted them to some HP external stakeholders, and adjusted the tools. I reviewed the HP capacity assessment questionnaire used in Malawi, and adapted it for the South African context and each level of the health system.
- *Data collection*: I was responsible for the actual collection of data, conducted all the interviews, facilitated the workshops and was responsible for note-taking (national to facility level) during the data collection process.
- *Data analysis*: I conducted the initial data analysis of the PhD and for each of the three manuscripts included in this thesis. This included checking all the transcript files against their original recordings. Importing both the quantitative and qualitative data into their appropriate software and preparing them for analysis, as well as the thematic coding and analysis of the data.

- *Write-up of findings*: I was the first and lead author of all manuscripts included in the thesis performed the initial write-up of the manuscripts and the overall thesis and preparing presentations of the research for conferences, as well as incorporating supervisor comments and feedback to paper drafts and the overall thesis.
- *Dissemination of findings*: Furthermore, I was responsible for disseminating the findings of the PhD through an interim seminar, dissemination meetings with DoH and conference presentations.

RESULTS CHAPTERS

CHAPTER FOUR

This chapter was published by the *Health Promotion International Journal*, the reference of the article is:

Rwafa-Ponela, T., Christofides, N., Eyles, J., and Goudge, J. (2020) Health promotion capacity and institutional systems: An assessment of the South African Department of Health. *Health Promotion International.* https://doi.org/10.1093/heapro/daaa098

4. HEALTH PROMOTION CAPACITY AND INSTITUTIONAL SYSTEMS: AN ASSESSMENT OF THE SOUTH AFRICAN DEPARTMENT OF HEALTH

4.1 Abstract

Introduction: Health promotion (HP) capacity of staff and institutions is critical for health-promoting programmes to address social determinants of health and effectively contribute to disease prevention. HP capacity mapping initiatives are the first step to identify gaps to guide capacity strengthening and inform resource allocation. In low-and-middle-income countries, there is limited evidence on HP capacity. We assessed collective and institutional capacity to implement and support HP within the South African Department of Health (DoH)

Methods: A concurrent mixed methods study that drew on data collected using a participatory HP capacity assessment tool. We held five one-day workshops (one national, two provincial and two districts) with DoH staff (n=28). Participants completed self-assessments of collective capacity across three areas: technical, coordinating and systems capacity using a four-point Likert scale. HP capacity scores were analyzed and presented as means with standard deviations. Thematic analysis of verbatim transcripts of audio-recorded group discussions that provided rationale and evidence for scores were conducted using deductive and inductive codes.

Results: At all levels, groups revealed that capacity to develop long-term, sustainable HP interventions was limited. We found limited collaboration between national and provincial HP levels. There was limited monitoring of HP indicators in the health information system. Coordination of HP efforts across different sectors was largely absent. Lack of capacity in budgeting emerged as a major challenge, with few resources available to conduct HP activities at any level. Overall, the capacity mean score was 2.08/4.00 (SD=0.83).

Conclusion: There is need to overcome institutional barriers, and strengthen capacity for HP implementation and evaluation within the South African DoH.

Keywords: Health promotion capacity, organizational capacity assessment, health department, South Africa

4.2 Introduction

The Ottawa Charter indicates that one of the key health promotion (HP) pillars is reorienting health services from being curative-focused to emphasizing HP and disease prevention (World Health Organization, 1986). Effective health-promoting services contribute to addressing social and behavioural determinants which contribute to achieving population health goals (Ziglio et al., 2011), and reaching the 2030 sustainable development goals (SDGs) (World Health Organization, 2017a). Capacity of HP staff, as well as the institutions responsible for HP, is critical if potential is to be reached. The purpose of this paper is to assess collective and institutional capacity for HP to see its potential in contributing to sustainable development.

The Bangkok Charter for HP (2005) steered countries to build national capacity for HP (Catford, 2005). In the early 2000s, World Health Organization (WHO) introduced a global initiative to map country-level capacity for HP. The aim was to investigate what infrastructure exists in different countries to plan, implement, coordinate and evaluate HP efforts (World Health Organization, 2010). Capacity mapping assesses pre-existing capacities, how well they link together as a system (Aluttis et al., 2014, Battel-Kirk et al., 2009). They need to remain context and content specific, and be able to capture change of capacity building initiatives over-time (van Herwerden et al., 2018).

HP capacity can be defined as a system's collective ability to deliver and support HP programmes (Lin et al., 2009a). It includes knowledge, skills, commitment, structures, systems and leadership (Smith et al., 2006), which are affected by the availability of supportive environments, workforce, resources, and funds. Understanding where capacity

gaps and limitations exist could inform efforts to strengthen them (DeJoy and Wilson, 2003, Cosme Chavez et al., 2017).

Many countries globally have systematically mapped HP capacity (Ebbesen et al., 2004, Nam and Engelhardt, 2007, Mahmood, 2015, Lin and Fawkes, 2005, World Health Organization, 2010, Mittelmark et al., 2005). Yet, in African settings, there is much less evidence available on HP capacity, despite significant investment in strengthening HP capacity by donors, for example, the United States Agency for International Development (USAID) (Jana et al., 2018). Malawi's HP capacity assessment, an example of a donor-funded initiative, showed a relatively low capacity among district-level HP staff to plan, implement and evaluate HP interventions, and a fairly-strong institutional capacity to lead and co-ordinate HP activities at both national and local levels (Jana et al., 2018).

In South Africa, a middle-income country, the Department of Health (DoH) has a mandate to deliver HP. The national HP directorate offers technical support, while provincial and local (district) levels implement activities (Department of Health, 2014). Almost a decade ago, training workshops to enhance HP capacity targeted senior HP officials from Mpumalanga and Free State provinces and cadres of health promoters working at district level in Gauteng province (Van den Broucke et al., 2010, Wills and Rudolph, 2010). However, it is not clear whether these initiatives resulted in HP staff acquiring necessary skills (Jana et al., 2018), or whether staff who participated are still available in their positions. Furthermore, there is lack of data to show whether HP capacity strengthening was based on any systematic assessments prior to the training.

Recently, South Africa finalized its first national HP Policy and Strategy (2015-2019) based on a number of international and regional declarations on HP (Department of Health, 2014).

The policy states that successful implementation depends on a variety of components, including the establishment of HP norms and standards of operating procedure, adequate financing, and a clear plan to build HP practitioners' (HPPs) capacity (Department of Health, 2014). This paper addresses an important issue in the HP field: capacity mapping at government levels, which should guide planning, implementation and evaluation of HP programme activities. Therefore, the aim of this study was to assess collective and institutional systems capacity to prioritize, plan, deliver, monitor and evaluate HP within the DoH in South Africa.

4.2.1 Conceptual framework

We used an adapted HP capacity assessment framework, that contributed to the development of the data collection tool (Jana et al., 2018). The framework as shown on *Figure 11* assessed current collective capacity in three broad areas (*Table 11*): i) *HP Technical Capacity*: specific capacity linked to planning, designing, implementing, budgeting, monitoring and evaluating HP programmes; ii) *Coordinating Capacity:* capacity of the organization to coordinate and lead multi-sectoral collaboration; iii) *Systems Capacity*: capacity of the wider organization to support HP programmes such as communication mechanisms, policies, priority setting, and human resources. This domain also influences the others. The domains we assessed overlapped substantively with capacity mapping conducted elsewhere (World Health Organization, 2010, Barry et al., 2009).

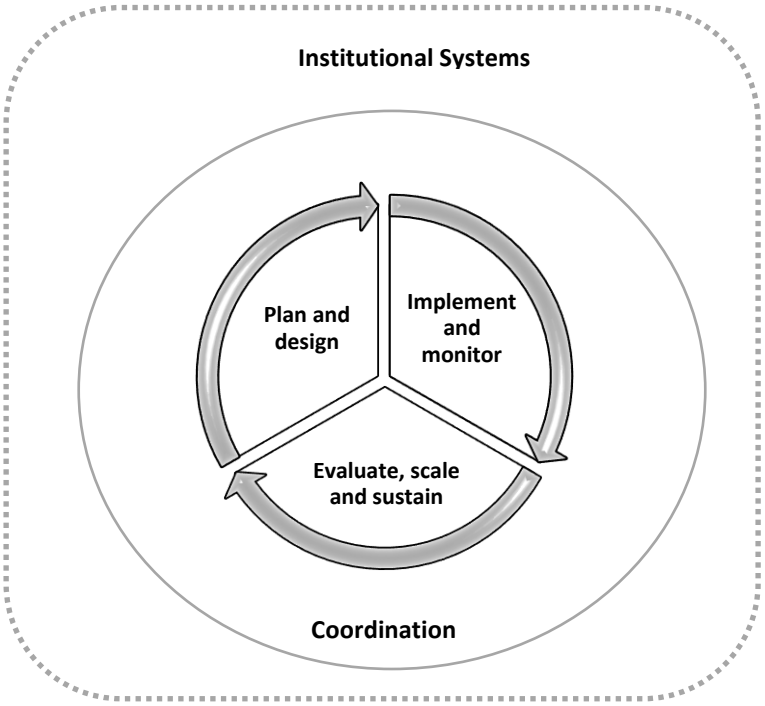


Figure 12: Health promotion capacity assessment framework, Adapted (Jana et al., 2018)

Table 11: Description of the three broad capacities, domains and their definitions

Capacities	Domains	Sub-domains	Definition
HP Technical Capacity	**1. Plan and design**	• Situational analysis • Using data and evidence in priority-setting • Budgeting for HP interventions/activities • Developing a HP communication strategy • Designing campaigns and material development	This domain covers the HP competencies needed to effectively plan and design HP programmes. This includes conducting a situation analysis to guide/build a HP programme around evidence; set priorities; designing an appropriate health promotion approach to address the identified health or other social barriers to change; etc.
	2. Implement and monitor	• Monitoring of implementation	This domain covers best practices for implementing and monitoring HP programmes. This includes developing and use of programme implementation and monitoring plans; supervision and mentoring; having HP staff development plans, etc.

	3. Evaluate, scale and sustain	• Conducting outcome evaluations • Re-planning based on data • Quality assurance	This domain covers the HP competencies needed to evaluate HP programmes and to scale and sustain HP programme progress. This includes evaluating programmes; documenting and disseminating results; adapting and adjusting programming based on data for sustainability to scale up, etc.
Coordinating Capacity	**4. Partnership building**	• Developing effective collaborative partnerships • Coordination of implementation • Commissioning evaluations	This domain covers identifying and building HP partnerships; coordinating HP implementation of inter-DoH HP efforts; collaboration with other stakeholders within and outside the health sector, and with other government and non-government institutions to enhance the success of HP efforts; engaging with external evaluators
Systems Capacity	**5. Institutional systems**	• Institutional priorities • Institutional mandate and operations • Staffing structure • Staffing retention and management • Resource allocation • HP coordination	This domain covers institutional systems within the DoH that are essential to lead, coordinate and harmonize HP programmes. Improved HP involves more than strengthening individual HP competencies. Institutions must be strong themselves to conduct HP programming. They must be able to lead and navigate complex and adaptive systems. In the Institutional Systems domain, we discuss systems that directly influence HP intervention planning: internal HP mechanisms; human resource systems (recruiting, supervising and supporting personnel and volunteers; management information and reporting systems, etc.)

Adapted (Jana et al., 2018)

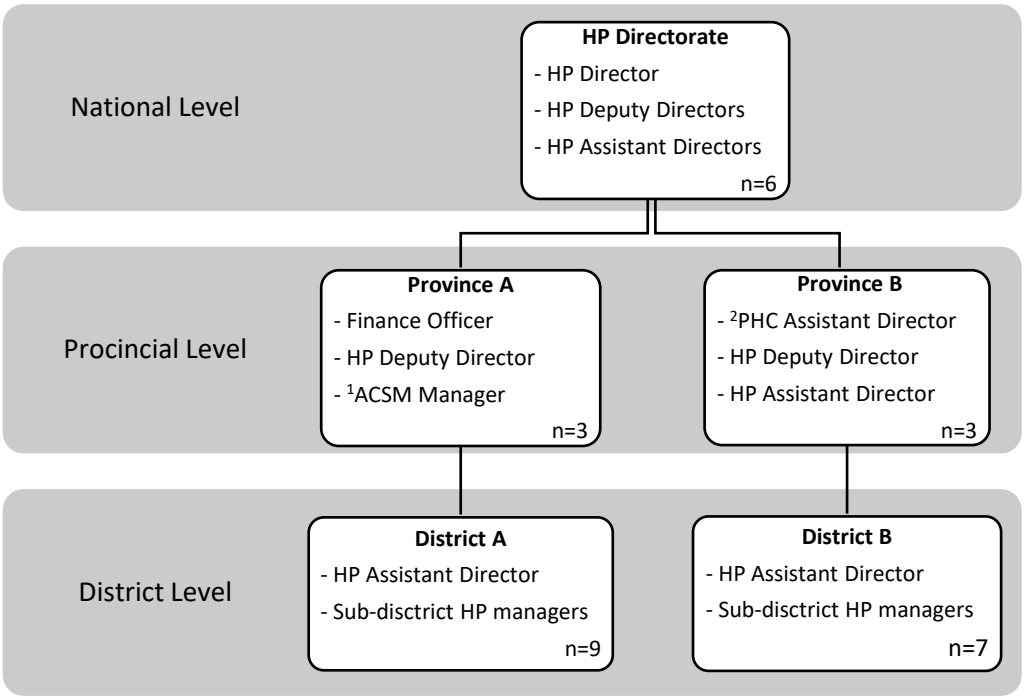
4.3 Methods

4.3.1 Study design

We used a concurrent mixed methods design to assess organizational HP capacity at three levels of the South African DoH (national, provincial and district). This approach allowed for both a self-assessment of collective and institutional capacity, in addition to in-depth exploration of reasons behind the scores. Data were collected at the same time to enhance interpretation of findings (Zhang and Creswell, 2013). The study was primarily qualitative in nature with quantitative self-assessment occurring during the same session as the discussions. Participants had to reach consensus on the capacity scores. The questionnaire, which was used for the quantitative self-assessment contained the open-ended non-directive questions that guided the group discussions.

4.3.2 Study sample

We collected data from five study sites: the national HP directorate, two provinces, and one district from each of the two selected provinces. Study sites were purposively selected based on the availability of stable HP structures within the province and district. We selected provinces based on: perceptions that they had 'stronger HP models', and higher numbers of designated HP staff. Districts were selected based on employing a greater number of HPPs. Twenty-eight DoH staff participated: six national, six provincial (3 HP managers and 3 non-HP managers) and sixteen district and sub-district HP coordinators. Names of provinces and districts have been anonymized (Province A and Province B, plus Districts A and B respectively).



[1]ACSM stands for Advocacy Communication and Social Mobilization
[2]PHC stands for Primary Health Care

Figure 13: Study sample for the HP capacity assessment workshops, *(n=28)*

4.3.3 Data collection

Data were collected through five one-day workshops (December 2017-February 2018). Adapted participatory HP capacity assessment tools (HP CATs) were used to collect both qualitative and quantitative data (Jana et al., 2018). The HP CAT was developed by USAID under the Health Communication for Life Project, as part of work to strengthen Malawi's social and behaviour change communication (SBCC) capacity among HP staff in 2016 (Jana et al., 2018). Three versions of the tool were adapted depending on the level it was administered (national, province or district). The same questions had to reflect HP activities appropriate for either strategic or coalface level of implementation. Changes made to the tool included use of terms like HP, DoH or HP directorate and sub-directorate versus SBCC, Ministry of Health or organization respectively. The tool was administered through

extended focus-group workshops with extensive discussions with teams of DoH staff. The purpose of the workshops was for DoH HP staff to self-assess their collective and institutional capacity in three main areas as outlined in *Table 11*. Ethical approval was obtained from the University of the Witwatersrand and the DoH. All participants provided informed consent.

Participants discussed each question posed by the researchers, and had to agree on a collective capacity score, using a four-point Likert scale (1-4). Scores between 1.00-1.49 were Stage 1, indicating capacity was not present; scores ≥1.50-2.49 were Stage 2, indicating present but no/poor application; scores ≥2.50-3.49 were Stage 3, indicating some application and adherence; and scores ≥3.50-4.00 were Stage 4, indicating complete application and adherence. Group discussions were audio-recorded with consent, allowing further rich qualitative data to be collected. Workshops lasted an average of eight hours, ranging from six to ten hours.

4.3.4 Data analysis

Capacity scores recorded on the HP CATs were entered onto an MS Excel spreadsheet. Then imported into STATA 13 software for analysis. Content analysis of the discussions was supported by MAXQDA 2018 software.

4.3.4.1 Quantitative data

The data were cleaned and checked for completeness and accuracy. We created composite scores for each sub-domain, by adding scores for each question. We used descriptive statistics, calculated and represented as mean scores with standard deviations (SDs) to

identify lower and higher capacity in each domain, and across the five study sites. A higher score indicated a higher self-assessed collective and institutional HP capacity.

4.3.4.2 Qualitative data

Transcribed data were checked against their original recording to ensure accuracy. Based on the standardized HP CAT questionnaire, deductive or topic codes were identified using the five domains of the tool: plan and design, implement and monitor; evaluate, scale and sustain; coordinate and institutional systems, while the sub-domains were used to develop the sub-codes (*Table 11*). These codes were supplemented with inductive codes that emerged during analysis of the workshop discussions. Trustworthiness of the data was assured through checking parts of coded transcripts by one of the co-authors and verification through the multiple methods that were used. Participants also provided some documents to verify their self-assessments.

4.4 Findings

The majority of study participants had been working for the DoH for over ten years (ranging between six months to 30 years). Participants were aged 35 years or older. Qualifications varied with the position of the participant. Most of the managers had a tertiary level qualification with a post-graduate degree; however, other staff had a high school certificate.

4.4.1 Capacity to effectively plan and design HP activities

4.4.1.1 Conducting situational analyses

The understanding of what constituted a situation analysis varied across the different levels of the health system. At national level, it was expected that the HP directorate would have the capacity to review and interpret national burden of disease and risk factors and to be

able to conduct desk reviews of motivational and other drivers underlying behaviours, environments and policies. At district level, there was an expectation of collective capacity to conduct community assessments. Groups at all levels revealed that capacity to conduct such situation analyses was very limited and in most cases were not done, *"It's prescribed what we need to focus on. So we do not have to conduct any assessments"* (District B). In very limited circumstances where elements of a situation analysis was done, it was conducted informally. Provincial and district participants commented that there were HP activities developed by the National programmes (e.g. non-communicable diseases), which sometimes contradicted with HP priorities at sub-district or facilities: *"HP activities should also be based on what is happening in the area"* (Province A). These discrepancies were commonly discussed during all workshops.

Needs assessments were sometimes conducted in form of *'community disease profiling',* which *"will influence what programmes you initiate"* (District B). However, few participants reported the collective capacity to interpret statistics about the prevalence of various diseases: *"Data literacy, we don't know it. Sometimes even during a review, they'll tell you about 50%, and we don't know what 50% is. It doesn't make sense until they can explain"* (District A). HP activities were also determined by firefighting disease outbreaks, requiring immediate attention, and there was a perception that there was no time to conduct a situation analysis during such instances. Emergencies may also be used, as an excuse not do situation analyses.

Capacity to use behaviour change theories was limited and they were not used for planning activities. Staff competencies in this area were identified as a major barrier, *"people are*

planning activities for HP without any HP degree or academic training and knowledge of actual behaviour change" (Province B). Some participants were critical of use of theory, stating that they were abstract and impractical: *"Theories work in an ideal situation. Unfortunately our situation is not ideal"* (District B).

4.4.1.2 Using data and evidence in priority-setting

Participants described how national programmes generally set priorities. As one of the district staff members stated: *"Somebody somewhere decides for us"* (District A). These priorities were thought to be influenced by politics, *"It depends on whether that disease is high on the political agenda, like HIV and TB"* (National HP). This top-down approach often was perceived to ignore local needs. An explanation for this was the absence of a formal system to collect HP indicators that could feed into decision-making, "*We don't have reporting structures, tools, and data collection instruments for information to move up all the levels"* (National HP). This may also be caused by decades of focus on implementation and little action on monitoring and evaluation. Top-down pressure was exacerbated at the district level by the needs of clinics or district. For example, if immunisation coverage from clinic statistics was low, then HP staff were expected to carry out activities like conducting mobilizations or awareness campaigns to increase coverage:

> *"Due to the pressures of what happens in facilities and sub-districts, health promoters end-up not having the opportunity to plan according to needs or to implement what they have planned"* (Province B).

In some places, clinic statistics provided an empirical basis to some targeted activities. This influenced whether health promoters chose to conduct a health or radio talk, *"statistics*

coming from the clinic are the ones that inform us there is something wrong, for example STIs. We then develop an action plan to address that" (Province A). Clinic statistics were found to be quite useful in highlighting community needs for HP activity planning at the district level, but were usually interpreted by others, e.g. facility managers.

4.4.1.3 Developing HP programmes

There was limited capacity to develop long-term, sustainable HP interventions at multiple levels. As a result, the approaches most commonly relied on interpersonal communication, often in the form of a health talk to patients waiting in clinic queues.

Since there was limited capacity in priority setting for HP and conducting needs assessments, a health calendar was often used to plan HP activities. Produced by the DoH, it highlights particular health issues on particular days of the year, in alignment with some of the world health days. For example, one day may focus on diabetes awareness while another on mental health, *"we plan our things according to the health calendar"* (District A). The health calendar results in short-term activities rather than sustained evidence-based programming. HP programming was restricted further by a limited or lack of a budget and the only available channels were free media, or patient education, *"it's expensive, we go with freebies"* (National HP).

The reasons that HP staff provided for weak collective capacity to develop systematic, evidence-based programmes was limited access to and control over resources. It was not possible to drive, coordinate and control HP within DoH, *"we piggy-back on other programmes…it's often that approaches are determined by the resources we have*" (National HP). This highlights a weakness in the system.

4.4.1.4 Designing HP campaigns and materials

Participants indicated that there was limited collective capacity to develop HP activities or materials. Provinces and districts received ready-made information, education and communication material from various programmes, *"we just get whatever comes. Last time it was Khomanani* [an HIV prevention programme]. *Now we are getting stuff from PHILA* [a national-based HP campaign addressing a range of health issues]" (District A). *"We don't have enough resources to produce our own and it won't be approved if we do it independently. The whole idea is for PHILA to do it"* (National HP). At the time of study, PHILA was responsible for a national HP campaign that included billboards and other material with key messages.

4.4.1.5 HP budget and resource allocation

Participants described limited capacity for HP-specific budgeting to support planning. Each year, HP was expected to submit costed plans, and a budget was rarely made available: *"We meet just for the sake of meeting and costing an operational* [plan]*…submit it, but we don't get the budget*" (Province B). When there was a budget, there were no systems to track or monitor them, "*Two-years ago, they said we overspent. How do we overspend when we don't have money?"* (Province B).

Some vertical programmes within DoH were better resourced for HP activities, and instead of working with existing HP staff and structures, created a parallel system, for example, the advocacy, communication and social mobilization (ACSM) staff funded through conditional grants in the HIV/AIDS and TB Cluster. The HP directorate seemed to have limited capacity

to take these responsibilities on, claim it for themselves and motivate for joint programming.

In summary, HP programme scored their collective planning and designing capacity as absent-to-limited (*Table 12*), with an overall mean sore of 1.85/4.00 (SD=0.34). Collective capacity to use data and evidence in priority setting for HP sub-domain had the highest overall mean score of 1.98/4.00 (SD=0.33) which was supported by the qualitative findings.

4.4.2 Capacity to implement, monitor and evaluate HP activities

4.4.2.1 Inadequate systematic monitoring of HP activities

We found limited organizational capacity to capture and submit HP monitoring information from provinces to the national HP directorate. Although some indicators in the HP strategic plan existed, there were no tools for data collection. There was consensus that there are no routinely collected HP indicators in the District Health Information System. This meant that the contribution of HP to any health outcomes could not be quantified: *"even when general indicators within the Department are being achieved, we cannot prove HP assisted with it"* (National HP). Some stated that they collected monitoring data using a non-HP specific template, *"The template we are using is for healthy lifestyles* [a major activity under HP]*. It does not have all the activities for HP"* (Province A). The piecemeal approach was attributed to inadequate structures and systems to collate HP information. Some lower level participants mistook routine report writing for monitoring and evaluation (M&E). The national-level staff described that there were bigger challenges with monitoring, as *"proxy indicators*" are used, such as "*reducing risk factors of non-communicable diseases"*.

Again, participants emphasized fragmentation of HP implementation within DoH where vertical programmes such as HIV/AIDS have their own HP structures, *"big programmes like HIV, TB and child health have their own HP-type of indicators, which we are not part of, as they have funding"* (National HP). If there were other HP-related programmes with measurable outcomes, the HP directorate did not have the capacity to adopt them. The spirit of 'no can't do' dominated.

4.4.2.2 Commissioning and conducting HP programme evaluation

There was consensus among all levels that there was no internal capacity within the DoH to conduct or commission evaluations, *"HP is not being evaluated. We implement only*" (District B). National HP staff members were concerned about the effect of programmes, *"We don't see the impact, because HP does not have direct results. For example, in creating awareness for antenatal care [ANC]. After mobilization as HP, many pregnant-mothers may present for early booking. You ask yourself did HP achieve this. It is not easy to say, if their intervention was helpful*" (National HP). Since HP programmes are not being evaluated, it would be possible for HP staff to link awareness activities to ANC visits. Yet, reaching targets on measured programmes is a form of evaluation but the contribution of HP to the targets was not possible to measure. The tendency not to take any credit even for reach could be explained by the low morale among HP staff.

4.4.2.3 Re-planning based on evaluation data and formative research

Views on capacity to re-plan based on data varied across levels. The kinds of data that informed HP interventions were on disease prevalence or service uptake (e.g. immunization coverage) rather than on the results of evaluations of HP programmes, which showed

whether there were desired changes in individuals or environments. District levels showed better capacity to use clinic data for planning activities like health talks or awareness campaigns as mentioned earlier.

4.4.2.4 Quality assurance and coordination of implementation

When asked about the capacity to carry out quality assurance checks to determine whether predefined standards were met, there was consensus that, *"there is no system to monitor quality of activities"* (Province B). Quality assurance was an area that participants had not thought about much prior to participation in the capacity assessment. It is an example of where the DoH could not only be assessing materials and activities within the DoH but also those developed by non-governmental organizations both for-profit and non-profit. A participant stated, *"We don't have quality assurance. We need a standard for our work we can go and check ourselves against whatever we are doing"* (District A). There was very limited institutional capacity to coordinate activities within the DoH, particularly for the national HP directorate and they had not considered that their role could extend beyond the DoH to other stakeholders.

In summary, all levels had limited capacity to monitor and evaluate HP activities and programmes, with a mean score of 2.19/4.00 (SD=0.71) (*Table 12*). Provinces and their districts had similar results for the implementation and monitoring domain. Capacity to evaluate, scale and sustain HP activities had the lowest score. All sites had mean scores ≤2.00/4.00 (range 1.22-2.00), indicating HP evaluation capacity was mostly perceived as absent.

4.4.3 The state of capacity in institutional systems to support HP work

4.4.3.1 Institutional HP mandate and operations

In order to understand institutional HP capacity, participants believed that it was important to understand the history of HP within the DoH. HP was introduced in the 1990s, when existing cadres of family planning advisors were incorporated into the programme by simply changing their job titles without any retraining or a guiding policy. The HP policy was first introduced in 2015 after being in draft for more than two-decades, indicating that institutional constraints affected HP work.

The official national HP policy guides programming across all levels of the DoH. Although HP staff were grateful for the HP policy document and strategic plan, they did not fully support the contents, stating, *"When you look at the policy, it is more theoretical than practical"* (Province B), implying the policy in perceived as not relevant to local needs. Some district participants were unaware of the HP policy, "*there are no policies… we are not given"* (District A). From an institutional capacity perspective, this shows that while guiding documents exist they have not been well communicated to all staff and are not perceived to be very practical.

4.4.3.2 Institutional constraints to HP capacity

Participants viewed that institutional systems constrained the implementation of HP activities. In terms of HP reporting, two lines of authority were in place. Frontline health promoters, based in clinics reported to both a facility manager and to a HP sub-district manager, some participants described: *"so there is always dual reporting except at district. It is very awkward, because there is no centre of power.*" (District B). This means HP

activities become disjointed due to local power dynamics, as the sub-district HP manager generally deferred to the facility manager.

4.4.3.3 Occupational classification

A structural barrier to institutional capacity was the lack of uniform job descriptions and the absence of an occupational category for HP within the DoH human resources system. The National-level participants stated, "*There is no standardization of ranks, structures, salary levels. We are looking at creating an occupational class for HP; and having them registered with a professional body"* (National HP). Only one province (Province A) had professional recognition of health promoters.

> *"The role and function of HPPs differs in terms of what they do. There is no uniformity throughout the country … their occupational classes vary from community liaison officers, communication officers, auxiliary service officers or assistants"* (National HP).

4.4.3.4 HP workforce, recruitment and retention

In general, retention of HP staff was very high. Many staff had been in their positions for many years. Various reasons were provided for this, *"there's no formal education to do HP. I cannot leave. I must stay here, because I don't have qualifications to apply for another* [job]*… those who have left for greener pastures, were qualified in other disciplines"* (District A).

However, where posts became vacant due to staff retiring they were not filled because posts were frozen. It should be noted that in one province all posts were frozen (this was

not specific to HP), a participant elaborated: *"if people are in a post they stay forever until they retire"* (Province B). The increase in the number of unfilled HP posts in Province A was verified with supporting documents from district reports.

Challenges that limited institutional capacity included budgetary constraints and a lack of clarity regarding minimum qualification levels, *"there is two parts, qualifications and filling posts because of money. Our problem is both"* (National HP). Most HPPs entered the field by chance. Some staff had a high school qualification while others had done in-service training or diplomas. Few staff had HP-specific qualifications.

Both provinces under study had developed a HP orientation manual to address the inadequate qualifications*, "we developed an orientation manual. We realizerealized our health promoters are appointed without any HP qualifications. Even the managers, most of them don't have any HP qualification"* (Province B). Tension exists between the need for qualified staff and expectations of graduates for higher positions. Some participants articulated, *"If we are talking about implementation, you want foot soldiers, like a mid-level worker. These HP graduates all want to be managers. …We are not saying we don't need graduates, we do; at the same time you can't just go into a job and be a manager"* (National HP).

4.4.3.5 Stakeholder Coordination

Capacity to engage with stakeholders was variable. Province B reported engaging a wide range of internal and external stakeholders on priority setting or planning. HP staff collaborated with other departments within the DoH and with community stakeholders. However, engagements with other stakeholders did not extend to coordinating activities as

mentioned earlier. This is problematic, as one of the main aspects of successful HP is multi-sectoral collaborations s to address determinants of health. National-level HP were least likely to report engaging with external stakeholders. This may be explained by the fact that provinces and districts are implementers, and national is meant to provide strategic direction and technical assistance to provinces. However, our findings suggest that national-level HP has a very limited role in guiding what happens in provinces. National participants articulated that another structural barrier was "*provincial autonomy"* described as provinces being able to run HP independently from the National HP structures. This resulted in limited collaboration between national and provincial HP levels within DoH.

In summary, capacity of institutional systems had the highest scores in the assessment (*Table 12*), with a mean score of 2.82/4.00 (SD=0.51). Institutional systems directly influenced planning: communication mechanisms, human resource systems, management, information and reporting systems.

Table 12: DoH HP capacity self-assessment scores

Domains and sub-domains	National level	Provincial Level		District level		Mean Score (SD)
	National	Province A	Province B	District A	District B	
Plan and design						
Situational Analysis	1.00	1.33	2.33	2.00	2.00	**1.83 (0.55)**
Using data and evidence in priority setting	2.40	2.00	2.10	1.40	2.00	**1.98 (0.33)**
Budgeting for HP activities	1.00	1.00	2.00	2.00	4.00	**1.83 (1.17)**
Developing a HP communication strategy	1.70	1.80	2.00	2.20	1.90	**1.95 (0.19)**
Designing campaigns and material development	1.67	1.00	2.25	1.67	1.67	**1.63 (0.40)**
Mean score (SD)	***1.55 (0.58)***	***1.43 (0.46)***	***2.14 (0.15)***	***1.85 (0.32)***	***2.31 (0.95)***	***1.85 (0.34)***
Implement and monitor						
Coordination of Implementation	1.90	1.40	3.20	1.40	3.60	**2.15 (1.00)**
Monitoring of implementation	1.43	2.43	3.00	1.57	2.57	**2.24 (0.61)**
Mean score (SD)	***1.67 (0.33)***	***1.91 (0.73)***	***3.10 (0.14)***	***1.49 (0.12)***	***3.09 (0.73)***	***2.19 (0.71)***
Evaluate, scale and sustain						
Commissioning and conducting outcome evaluations	1.00	1.00	1.33	1.00	1.37	**1.17 (0.28)**
Re-planning based on data	1.33	1.67	2.00	2.00	3.33	**2.00 (0.70)**
Quality assurance	1.50	1.00	1.00	1.00	1.00	**1.17 (0.26)**
Mean score (SD)	***1.28 (0.25)***	***1.22 (0.39)***	***1.44 (0.51)***	***1.33 (0.58)***	***2.00 (1.25)***	***1.44 (0.28)***
Institutional systems						
Institutional priorities	3.67	4.00	3.67	3.00	3.67	**3.50 (0.41)**
Institutional mandate and operations	2.75	3.75	3.00	3.25	2.75	**3.20 (0.46)**
Staffing structure	2.00	2.75	3.38	1.50	3.75	**2.65 (0.84)**
Staffing retention and management	3.00	3.67	2.33	1.00	3.00	**2.78 (1.00)**
Resource allocation	1.00	4.00	1.00	1.00	3.50	**2.42 (1.56)**
HP coordination	1.50	1.83	3.33	3.00	2.67	**2.41 (0.71)**
Mean score (SD)	***2.32 (1.00)***	***3.33 (0.83)***	***2.78 (0.99)***	***2.22 (1.07)***	***3.22 (0.48)***	***2.82 (0.51)***

****Key** for the presence or absence of function and or system: Stage 1 ≥1.00-1.49= absent/not present; Stage 2 ≥1.50-2.49= present, limited capacity; Stage 3 ≥2.50-3.49= present, regular capacity; Stage 4 ≥3.50-4.00=present, full capacity*

4.5 Discussion

HP capacity gaps existed across all three levels of the South African Department of Health. Capacity gaps occurred in all domains assessed and were compounded by serious structural divides between national and provincial HP levels. Lack of regular contact between national HP and the provincial-level directorates resulted in limited monitoring of activities and centralized strategic planning. This was further impeded by the lack of HP specific indicators being monitored and reported on the health information system, and failure to integrate and use what could be borrowed from other programmes. HP staff, particularly at the district level, were aware of some local health needs, based on clinic-facility performance and statistics. These sometimes contradicted with the national strategic plan. Lack of external and internal HP coordination among national HP staff was evident. The qualitative findings largely aligned well with the collective capacity scores in each domain. Institutional capacity was an exception where scores suggested greater capacity to support HP, but the qualitative data revealed substantive barriers. An example was the re-direction of the HP budget, which emerged as a major challenge to HP planning, with participants reporting few resources to conduct HP activities at any level. Such institutional constraints further reduced HP capacity within the Department of Health. The HP directorate and provinces engaged in the same practices that had been implemented for years without consideration for whether they were achieving results or whether there were gaps.

Scholars argue that there is limited infrastructure and capacity to support HP delivery in low-and-middle income countries (LMICs), because available resources are usually allocated to medical and preventive approaches (Mahmood, 2015). Results from our current South African study confirm this argument. High-income countries (HICs) seem to have better HP

capacity to achieve public health goals (Lin and Fawkes, 2005). This is because HP capacity development occurs as part of ongoing health system strengthening efforts (Mahmood, 2015). In addition, there are clear entry requirements for HP professionals in HICs, such as Australia, which specify qualifications and experience requirements and opportunities for Masters programmes and specialised in-service training are available and in some cases funded (Mahmood, 2015, Shilton et al., 2008). In South Africa, HP competencies have not yet been clearly defined. Attention is therefore needed on how to strengthen HP infrastructure, capacity and organizational performance in LMICs (Battel-Kirk et al., 2009).

Inadequate HP qualifications are a challenge within the DoH. Those appointed mostly have learned HP skills on the job and are limited in their capacity to conceptualize or plan programmes beyond what has been implemented for years. An example of this is the reliance on the health calendar to plan activities. Training inadequacies among DoH HP staff have been long-established (Onya, 2007, Wills and Rudolph, 2010). In-service training was provided in some instances; however, it mostly focused on health education. Some HP staff have individually enrolled in HP courses or programmes even at the post-graduate level but are often constrained in being able to implement new ways of doing things because of institutional barriers and a non-supportive environment, which limits HP practice. Our findings are similar to those from the Western Pacific, South Korea and parts of Peru, which found gaps in professional skills development for HP staff (Lin and Fawkes, 2005, Cosme Chavez et al., 2017, Nam and Engelhardt, 2007). This might be one of the reasons HP is attributed a low status. LMICs need to develop HP capacities and competencies to strengthen implementation among the HP workforce.

Self-limiting aspects were also found, such as siloed attitudes of front-line HP workers, lack of moral and feelings that 'a lot is impossible'. The reason for this could be rooted in the history of HP in South Africa and decades of limited institutional support for HP. A Canadian and Australian study revealed institutional constraints to be pertinent to moral distress among the HP workforce (Sunderland et al., 2010). In addition, at the national HP directorate there was a lack of capacity to lead multi-sectoral coordination as a central role. However, tobacco control work emerged as an exception, where the national HP directorate took ownership and provides leadership across sectors (Rwafa-Ponela et al., nd). These findings suggest a need to look at the whole system rather than focusing on particular levels in the health system or on particular capacities if we are to effectively close capacity gaps needed to promote health, and address determinants (Lin et al., 2009a, Mahmood, 2015). In addition, multi-sectoral collaboration is required to build Health in All Policies and create sustainable health-promoting systems (Agarwal et al., 2009, Mahmood, 2015).

Our study highlighted several institutional barriers to HP capacity within the South African DoH, including re-direction and/ non-existent HP budgets and lack of resources. These findings resonated globally (Cosme Chavez et al., 2017, World Health Organization, 2010, Lin and Fawkes, 2005). Limited financial resources persistently hinder HP strengthening efforts at any level and inhibits its ability to drive, coordinate and control HP within the DoH or outside government. Although systems capacity was rated higher than other domains in our assessment, institutional system constraints were evident. In particular, we noted a lack of HP-specific indicators, limited data use, and complex chains of command and responsibility. Our assessment tool may not have been sensitive for scores to reflect all the institutional barriers, as it focused more on the presence of structures rather than functionality.

Capacity-strengthening initiatives need to address health information systems, with indicators that are focused specifically on HP, as staff capacity alone is not sufficient to address shown gaps. HP implementation has to be sensitive to local needs, with the national-level providing vision and strategy and lower-streams paying attention to local specific contexts. Therefore, there is need to strengthen skills that target the different HP levels and not a 'one-size-fits-all'.

4.5.1 Study limitations

Results of this capacity assessment should be interpreted in light of some limitations. Social desirability bias may have occurred where participants may have overstated their HP capacity. Evidence was requested from participants to verify their self-assessment. Sometimes the evidence was not provided and it was not possible to determine whether the participants failed to follow through or did not have the evidence. In addition, reaching consensus for a particular score was not always easy and in a few instances, an average score was given as participants felt that consensus was not possible. Capacity domains sometimes overlapped, for example, monitoring was captured as a technical skill but also was a gap in the institutional system. Overall, participants commented that the workshop was the first opportunity to reflect systematically and collectively about their jobs and roles. Robust discussions occurred, allowing for the recognition of gaps and blind spots in HP implementation. Discussions were open despite the different ranks of participants present, in most cases senior staff allowed more junior staff to engage and respond before adding their thoughts. One exception was workshop in District B, which was dominated by the district HP manager who felt the need to speak on behalf of the group. The findings of the study are not generalizable to the country. However, we believe that the findings could be

considered transferable to other districts in the two selected provinces. Other provinces that have similar structures and cadres of HP staff with similar characteristics and experience may have similar levels of capacity.

4.6 Conclusion

This assessment adds to existing international efforts to map HP capacity. It provides evidence from an African middle-income country, which can be used to inform capacity-strengthening efforts. There is need to overcome institutional barriers, and strengthen HP capacity for HP implementation and evaluation within the South African DoH. Monitoring systems and assessment tools need to be developed and implemented.

CHAPTER FIVE

This chapter is currently under-review at *BMJ Open Journal*, for which the proposed title and authors of the article is:

Rwafa-Ponela, T., Goudge, J. and Christofides, N. Institutionalization of health promotion in the South African health system: A qualitative case study - *"The one who pays for you has no name for you"*. *Manuscript under-review at BMJ Open Journal.*

5. INSTITUTIONALIZATION OF HEALTH PROMOTION IN THE SOUTH AFRICAN HEALTH SYSTEM: A QUALITATIVE CASE STUDY- *"THE ONE WHO PAYS FOR YOU HAS NO NAME FOR YOU"*

5.1 Abstract

Introduction: Despite international recognition of health promotion (HP) as a cost-effective way to improve population health, it is not highly regarded nor is it sufficiently institutionalized in many health systems, particularly in low-and-middle-income countries. This diminishes its ability to deliver on public health promises. This paper considers the role of organizational structure and agency within the South African health system (drawing on Giddens's structuration theory) in determining the extent of, and barriers to, institutionalization of HP.

Methods: We conducted a qualitative study using a combination of in-depth interviews (37), key informant interviews (8) and one-day workshops (5) with Department of Health (DoH) staff (HP and non-HP personnel) from national, provincial, district levels as well as external HP stakeholders.

Findings: Within the curative-focused South African health system, there are dedicated HP staff, with no specified professional competencies or a coherent hierarchy of job titles. There was inadequate evidence on the impact of HP. As a result, allocated HP resources were frequently shifted to other programmes. While we found some examples of successful HP organization and implementation, such as tobacco control legislation, overall, HP staff had limited agency, were often unable to articulate the vision for HP Uncertainty about the

role of HP have led to powerlessness, and feelings of resentment have generated demotivation and moral distress.

Conclusion: Although a stable HP structure existed within DoH, in sum, HP suffers from an identity crisis. HP voices were seldom heard, and were repressed by dominant curative structures. If the leaders of HP continue to be embedded such an institution, there is little chance of moving forward. There is need to engage with policy-makers to integrate HP within the health system. Establishment of an external HP Foundation is necessary to drive the HP agenda, work multi-sectorally, and contribute to research, public policy and advocate for public health.

Keywords: Health promotion, structure and agency, institutionalization, health department, South Africa

5.2 Introduction

The emergence of health promotion (HP) and its subsequent development as a discipline gave rise to new perspectives and approaches in public health (Davies, 2013). The World Health Organization's 1989 Ottawa Charter provided a comprehensive framework and enabled global recognition of professional HP practice. However, despite international acknowledgement that HP is a cost-effective way to improve population health (Kumar and Preetha, 2012, Coe and de Beyer, 2014, Murray et al., 2013), it is characterized by insufficient investment, particularly in low-and-middle-income countries (LMICs) (Tangcharoensathien et al., 2008). This hinders HP's ability to address key social, behavioural and other determinants of health (Bayarsaikhan and Muiser, 2007, Melville et al., 2006b, Sanders et al., 2008). Given the international changing policy environment and efforts to strengthen health system performance, there is need for more empirical evidence in understanding how HP is organized and implemented.

Across most countries, health systems are almost universally curative-focused. This diminishes the ability of HP to deliver on public health promises, such as reducing burden of disease, health expenditure due to ill-health and or overall increase in population health gains (European Commission, 2019). While government is mainly responsible for public health in many countries, multi-sectoral collaboration between different government departments, and with actors outside government, are necessary to improve health (Nutbeam, 1998a). Although health systems cannot be entirely held accountable for the health status of the population they serve, they have to take the leading role (World Health Organization, 1986). In this context, HP capacity needs to be woven into the health system's fabric in order to facilitate collaboration at all levels, however designing and implementing 'Health in All Policies' is complex (Kumar and Preetha, 2012, World Health Organization, 2009b).

In South Africa, the mandate of the national HP directorate is to provide strategic vision, set goals and coordinate activities, while lower provincial levels are responsible for implementation, and civil society organizations are mandated to implement HP interventions and activities (Department of Health, 2014, Onya, 2007). Other scholars have cited that in many countries, HP is not sufficiently institutionalized or embedded, within the health system to achieve goals set out in national HP policies (Ziglio et al., 2011, Wise and Nutbeam, 2007). Only when HP is well institutionalized can efforts to strengthen functioning and collaboration occur, and implementation gaps be closed.

5.2.1 Theoretical framework

Giddens' structuration theory posits that both agency (ability to deploy power or perform actions), and structure (set of rules and resources organized as properties in a system) give rise to day-to-day practices (Giddens, 1984, Giddens, 1989). Structure and agency emerge from institutional knowledge that agents/actors generate from their experiences with resources and rules (formal and informal) and people's ability to perform actions. Agency and structure are interdependent, and the interaction between these two facets governs the permanence of structures and reproduction of social systems (*Figure 13*) (Giddens, 1989). In this paper, we use the structuration theory to explore how structure and agency facilitate or impede the institutionalization of HP within the South African health system.

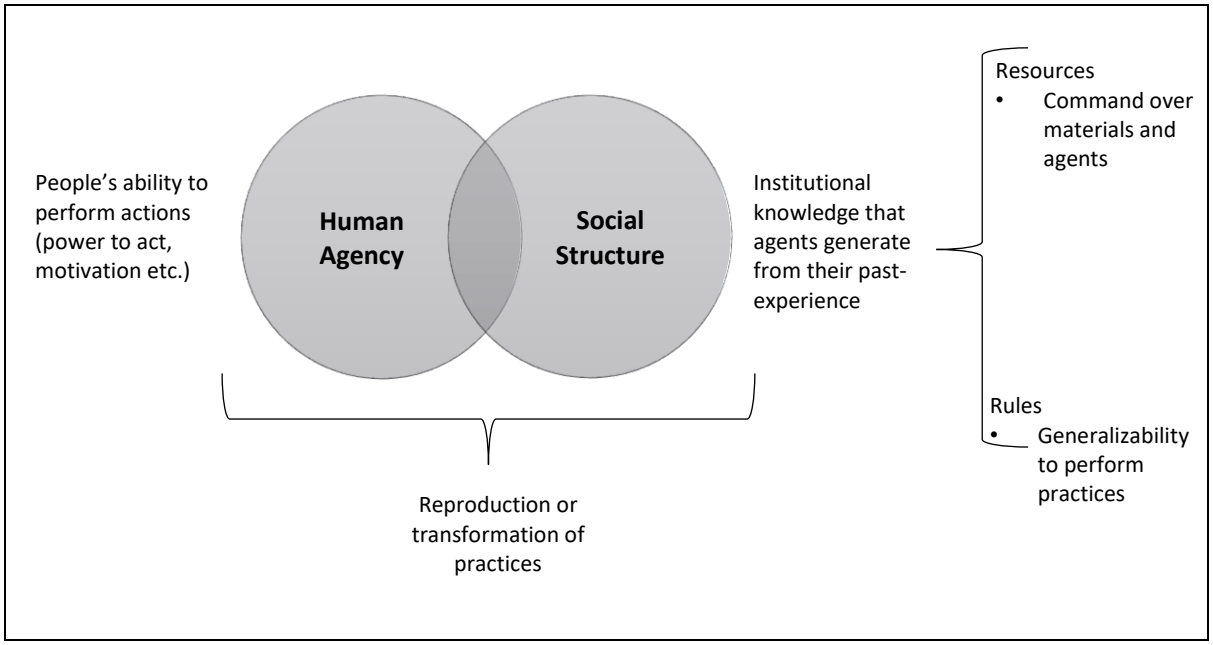


Figure 14: Structuration theory adapted from (Giddens, 1989)

5.3 Methods

We chose a qualitative case study approach, with South Africa as the case, to understand *what* is happening, *how* and *why* (Sosulski and Lawrence, 2008). Data analysis was done in two stages. Firstly, we used an interpretivist approach to inform our deductive analysis and understanding of the data (Vaismoradi et al., 2016). This was followed by a deliberate use of the domains of the sociological structuration theory to inductively categorize the data, so as to elucidate how structure and agency have impacted on the institutionalization of HP in the health system (Ghauri, 2004). Given this complex nature, an interpretive approach was selected as it enabled a higher level of theme abstraction across the three qualitative methods used (Dixon-Woods et al., 2005, Lopez and Willis, 2004). *Figure 10* depicts how the data collection methods were combined. We also provide two case narratives that emerged from the data to help strengthen the story line.

South Africa has a three-tiered health system with national, provincial and district levels (South Africa, 2009). Study sites were purposefully selected to represent all health system levels, as well as civil society, and ensuring maximum variation (*Figure 14*): national DoH (NDoH); provinces (*n=2*); districts (*n=2*); sub-districts (*n=4*); clinic-facilities (*n=12*), and; civil society organizations (*n=7*). Provinces were selected based on having stable HP structures at local levels (district to clinic-facilities). Civil society organizations were chosen from representatives of the South African HP and Development Foundation Network (HPDFNet). This is a group of volunteers and organisations that was formed in 2011 to advocate and lobby for a HP agenda in the country (Perez et al., 2013). Study sites are anonymized.

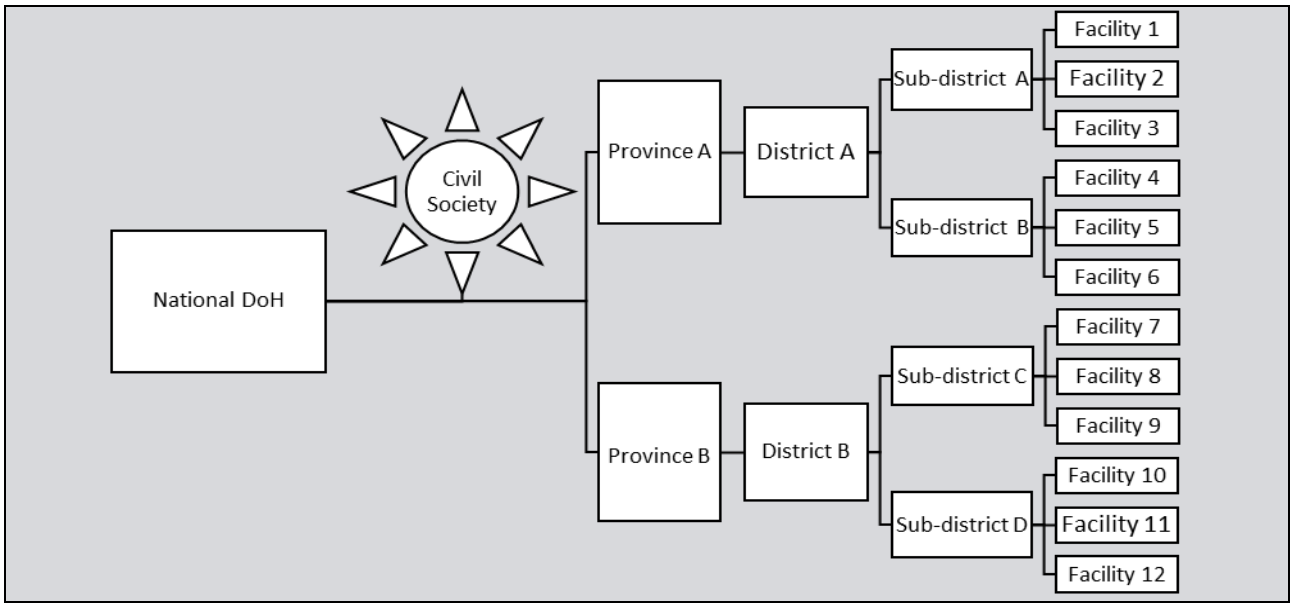


Figure 15: Sampling algorithm of study sites, *(n=27)*

5.3.1 Data collection

Data were collected as part of a larger mixed-methods research seeking to examine how HP was institutionalized within the South African health system (Rwafa-Ponela et al., 2020b). Purposive multistage sampling was used to recruit a sample of DoH staff across the different

health system levels. HP practitioners (HPPs) were involved in identifying which study setting to recruit, namely sub-districts and clinic-facilities (Rwafa-Ponela et al., 2020b). Snowball sampling was used to recruit key external HP participants. Information-rich HP experts (Patton, 1990), in turn recommended other HPDFNet members for selection into the study.We used emails, telephonic and face-to-face invitations to approach participants. No one refused to participate, however, one clinic-facility was substituted, as the health promoter, although willing to participate, was not feeling well.

Data were collected from November 2017-February 2018. We used qualitative methods including individual and group interviews (in-depth and key informant) and workshops allowing data triangulation (*Figure 3*). Group interviews came about because of the availability of more than one willing potential participant. We opted to conduct group-interviews than exclude anyone. While interviews were carried out at participants' workplaces, for example offices and clinics, workshops were conducted at centrally booked conference and meeting rooms. Only participants and researchers were present during data collection. The lead investigator (TR) conducted all interviews and used unique identifiers to anonymize the data. TR and NC facilitated the workshops. The research team had no prior relationship with DoH participants, except for one who had been a student at the researchers' institution, and knew some of the key informants. TR was a doctoral researcher; with training and experience in HP, and qualitative research. Authors JG, and NC were her academic supervisors with extensive experience and expertise in conducting qualitative research and data analysis.

5.3.1.1 Interviews

Thirty-seven in-depth interviews (IDIs) were conducted with 34 individuals plus 3 group-interviews (with 2-3 participants) among HP and non-HP DoH staff, while seven civil society members (three non-governmental and four academic institutions) were interviewed as key-informants (KIIs), and an eighth one was conducted with an NDoH non-HP senior manager. A semi-structured interview guide was developed, and adjusted accordingly for each health system level and participant type. The guide was piloted with a HP expert. This interview was retained and analyzed. Interviews gathered data on how participants viewed their role, the vision and strategy of HP within DoH, how HP is implemented within the health system, facilitators and barriers to HP practice, role of HP in primary healthcare (PHC) reforms, and perceptions about the future of HP in South Africa (Rwafa-Ponela et al., 2020b). Some HP managers participated in both workshops and IDIs. Interviews lasted for an average of 60 minutes (30-120 minutes) (Rwafa-Ponela et al., 2020b).

5.3.1.2 Workshops

We used the HP capacity assessment tool (HP CAT) developed by the United States Agency for International Development (Jana et al., 2018), to guide five one-day workshops among national, two provincial and two district levels selected into the study. These consisted of a minimum of three to nine, mostly were HPPs to maintain homogeneity of the group. Twenty-eight DoH staff participated in the workshops, using a focused group discussions (FGDs) format: 6 national, 6 provincial (3 HP managers and 3 non-HP managers) and 16 district and sub-district HP coordinators. Participants were asked to discuss their collective technical HP capacity, ability to effectively coordinate and implement HP activities and the state of institutional systems to support HP activities for each question posed (Rwafa-Ponela

et al., 2020a). This allowed rich and in-depth HP data to be collected. Workshops lasted for about 480 minutes (360-600 minutes) (Rwafa-Ponela et al., 2020a).

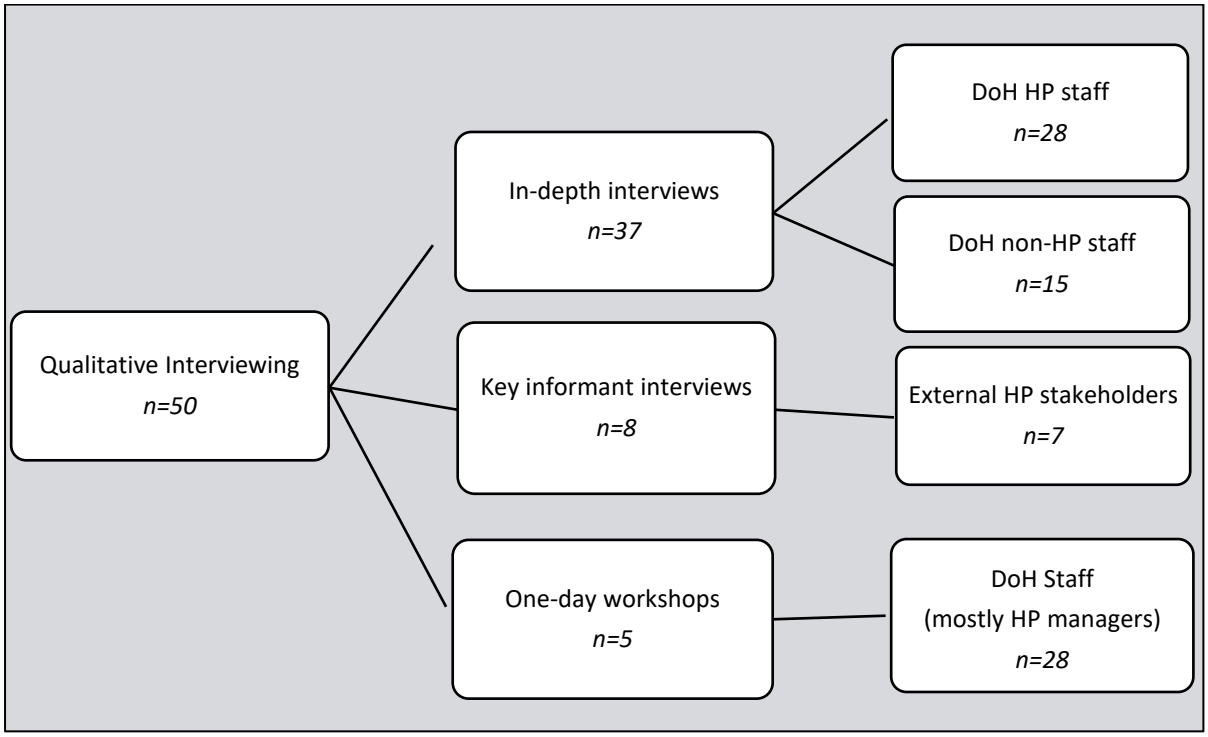


Figure 16: Mix of data collection methods and sampling

All interviews and workshops were audio-recorded, and field notes made during data collection. Data were collected until all sampled DoH sites (*n=21*) had been reached (Rwafa-Ponela et al., 2020b), and all five workshops had been conducted, including all questions on the HP CAT discussed. In terms of KIIs, data saturation was considered to be reached when new themes no longer emerged and data collection stopped after the eighth interview.

5.3.2 Analysis

Independent transcribers transcribed verbatim audio files from interviews and workshops. In an iterative process, we familiarized ourselves with the data by re-reading the transcripts several times. MAXQDA software (2018) was used to organize transcripts and supported

inductive (interpretive) and deductive (domains of the structuration theory) coding of text segments. Codes were organised under emerging themes, through a systematic process as follows: a) labelling of qualitative quotes, b) grouping quotes into first order sub-categories, and c) categorizing into sub-themes into second order themes (Vaismoradi et al., 2016). Once we had derived emerging themes, we chose the structuration theory as an appropriate framework with which to provide category names and interpret data. We then returned to the raw data to use the three domains of structuration theory to code re-occurring themes and other patterns in the data; sixteen first order sub-themes emerged. TR developed a codebook, which was verified by the two researchers involved in this study. She then performed initial data coding, which was reviewed by the two researchers who have extensive knowledge in qualitative research. Together, they held meetings to review and discuss the data for further classification and analysis, and any identified discrepancies were addressed at this level (Braithwaite et al., 2017). This was key in enhancing trustworthy and reliability of the data Triangulation across all data sources and methods enabled integration of findings.

5.4 Findings

5.4.1 Characteristics of study participants

DoH staff (28 HP and 15 non-HP staff) from national to facility level, and civil society representatives (n=7) participated in the study. *Table 13* shows participants' socio-demographic characteristics.

Table 13: Participant demographics and study identifiers

Data source	Study ID	Participants	Total (no.)	Sex	Race	Highest & lowest qualification
External	*EX*	Key HP stakeholders	7	3 male 4 female	5 White 1 Indian 1 Coloured	PhD Masters
National	*ND*	*Chief Director Cluster Manager	2	1 male 1 female	1 White 1 Black	Masters
		HP Directorate staff	5	All female	4 Black 1 Indian	Masters Bachelors
Provincial	*P*	Provincial HP Managers	3	All female	2 Black 1 White	Masters Diploma
District	*D*	District HP coordinators	2	1 male 1 female	All Black	Diploma
Sub-district	*SD*	Sub-district HP coordinators	5	3 male 2 female	All Black	Diploma Certificate
Facility	*FM*	Facility managers	13	2 male 11 female	All Black	Masters Diploma
	HPP	Health promoters	12	All female	All Black	Diploma Some secondary
Workshops (national-district)	*FGD*	HP managers DoH managers	28	10 male 18 female	1 Indian 27 Black	Masters Diploma

**Recruited as a senior DoH official key informant. Note: AP signifies a participant from Province A, and BP denotes a participant from Province B. The meaning of each participant identifier is provided under the study identifier column.*

5.4.2 Structure

5.4.2.1 Occupational class and organograms

While a HP workforce is present within DoH bureaucratic structures: "*The DPSA* [Department of Public Service and Administration] *does not have a category for HP"* (FGD-National HP).

> "*They are just being squeezed into vacant positions, and have a variety of names [e.g. community liaison officers, communication officers, auxiliary service officers or assistants]. The one that pays you has no name for you*" (IDI-ND003_HP Manager).

Where HP cadres exist, there is a lack uniformity across provincial organograms: "*There are disparities in terms of ranks…. Some* [provinces] *have HPPs at director level and others have HPPs at the highest level, for example, the DG* [director general]*"* (IDI-ND003_HP Manager). There are different roles, responsibilities, and salary levels for people deployed in the same HP posts. Some provinces do not have dedicated HP staff, *"They are dependent on community health workers* [CHWs] *for HP activities"* (FGD-Province B).

HP competencies have not yet been defined by NDoH, as a result "*in one province, health promoters are qualified, in another they're not"* (IDI-ND003_HP Manager). There is no formal guidance on how to recruit new HP staff. The national HP directorate are working on an accreditation system, "*we are looking at creating an occupational class for HP and having them registered with a professional body"* (FGD-National HP). An external stakeholder explained:

> *"Government needs to invest in the right people with the right skills to do HP; a whole structure is needed to implement HP"* (KII-Pilot001_Stakeholder).

A DoH official described different HP skills required at different system levels:

> *"At sub-district level we need people maybe with a diploma in HP. They should be working with CHWs whom they support and capacitate to do the actual work. But as you move up, at strategic level you need people with something different."* (IDI-ND001_National Manager).

This participant could not easily articulate what is actually needed at higher levels.

5.4.2.2 HP data and evidence

Although data on HP was collected, we found that it was insufficient: *"HP indicators are not included in the district health information system* [DHIS]" (FGD-National). This made it difficult to set priorities or measure progress. DoH operational plans did not include health outcomes associated with HP, *"staff are given targets like organizing campaigns"* (FGD-District B). A senior NDoH official explained the link between the lack of HP evidence on health outcomes and funding:

> *"Health promoters seem like a good idea, but much more research and evidence is needed in terms of their impact, then maybe I will invest a bit more in them"* (KII-ND007_National Manager).

5.4.2.3 HP budgets, resources and outsourcing of HP activities

Indeed, there were funds allocated to HP at the beginning of each financial year. However, these funds were frequently re-directed to other uses. Many HPPs expressed disappointment that the presence of the HP policy had not led to greater budget allocation: *"the policy is just for nothing. If you talk about a policy, there is meant to be a budget for its activities"* (IDI-AP009SD_HP Manager). As a result, the HP directorate was dependent on resources from specific disease programmes, and were often an afterthought:

> "*We come in at the tail-end. Staff in Child Health* [an example] *have power over their programme; we are just accessories when they want us in…. "* (FGD-National).

District level HP programmes were mainly dependent on external sponsors to support HP activities*, "we have gained a skill of looking for funding elsewhere"* (FGD-Province B).

Limited budget allocations were not the result of lack of funds within DoH. A large amount of funding was directed towards outsourced HP activities: *"we used to receive R16 million* [US$1 150 000] *as HP. They take all our money and give it to PHILA to do things we used to do"* (IDI-ND004ABC_HP Manager). The PHILA campaign (a national DoH HP programme addressing non-communicable diseases, HIV&AIDS and TB, violence, injuries & trauma, maternal & child health and women's health) is run by a private consulting company (Department of Health, 2016). A manager at NDoH explained:

> "*We do give money to groups like* [PHILA] *and others to do more complex HP… Changing behavior is difficult and it is expensive*" (KII-ND007_National Manager).

Despite an overwhelming discourse about lack of HP budgets, one district HP manager had successfully motivated to recruit new HPPs and purchase HP equipment (Case Narrative *1*).

5.4.2.3.1 Case Narrative 1: Agency of one district HP manager

A 45-year-old male HP manager explained: *"I came into HP by chance, as I couldn't pursue the studies that I wanted. For many years, I was a health promoter based at facility-level.* [Now] *I am a district manager responsible for the* [HP] *programme, including implementation, budgeting, and coordinating activities*".

When he took up his position, there was no clear budget for the HP programme: *"I started advocating and pushing, and the thinking is changing a bit"*. He had been able to procure equipment for HP, such as "*loud hailers, flipcharts and condom demonstration models. We are now in the process of getting sound systems"*.

Despite a freeze on hiring new staff, which prevented the recruitment of new HP staff for several years, the manager had appointed staff in his district, *"we recruited one community liaison officer last year. Somebody had left so we had to fill* [post]*"*. Two years ago, they had managed to hire

four HPPs, *"We were closing gaps…. We need to ensure that each facility has at least one health promoter".*

5.4.2.4 Vertical programmes and activities

At national level, well-resourced health programmes did not sufficiently engage with the HP directorate, but ran their own HP activities, *"The HIV&TB programme, for example, hire people to do HP for them*" (IDI-ND003_HP Manager). A senior NDoH manager explained: *"HIV for example has donor funds. They decide their own activities. It's not a way of saying we don't have trust in HP* [directorate]" (KII-ND007-National Manager). This respondent seemed aware of the sensitivity of the issue.

The siloed implementation of HP activities lead to confusion of the role of the HP directorate. An external stakeholder stated:

> *"Everybody* [within NDoH] *is fighting in their own little corner for their little understanding of the role of HP. Departments have different priorities*" (KII-EX001-Stakeholder).

Although at national level, staff felt excluded by other programmes with resources for HP, at lower-levels, HPPs were expected to cover all health issues. Instead of seeing this integration as a strength, some district HP managers saw this as a challenge: *"They see HP as cutting across. It means I have to carry the activities of all programmes like nutrition, mental health and HIV"* (IDI-BP015D_HP Manager), suggesting that such integration, and institutionalization, at lower levels, without sufficient resources, leaves staff feeling overwhelmed.

5.4.2.5 A curative focused health system

Many participants felt that curative healthcare was seen as a more important priority than HP, *"the mindset within the DoH is about cure. PHC has not been translated into proactive HP and preventive work"* (KII-EX004-Stakeholder). Another external stakeholder stated, "*They* [DoH] *think treatment demands more immediate attention"* (KII-EX005_Stakeholder). Thus, HP is pushed to the margins. A senior NDoH official argued,

> *"We* [DoH] *are not coping…. too many people are getting sick. That means long clinic queues and spending more money on medication"* (KII-ND007_National Manager).

As a result, *"healthcare workers remain focused on curative care and often don't put sufficient time into health education in their client engagement"* (KII-EX006_Stakeholder). Another external stakeholder explained: *"Governments think in five-year cycles. They don't see the benefit of investing millions today, to prevent diseases in twenty years' time" (*KII-EX005_Stakeholder). One HPP expressed a more cynical perspective:

> *"They* [DoH] *are supposed to pump money into HP for prevention purposes. They put it into clinical, because they want people to be sick. Then they can treat them, rather than preventing people from getting sick"* (IDI-ND004ABC_HP Manager).

5.4.3 Agency

5.4.3.1 HP strategic vision and leadership

Amid the presence of some strategy used to implement HP, for example the use of the "health calendar". This is not strategic nor is sustained for any length of time. We found a limited strategic vision for HP within the DoH. Decision-makers did not clearly outline the role of HP and its staff in contributing towards health.

> "*Nationally, the directorate pushes for awareness and campaigns. Even if you motivate for something else* [a non-health education activity]*, you have to give compelling reasons why would you want something different"* (IDI-BP015D_HP Manager).

The history of HP in South Africa may have contributed to shaping this mentality, *"HP started as health advisors focusing on reproductive health, promoting door-to-door family planning education for women"* (IDI-BP015D_HP Manager). Health education has remained the focus of HP:

> *"What is understood to be HP is an over simplistic idea of how people change their behaviour. It is an old idea of knowledge, attitudes, practices, which has long been shown not to work"* (KII-Pilot001_Stakeholder).

One senior NDoH official described her vision for HP:

> *"A health promoter should be doing bigger analyses in terms of what causes behaviour, asking what could be the best interventions, instead of seeing yourself as responsible for day-to-day health education. HP has not been positioned properly. We need to be assisted in positioning it, and making sure that it plays a strategic role in influencing behaviour change"* (IDI-ND001_National Manager).

While realizing there was need for more HP strategic roles, this participant, despite holding a leadership role, did not feel able to lead the way. An external stakeholder expressed frustration at the extent of organizational change required:

> *"How do you change the culture of primary healthcare to truly embrace the value of HP and reducing disease burden? Such that it really becomes a critical part of*

everybody's work. Not neglected, overridden by curative demands?" (KII-EX006_Stakeholder).

However, we found one example of a HP activity where the national HP directorate had shown strategic vision (Case Narrative 2).

5.4.3.2 Case Narrative 2: Leadership in Tobacco control legislation

The national HP directorate is responsible for tobacco control legislation. Some attributed this to the agency of one former health minister (Nkosazana Dlamini-Zuma) with the support of National Council Against Smoking…."*Under her they initiated tobacco legislation, which was really a positive HP move…"* (KII-EX001_Stakeholder).

The directorate is developing new legislation for electronic cigarettes: *"In the last 6 months, we have been gathering information on best practices* [internationally]*"* (FGD-National HP). These efforts included some evidence-based research, not observed in other HP programmes: "*We did an initial socio-economic impact assessment with UCT [University of Cape Town]. We will need to disseminate that to many civil society organizations and get it to parliament. This will include being part of an advocacy campaign, which would be based on evidence from international scenarios that have been used to mitigate tobacco industry arguments"* (FGD-National HP).

A national HP manager said *"the success of HP, it's only one, in tobacco*" (IDI-ND004ABC_HP Manager).

5.4.3.3 Collaboration and Coordination

Facility-based HPPs had collaborations with various stakeholders at community level. The NDoH placed insufficient effort in creating and sustaining partnerships:

"DoH hasn't engaged other necessary sectors to understand that they have a role in promoting health. DoH should be the facilitator, the advocator for a developmental

approach that intersects with other sectors. Instead, the DoH separates HP from issues of [social] *development..."* (KII-EX004_Stakeholder).

There was also limited coordination between national HP and provinces, with little dissemination of strategy, or upward flow of information. In previous years, planning meetings used to happen, but had since stopped, due to lack of funds. Provinces also reported irregularly:

"[Provinces] *report when they want. This quarter, five provinces will report; in the next, two will do so. You can't collate and analyze that."* (FGD-National HP).

Another participant explained that: *"provinces usually say that national is not supporting them….therefore they do not need to report"* (FGD-National HP). National has no way to hold provinces to account. The two levels of government are acting independently.

5.4.3.4 Ability to insist on HP role for lower cadres

Although the presence of HPPs at PHC level was viewed as important by facility managers. Health promoters reported that most nurses saw their role as patient entertainers: *"*[Nurses] *see HP as a programme to distract patients from complaining. If they find me seated, they will say: 'patients are bored, why don't you go and teach them'."* (IDI-BP011HPP_Health Promoter). Some health promoters were hindered from performing community-based activities: *"If health promoters do not push for the HP agenda, they are stuck with conducting health talks, as facility managers refuse to allow them to go outside the clinic"* (IDI-BP015D_HP Manager).

One facility manager admitted this was a problem: *"They play a part in HP, environmental health, prevention and all. Do we recognize them? We don't"* (IDI-BP003FM_Facility Manager). Requests to perform duties outside HPPs' job descriptions were reported as common: *"Health promoters complain that their managers ask them to make tea, help with clerical work or taking patient measurements"* (IDI-BP011HPP_Health Promoter). Being viewed as nursing assistants, *"the facility manager expects you, when there is a staff shortage, to pitch in. But, it is not our job… They don't know what we need to be doing"* (IDI-BP002HPP_Health Promoter).

5.4.3.5 Feelings of uncertainty and powerlessness

HPPs have operated in challenging circumstances over many years. Feelings of resentment and uncertainty about the role and current model of HP were common: *"it's a programme in my observation that has been taken for granted"* (IDI-BP004FM_Facility Manager), in part, because the effects of the HP programme were not apparent:

> *"HP would be better respected if it were visible. One should be able to demonstrate the results of what you have done. Then people will start looking at us* [HP] *seriously"* (IDI-ND001_National Manager).

A sense of powerlessness among some HPPs had led to moral distress: *"It seems that they* [clinical staff] *are the ones who are important. We are not as important as they are"* (IDI-AP016HPP_Health Promoter). Circumstances such as this resulted in tension between some HPPs and other health workers*, "when you speak out, some of them* [nurses] *will say: 'Who are you?' You are just a health promoter…"* (IDI-BP007HPP_Health Promoter). Feelings of being less important than other health cadres were common and led to demotivation.

While committed HP staff were present, one district manager expressed frustration at the lack of a career path, often reported by HPPs: *"Basically we're breeding a crop of people who don't see themselves anywhere"* (IDI-BP015D_HP Manager). Some HPPs from Province B described their fight for promotion:

> *"I've been doing HP at Level three since 2008. The lack of career progression demoralizes everyone. I would drag my feet and not do my best because I am not paid well. When you check other regions, they're in level five, six. We fought so they could take us to level five"* (IDI-BP002HPP_Health Promoter).

This is an example of collective power to act and change the status quo for HP. Although, some health workers, particularly nurses, were reported to make an issue of the increased salary for HPPs, who they view as not having *"formal qualifications".*

5.5 Discussion

We have described that a structure in place for the organization and implementation of HP within the Department of Health. However, HP practitioners have operated within challenging conditions form many years, evidenced by structural constraints of a curative-focused health system and a limited strategic vision for HP. Dedicated HPPs existed in South Africa. However, they lacked specified HP competencies or a coherent hierarchy of job titles within the DoH organogram. While resources needed to support the continued employment of HPPs were available, this was compounded by redirection of funds and parallel implementation of HP activities, by other well-resourced programmes, particularly at national level. Lack of evidence of what improves health outcomes and what does not in HP attempts due to inadequate indicators further weakened any case for investment (see

Domain 1, *Figure 16*). While we found some examples of successful HP organization and implementation, such as tobacco control legislation, overall HP staff have limited agency (Domain 2), and are often unable to articulate the vision for HP, ensure collaboration between the national HP directorate and provinces, or hold provinces to account. Some facility-based health promoters were unable to convince their clinical supervisors that their focus should be HP activities. Many HPPs blamed the national HP directorate for lack of leadership in the programme.

The structural constraints described in the study interact with low levels of agency, forming a vicious cycle that hampered the institutionalization of HP within the health system. The result is that HP within the DoH was predominately health education (Domain 3). The national DoH HP programme in South Africa lacked credibility. As a result, HP activities were outsourced from external consultants and funds redirected to curative care. This lead to HPPs at all levels feeling demotivated and powerless to be able to change existing structures. In sum, HP suffered from an identity crisis, as its potential contribution in the health system was undervalued. In the process of creating social systems some voices like HP voices are seldom heard, and are repressed by dominant curative structures (Frohlich and Potvin, 2010, Abel and Frohlich, 2012). Unless barriers to the institutionalization of HP in the South African health system are adequately addressed, efforts towards the implementation of the national HP policy are likely to fail.

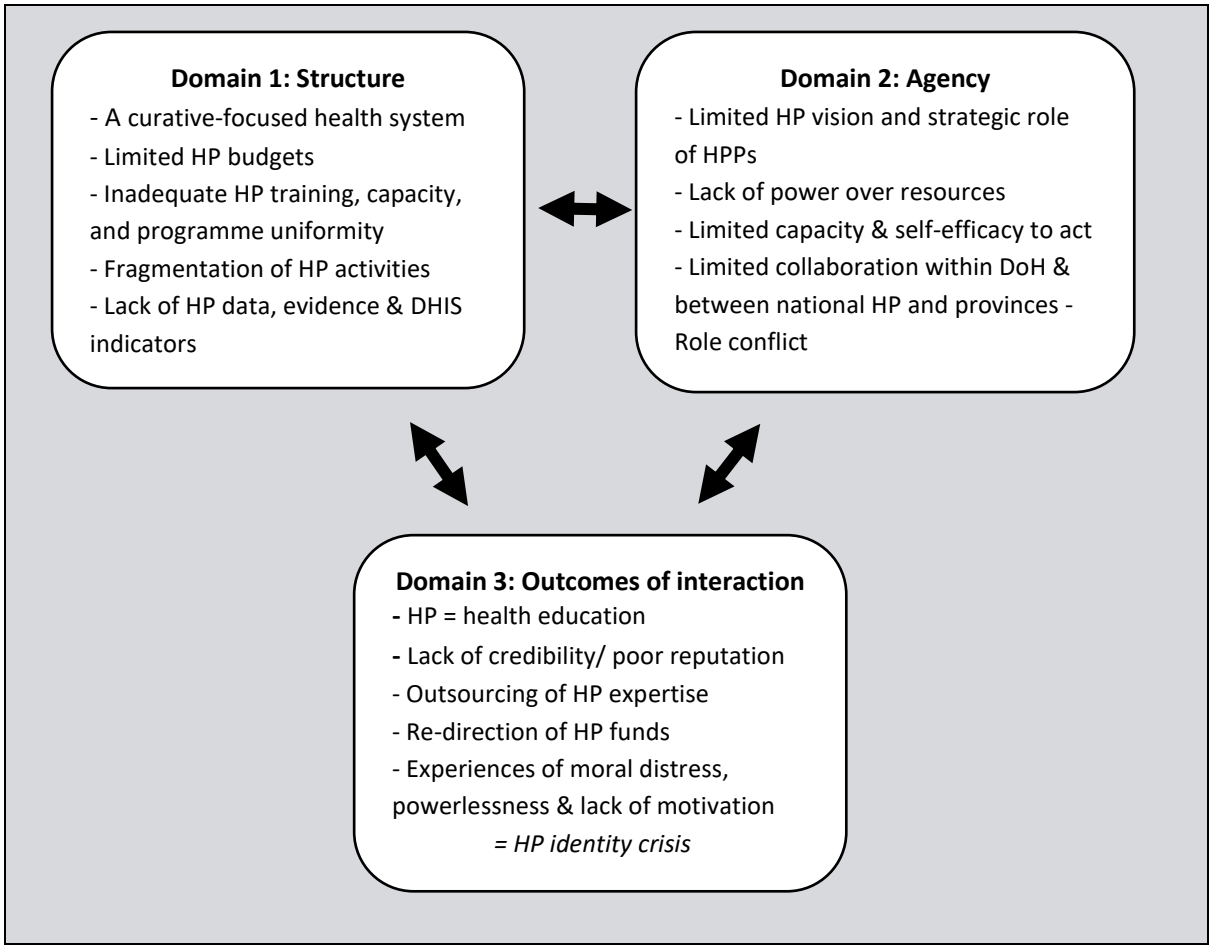


Figure 17: Structure-agency in the institutionalization of HP

In South Africa, historically there has been inadequate training of staff deployed into dedicated DoH HP posts (Onya, 2007, Coulson et al., 1998, Wills and Rudolph, 2010). The skills and educational qualifications of HPPs differed resulting in capacity gaps (Coulson, 2000). Nearly two decades ago, HP infrastructure was reported as weak (Onya, 2007). Our study confirmed that the presence of a HP policy and strategic plan (2015-2019) has not yet changed the structure and implementation of HP within DoH (Department of Health, 2014). In this context, the concept that every health worker has to do HP is compromised, where human resource shortages and long-clinic queues are evident, HP efforts tend to fall on the wayside (Alcalde-Rabanal et al., 2017). The existence of some commitment towards HP

within government structures provides a basis for future development of the profession, during health system strengthening efforts.

Given evolution of the HP field internationally, HP practice in South Africa has changed little, with health education remaining the focus since the programme's inception like many other countries (Alcalde-Rabanal et al., 2017). We found that there was a strategy towards the implementation of HP within DoH, for example in the use of the 'health calendar'. Yet, these efforts were not enough to spearhead HP efforts to required standards of enabling health, which is beyond awareness raising (World Health Organization, 1986). In addition, HP staff seemed to continue working in a non-supportive environment that neither built their capacity nor enabled them to work better. Knowledge and training, foundations of agency although necessary (Giddens, 1979), may not be sufficient to increase the agency among HPPs across DoH levels within a myriad of structural constraints. However, HP staff showed some commitment to the work that they do.

With no firm place within the organizational structure and lack of political will to see the fuller promise of HP in public health and well-being, HPPs and their leadership viewed the source of power to change the status of HP as being outside their immediate control. For HP to function effectively in the health system, it requires policy-makers, leaders and staff who display agency and innovation towards its organization and implementation (Choonara et al., 2017). Therefore, governance structures that support a better HP agenda are required in South Africa. Notably, the same agency among staff at the national HP directorate in the sphere of tobacco control legislation was not observed in other public health challenges

faced in the country, such as gender-based violence, alcohol, road accidents, or marketing of sugary beverages and food.

HP gaps and challenges reported in this study are not unique to South African context but have been reported in other countries in the world, including many high-income countries (Carter et al., 2012, Barry and Battel-Kirk, 2011). Although DoH in South Africa has established a system or structure on HP functions, there are challenges with the vision for HP and buy-in from those in positions of power. Thus, there is need to strengthen HP norms and practices in ways that would integrate HP into the fabric of the health system. World health Organization stated that achieving effective HP organization and identity delineation, required streamlined, well-structured, and better performing health-promoting health systems (World Health Organization, 2010). In order to do this, a recent European Union (2019) report called for; broader advocacy for HP at policy level as outlined by the 'Health in All Policies' approach (European Commission, 2019, World Health Organization, 2014b). Policy elites need to be meaningfully engaged. The successful integration of HP within the fabric of the health system requires establishment of strategic HP organizations that provide technical HP expertise, avenues for research and evidence of what works, multi-sectoral collaboration within and outside government and mechanisms for community participation, as well as infrastructure for HP capacity training (European Commission, 2019).

Scholars argue that structural factors such as global health financing discussions for universal health coverage (UHC) have been systematically omitted resources to strengthen HP organization and implementation (Munodawafa, 2011, Watabe et al., 2016). Ensuring sustainable HP financing within health system structures is an important task for countries

and this should be comprehensively integrated into national financing strategies towards achieving UHC and the 2030 social development goals to enable HP (Bayarsaikhan and Nakamura, 2015, Watabe et al., 2016, World Health Organization and UNICEF, 2018). In the South African context, despite the presence of a HP levy on sugary beverages (Stacey et al., 2019, South African Revenue Service, 2018), HP financing was omitted in the 2019 National Health Insurance Bill, which aims to achieve UHC (Department of Health, 2019, Freeman et al., 2020).

In order to bridge the gap of limited HP financing and other structural and agency factors that impede HP, some countries such as Australia, Switzerland, Hungary, Korea, Malaysia and Thailand established HP Foundations (HPFs) (Bayarsaikhan, 2008, Bayarsaikhan and Nakamura, 2015, Prakongsai et al., 2007, Tangcharoensathien et al., 2008, Schang et al., 2012). HPFs are usually autonomous statutory organizations, endowed with sufficient resources to work multi-sectorally with all government levels and across many disciplines, planning and supporting HP priorities through various activities such as HP research contribution, evidence based healthy public policy, and advocacy activities (Vathesatogkit et al., 2011). Our results suggest that if HP structures continue to be embedded in a curative-focused structure like the DoH, it will always lose the tussle for resources (because *"people are going to die if we don't provide treatment"*). In a context that limits the structure of HP organization and the agency of staff to implement activities, HP will always be a Cinderella service without an ostensible commitment. In order to gain agency, find its identity in the health system, and provide the required strategic oversight, HP needs to be independent of the curative services. Therefore, the establishment of an autonomous HP Foundation may be one of the solutions necessary to drive the HP agenda and spearhead multi-sectoral

collaboration in South Africa (United Nations, 2015, Perez et al., 2013, Mouy and Barr, 2006). We provide some further recommendations in Box 1.

Box 1: Recommendations from the study

- An independent HP Foundation needs to be established. A HP Foundation will help drive the HP agenda, both within DoH and outside. This entity would coordinate multi-sectoral collaboration for HP, and support research across various levels for the generation of locally based HP data and evidence.
- National Treasury needs to facilitate a sustainable HP financing mechanism. Funds for HP activities could come from the HP levy collected on sugar-sweetened beverages or excise tax on tobacco, alcohol and other harmful substances.
- The national HP directorate needs to finalize the human resources for HP system, as well as advocating for a curriculum for HP training, qualifications, and accreditation of current and future staff to be recruited.
- The national and provincial HP communication gaps could be bridged by holding of routine monthly virtual or remote meetings via online platforms, as opposed to face-to-face ones that require more expenditure of more finances to cater for staff travel, conference room booking, and/ or catering.
- Capacity strengthening of HPPs is required at all levels. Current HP staff require routine in-service training and capacity building workshops.
- Every health worker needs to implement HP activities with the support of dedicated HP cadres across each level of the health system.

5.5.1 Strengths and limitations of the study

HP capacity assessments have not been conducted in South Africa before; this is the first attempt to systematically conduct such an exercise. The one-day workshop format and the use of the capacity assessment tool allowed critical, collective reflection on the reasons for the weaknesses in HP. However, we might have missed some capacity that HP staff have during this assessment. In addition, one individual manager dominated one of the five one-day workshops in order to share narratives of success. The research was conducted across

multiple levels of the South African health system, including external experts, allowing data on differing viewpoints to be collected. Limitations to the research are that purposive selection of the provinces and districts might have led to the omission of alternative potential viewpoints that would have strengthen the results, such as those outside HP but within the DoH.

5.6 Conclusion

Although a stable HP structure and dedicated HPPs exist at the DoH, HP faces various structural constraints and limited agency among its practitioners. This impeded its organization and implementation within the South African health system. If the barriers that undermine the contribution of HP to public health are not adequately addressed, they will continue to negatively impact on its identity, implementation and integration within the health system. There is need to engage with political forces and advocate for the integration of HP within the health system fabric. In order to sufficiently institutionalize HP and achieve goals set in the HP policy a skilled cadre of HPPs who are adequately resourced to support other health workers and facilitate multi-sectoral collaboration is required at every health system level. While leaders of HP are embedded within a curative-focused institution, there is little chance of moving forward; as such, the establishment of a HPF is necessary.

CHAPTER SIX

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6. IMPLEMENTING WITHOUT GUIDELINES, LEARNING AT THE COALFACE: A CASE STUDY OF HEALTH PROMOTERS IN AN ERA OF COMMUNITY HEALTH WORKERS IN SOUTH AFRICA

6.1 Abstract

Background: Internationally, there has been renewed focus on PHC. PHC revitalisation is one of the mechanisms to emphasise health promotion and prevention. However, it is not always clear who should lead health promotion activities. In some countries, health promotion practitioners provide health promotion; in others, CHWs are responsible. South Africa, like other countries, has embarked on reforms to strengthen PHC, including a nationwide CHW programme – resulting in an unclear role for pre-existing health promoters. This paper examined the tension between these two cadres in two South African provinces in an era of primary health reform.

Methodology: We used a qualitative case study approach. Participants were recruited from the national, provincial, district and facility levels of the health system. Thirty-seven face-to-face in-depth interviews were conducted with 16 health promotion managers, 12 health promoters and 13 facility managers during a 3-month period (November 2017 to February 2018). Interviews were audio-recorded and transcribed verbatim. Both inductive and deductive thematic content analysis approaches were used, supported by MAXQDA software.

Results: Two South African policy documents, one on PHC reform and the other on health promotion, were introduced and implemented without clear guidelines on how health promoter job descriptions should be altered in the context of CHWs. The introduction of

CHWs triggered anxiety and uncertainty among some health promoters. However, despite considerable role overlap and the absence of formal re-orientation processes to realign their roles, some health promoters have carved out a role for themselves, supporting CHWs (for example, providing up-to-date health information, jointly discussing how to assist with health problems in the community, providing advice and household-visit support).

Conclusions: This paper adds to recent literature on the current wave of PHC reforms. It describes how health promoters are 'working it out' on the ground, when the policy or process do not provide adequate guidance or structure. Lessons learnt on how these two cadres could work together are important, especially given the shortage of human resources for health in low- and middle-income settings. This is a missed opportunity, researchers and policy-makers need to think more about how to feed experience/tacit knowledge up the system.

Keywords: Health promotion, health systems, policy implementation, PHC reform, South Africa

6.2 Background

6.2.1 Introduction

HP and disease prevention have significant roles to play in reducing burden of disease by addressing key social, behavioural and other determinants of health (Baum and Fisher, 2014). In 2016, the Ninth Global Conference on HP recognized promoting health as significant to achieving the 2030 sustainable development goals (World Health Organization, 2017b). Many have argued that, HP needs to be afforded visibility and status at the highest level of government and the health system evidenced by governance, allocation of resources, and effective policies and programmes (Smith et al., 2009, Coe and de Beyer, 2014, Kumar and Preetha, 2012).

Over the last decade, there has been internationally renewed PHC focus (World Health Organization, 2008). PHC revitalization is one of the mechanisms to emphasize preventive and promotive health in the public health agenda (Jha, 2013). The 2008 WHO report stated that health systems have better outcomes when built on PHC approaches that have HP as a core component (World Health Organization, 2008). The early Ottawa Charter on HP noted the need for organizational change initiatives to provide valuable opportunities to 'reorient health services' towards prevention and promotion (World Health Organization, 1986). In this regard, it is essential to ensure that within initiatives to reform PHC and efforts to strengthen health systems, that HP is not just subsumed into PHC, but also sufficiently acknowledged as part of the new PHC-focused reforms. Research has a potential role in influencing PHC reform policy formulation and implementation, through identifying possible factors for and against policy solutions such as these, that seek to strengthen the health system (Clancy et al., 2012, Gilson, 2012a).

Despite the emphasis on HP integration into PHC, it is not always clear who should be leading its activities. Ideally, every health worker should do HP. However, in many low-and middle-income countries there are shortages of nurses and doctors, especially in rural areas. If there is no specific cadre responsible for HP, it tends to get neglected (Alcalde-Rabanal et al., 2017). Global health sector reforms have led to a re-emphasis of CHWs. International literature has highlighted HP as one of the critical roles for CHWs (Kane et al., 2016, Seutloali et al., 2018, Ozano et al., 2018). CHWs are often the lowest level health workers, working primarily close to communities they serve (Kane et al., 2016). Different countries provide numerous examples for HP delivery, for example Canada, Australia and Guatemala, HPPs provide HP (Sunderland et al., 2015, Maupin, 2011), in others such as Lesotho and Cambodia, CHWs are responsible (Seutloali et al., 2018, Ozano et al., 2018).

6.2.1.1 South Africa

The outlining of HP in various policy and legislative frameworks evidences South Africa's commitment. The 1997 White Paper on Transformation of Health Services highlighted the role of HP and health education (Department of Health, 1997, Wills and Rudolph, 2010). Within the bureaucratic structures of the DoH, there is a HP directorate at national level; each of the nine provinces have HP coordinators; and some clinic-facilities have health promoters (Wills and Rudolph, 2010, Onya, 2007). At PHC level, the role of HPPs is to plan, implement and coordinate HP activities (Wills and Rudolph, 2010), such as health education, social mobilization and outbreak response. In 2014, the national DoH finalized its first HP policy, after being in draft for almost two-and-a-half decades, together with a Strategic Plan (2015-2019) (Department of Health, 2014). In addition, the White Paper on the upcoming National Health Insurance includes HP as one of its PHC service benefits, including

establishment of a multi-sectoral National Health Commission (Department of Health, 2017c).

6.2.1.1.1 PHC revitalization

South Africa, like many other countries has embraced the concept of PHC revitalization; recommended by WHO in 2008 (World Health Organization, 2008). A series of strategies to strengthen PHC have been initiated. In 2011, the DoH adopted a three-main streams approach to reform PHC, called rPHC comprised of district clinical specialist teams, and ward-based outreach teams (WBOTs) as well as the integrated school-health programme. The aim of rPHC is to shift PHC focus to a health promoting community-based model (Pillay and Barron, 2011, Barron et al., 2010). Deployment of community-based outreach teams is key in rPHC (Pillay and Barron, 2011, Barron et al., 2010, Subedar, 2012). It propelled the "formal" integration of CHWs into the district health system (Pillay and Barron, 2011). According to DoH policy documents, the team should ideally comprise of a professional nurse who is the team leader, six or more CHWs, an environmental practitioner, and a health promoter (Subedar, 2012). WBOTs are attached to a particular PHC clinic-facility. Each team provides community, household and individual based health services within its catchment area (Subedar, 2012, Barron et al., 2010). HP and disease prevention are part of the essential elements of CHW and WBOTs' home visits and other community-based activities, such as screening, medication delivery and referrals (Subedar, 2012). The role of CHWs within WBOTs is considered central to achieving better health outcomes at PHC levels (World Health Organization, 2007b).

Some areas in South Africa have health promoters and CHWs co-existing at the same clinic-facilities, both doing HP activities. A gap in literature exists on how HPPs are actively engaging with CHWs/WBOTs in practice, amid rPHC and the first HP policy documents. Therefore, in this paper we examine experiences of health promoters in the context of the introduction of CHWs and implementation of the rPHC WBOT strategy in two provinces in South Africa. Our focus was to understand how HPPs as front-line policy implementers are working with CHWs and WBOTs on the ground, in the absence of clear operational guidelines. We adopted Lewin's organizational change theory (Lewin, 1947, Lewin, 1961, Cummings et al., 2016) as a lens to examine the effect of the introduction of the CHW programme among HPPs and the extent to which the two cadres are working together. Kurt Lewin postulated that organizational change occurs in 'three steps' (Cummings et al., 2016): firstly, 'unfreezing' occurs, when existing structures are disrupted, preparing people for change; secondly, change occurs; and lastly, new norms and practices, and operating procedures are created (Lewin, 1961, Lewin, 1947). Although the three-step change theory has been criticized by other scholars for over-simplicity, it provides a useful framework to understand change in this study (Cummings et al., 2016, Schein, 1961).

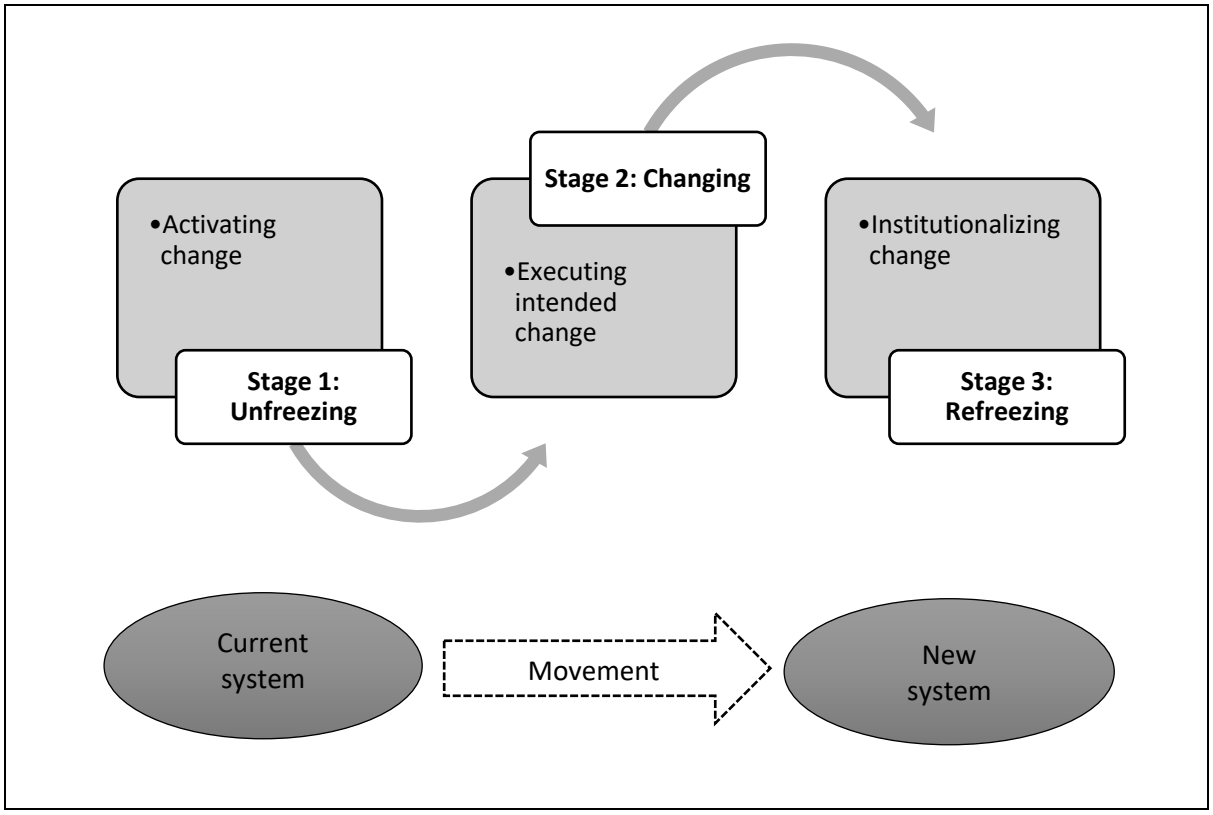


Figure 18: Lewin's three-step change model, Adapted (Cummings et al., 2016)

6.2.1.1.2 Introduction of policy initiatives towards PHC reform

The introduction of rPHC and the HP policy were an impetus for institutional change in HP, due to their unfreezing the status quo of HP practice. The HP Policy and Strategy (2015-2019), the first South African policy document to guide HP, was introduced at a time that the rPHC reform was being implemented. *Table 14* shows text extracts from the national rPHC implementation guidelines (Subedar, 2012) and the HP policy and strategic plan (Department of Health, 2014) describing the role of HPPs in the context of CHWs/WBOTs.

Table 14: Health promoters' roles and responsibilities in rPHC according to the two national documents of focus

Role of HPPs according to the rPHC implementation guidelines (2012) (Subedar, 2012)	Role of HPPs in rPHC according to the HP Policy and Strategy (2014) (Department of Health, 2014)
Acknowledges the role of HPPs at community level, and describes their role in PHC outreach teams, within the school health and in diseases outbreak teams	*"Support CHWs with HP interventions"*, and *"participate in school health teams" pg.25*
"Ideally a health promoter is to support each PHC outreach team" pg.17. This means all things being equal one HPP would support one WBOT; however, this is not possible, as *"the availability of suitably qualified (B Degree in HP) persons may vary across provinces, districts, sub-districts and communities" pg.17*. Where they do exist, it is usually one per health facility.	Promises to: *"support health workers within the PHC WBOT to plan and implement community and social mobilization efforts to meet the health needs of specific health systems and communities" pg.20*
Given lack of human resources for HP, where there is a HPP- *"a health promoter could support 2-3 PHC outreach teams linked to a PHC clinic" pg.17*	*"Support the PHC outreach teams" pg.25,* under its implementation plans at district and sub-district levels
The rPHC implementation guideline states that: *"the health promoter will provide overall support and technical assistance pertaining to HP to the PHC outreach teams"* and support to: *a. "Develop and disseminate HP messages* *b. Identify appropriate and relevant HP material for use and distribution, and* c. *Use a range of HP tools" pg.17*	*"HP should be aligned with the rPHC programme in order to enhance, compliment and strengthen HP in communities, schools and health facilities" pg.26*
"Assist and support CHWs by providing health information and updates on HP activities in accordance with the health calendar" pg.17	The HP Strategy (2015-2019) promises to: *"support PHC outreach teams to implement HP programmes" pg.30*

6.2.1.1.2.1 Policy Content

Both national documents suggest a shift in HPP roles towards rPHC (*Table 14*), but provide limited descriptions of how health promoters are meant to provide support to CHWs and WBOTs. The rPHC guidelines mentions HPPs supporting the WBOTs through developing and disseminating HP messages, and identifying appropriate materials and tools, however, the HP policy has even less detail.

6.2.1.1.2.2 Policy implementation

Even though national policy documents for rPHC and HP are in place, practices on the ground remain unclear. Despite the rPHC reform highlighting the need for HP and preventive services in South Africa (Subedar, 2012), there has been no formal processes undertaken to re-orient the role of HPPs, or re-aligning their job descriptions to include engagement in rPHC. The rPHC guidelines assume HPPs have higher levels of education than what currently exists for many. HPPs made no mention of developing and disseminating messages with or to the CHWs. Instead, they reported not having materials themselves, so would be unable to support WBOTs in this regard.

6.3 Methods

Content analysis approach was used to underpin the study. The study was conducted from a relativist perspective, using the social constructivism theory to understand a social reality. The paper presents findings of a qualitative study that examined the context of changing the approach to HP in PHC in South Africa, from the case study of the implementation of CHWs. Interpretivists believe that reality can only be understood through people's subjective lens and interpretation of lived experiences (Gilson, 2012a). We assumed that there are multiple perspectives of health promoters roles of at PHC level (Mack, 2010). Thus, we recruited participants using a whole system view (national to facility-level). The research feeds on health promoters and managers' (HP and facility) views and beliefs and how they provide meaning to HP and rPHC (Mack, 2010, Gilson, 2012a).

6.3.1 Study design

We used a qualitative case study research design in two provinces in South Africa. This design was selected because it enabled an in-depth understanding of the roles of health promoters at PHC level, particularly in the context of PHC revitalization. A case study approach allows for an empirical inquiry that investigates a contemporary phenomenon within its context, especially when the boundaries between phenomenon and context are not clearly evident (Yin, 1994). In this study the case of interest was the impact of the rPHC WBOT strategy implementation on health promoters; we describe their roles and activities (the "what") are and the "how" they are working with CHWs (Schneider and Nxumalo, 2017). The data were collected during a 3-month period (November 2017-February 2018). Forty-one participants were interviewed and two main national policy documents on rPHC and HP were reviewed. Data for this paper were collected as part of a mixed-methods research aimed at answering the research question 'how is HP institutionalized within the South African health system?' The research design of the larger project embedded quantitative data into a fundamentally qualitative approach [QUAL (quan)].

6.3.2 Researcher characteristics and reflexivity

At the time of the study, the first author (TR) and principal investigator (PI) was a doctoral research fellow. She conducted all the interviews and initial document reviews. Study participants did not know TR, prior to conducting this research. TR has a HP qualification and previous experience in HP. Although her professional training and experiences were mainly from another country, enabling her to assume the role of an outsider. Her education in HP made her more openly received, particularly by HPP participants. However, she found that some of the HP challenges highlighted by participants during the research resonated with

her own experiences. In this regard, she consciously found herself making efforts to assume her role as the researcher vs. being the practitioner and trying to keep an objective mind throughout the research process.

6.3.3 Study sites

The study took place in two districts of two selected provinces which offered different contexts, experiences, and views regarding HP and health promoters to ensure maximum variability on findings (Yin, 2014). Twenty-one study sites were purposefully selected to represent various levels of the health system: national (n=1), provinces (n=2), districts (n=2), sub-districts (n=4) and facilities (n=12). Names of provinces, districts, sub-districts and facilities have been anonymised. Selection of the two provinces was based on the availability of DoH health promoters practising at local PHC levels; not all provinces have designated HPPs at lower levels (district to clinics). Of the two provinces, Province A represented a mainly rural context, while Province B represented a largely urban setting. The two districts included, were selected based on having the highest number of HPPs, compared to other districts in each respective province. In the same regard, sub-districts and clinics were selected depending on the availability of a HPP during data collection.

6.3.4 Sample, sampling and sample size

6.3.4.1 Description of participants

A purposive sample of HP and facility managers and health promoters were recruited. Specific personnel were requested from each site for inclusion. Multi-stage purposive sampling was used to recruit the participants into the study. This was done to represent all levels of the health system for maximum variability. At each level, the HPP participant

identified would assist in identifying and recruiting other participants from the next level (district, sub-district and PHC clinics respectively). TR recruited the used direct face-to-face invitations to recruit participants. Thirty-seven interviews (34 individual and 3 groups) were conducted, with 41 interviewees. Three of the interviews were group-interviews conducted with 2-3 participants. Group interviews were conducted when more than one potential participant was present at a site and all willing to participate in the study. We could not exclude one over the other. The first author, made the decision to interview these participants in one interview. This enriched the interviews conducted. CHWs and WBOT leaders were excluded from this study. We felt that facility managers were able to provide a non-HP perspective to the study data. Facility managers directly supervise clinic-based health promoters, with the aid of HP coordinators at sub-district level. *Table 15* shows the participant recruitment procedure for the study, from national to local level.

Table 15: Category and number of participants in each province, *(n=41)*

Location /level of interviewees	**Number of interviewees**	
National level HP management	6 (with 1 group of 3 interviewees)	
	Province A	**Province B**
Provincial level HP management	2	1
District level HP management	1	1
Sub-district level HP management	3	2
PHC Clinics/Facility level		
Health Promoters	5	6 (with 1 group of 2 interviewees)
Facility Managers	6	7 (with 1 group of 2 interviewees)
Total interviews for each site	**17**	**18 (with 2 groups of 2s interviews)**

6.3.4.1.1 Units for document review

In addition, to the participants described earlier, two national policy documents were included in this study and specifically reviewed, namely the rPHC implementation guidelines (2012) (Subedar, 2012), and HP Policy and Strategy (2015-2019) (Department of Health, 2014).

The researchers used their knowledge of the availability of these national documents and guidelines. We regarded these two main policy documents as most relevant for this study, compared to any other and purposefully selected them for inclusion in the research. The two documents are publicly available. We retrieved copies of then online, through searching for their titles via the Google web search engine and downloaded them for analysis.

6.3.5 Data collection

6.3.5.1 Policy document review

National policy documents on rPHC and HP were reviewed to understand the role of HPPs in the context of CHWs and the primary health reform. The two main documents were selected based on their significance to HP practice and rPHC in South Africa. The first author read the full policy documents, and extracted content that spoke to the intent of policy direction of HP on rPHC or vice versa for inclusion in the study (Jolley et al., 2014). *Table 14* shows the policy extracts that were relevant for this paper). In addition, the HP and rPHC text segments from the HP policy and strategy documents were compared to rPHC implementation guidelines to seek for alignment and or identify any gaps. This process was done to have a baseline against which to assess the health promoters' practices in rPHC and HP.

6.3.5.2 Participant interviews

This paper draws on face-to-face in-depth interviews using a semi-structured interview guide (Baum et al., 2017). The purpose of the interviews was to inform the researchers how participants understood the role of HPPs, and the way in which these understandings shaped health promoter practice within the WBOTs strategy of rPHC (Baum et al., 2013). In-depth interviews were chosen as the main method to collect data for this study, as they allow collection of comprehensive and complex data about a participants' feelings, thoughts, perceptions and experiences (Goodman, 2001). During the study, most interviews were conducted from the participants' workplaces. The study participants themselves selected the space to be interviewed, which they considered private. We utilized DoH offices, for HP managers (apart from one that was done at the PI's office, as the participant had come for another meeting in the area), and clinics staff rooms and or consultation rooms for PHC facility-based staff (except for one which was conducted in the PI's car due to lack of space and privacy at the clinic). Interviews were audio-recorded using both a mobile device and a recorder. The PI took down field notes during the interviews in a notebook. Interviews lasted for an average of 1 hour, ranging from 30 minutes to 2 hours. Before an interview commenced, participants were provided with an information leaflet and were requested to complete consent and socio-demographic forms. We did not receive any refusals to participate. One clinic was excluded from the study, as the health promoter was not feeling well. Although, both the health promoter and the facility manager were willing to participate in the study. Another clinic facility had to be chosen instead. All interviews were audio-recorded and transcribed verbatim. Audio files were de-identified. Anonymity and confidentiality of the study participants was insured. Data collection ended when the targeted sampling frame and data saturation were reached. Data saturation was considered

as data collection stopping when we considered we had the answers we expected to answer research questions, coupled with no new data expected to emerge from further collection of data (Patton, 1990).

6.3.5.2.1 Interview guide

The first author developed the interview guide in English, under the supervision of the third author (NC). The research team used their personal experiences in qualitative research, knowledge of HP in the South African context, together with literature were used to guide development of the instrument. The interview guide was pre-testing to a single HP expert at the principal investigator's institution (this interview was retained and used in other parts of the broader research, not reported in this paper). No changes were made after the pre-test. However, the instrument was adjusted depending on participants' job location level and role. This resulted in six variations of the tool evolving for the study (national to facility). Topics covered by the instrument broadly included: (1) pre-questions, about the position of the participant's role; (2) introductory questions, about how HP is implemented within the DoH; (3) HP policy questions, about the vision and strategy of HP within the DoH; (4) questions about HP successes, challenges, facilitators and barriers to implementation; (5) rPHC questions, about the role of HP and health promoters in PHC revitalisation; and (6) closing questions, retrieving participant perceptions about the future of HP in South Africa.

6.3.6 Data processing and analysis

The authors conducted both inductive and deductive thematic content analysis, including descriptive statistics of participants' characteristics. An independent transcription company transcribed audio-files from the interviews verbatim. TR verified for consistency against

their original recording. A random sample of transcripts was shared with all research team members to familiarise themselves with the data. Codes developed, were discussed and revised by all the members of the research team (4) during consultative meetings, were necessary changes made. This was done to elicit similar meanings of codes among each research member. MS Word files of transcripts were imported into MAXQDA 2018 software, which supported coding together with their original audio-files for comparison. TR performed the primary data coding. NC was involved in the review of codes and sub-themes. During the inductive content analysis, each interview transcript was read and text segments were coded based on emerging themes. Codes were then categorised into broad themes (Hsieh and Shannon, 2005). In this paper, two major themes and their categories are described. Firstly, we presented the general role and purpose of HP at PHC level. Under this theme, four main categories emerged: (1) purpose of HP practice; (2) settings for HP; (3) HP roles, and (4) types of information used to prioritization HP activities. Of these, sixteen codes emerged. It is important to note that, some participant phases' cut across a number of codes and sub-themes. Secondly, we described HP and CHWs in the context of rPHC and the WBOT strategy.

Throughout the data collection phase, we had explicitly asked participants to discuss the role of HPPs in rPHC. Therefore, in the deductive process, we specifically coded transcript text segments (Polit and Beck, 2004) which spoke or referred to the second key theme: CHWs, WBOTs or rPHC. This particular theme was also used to extract text segments during the document analysis. Six key categories emerged under this theme: (1) role overlap; (2) CHW programme; (3) anxiety among HPPs; (4) working parallel; (5) training of CHWs by HPPs; and (6) working together. However, other sub-categories such as the school-health

programme and district clinical specialist teams' strategy, which spoke to rPHC, were not included for analysis in this paper. We had an iterative process of going back to data to confirm emerging themes for both the inductive and deductive approaches. Lewin's theory was identified once the categories started to emerge from the data. We then returned to the data to confirm usefulness of the framework in explaining the data. Therefore, the three-step change domains were used to deductively analyze, and present our findings, particularly under the second key theme of rPHC to unpack the 'what' and 'how' of HP and CHWs at coalface. However, in-between the two key an intersecting category emerged - introduction of policy. Thus, 23 sub-themes emerged in this paper. Quoted text in the paper were selected on the basis that it either exemplified a common viewpoint among participants or provided unique information (Baum et al., 2013). *Table 16* shows an example of the audit trail for data coding.

Table 16: Examples of an audit trail used to move from participant phases to themes

PARTICIPANT PHASES	CATEGORIZATION		
	CODES	CATEGORIES	THEMES
2. My role is to assist the community in preventing diseases … (BP011HPP)	Disease prevention	Role of HP	Health promoters at PHC level
3. We network with other institutions, NGO's and stakeholders … (BP001SD)	Stakeholder engagement	Purpose of HP practice	
4. Health promotion goes around in schools and crèches … (AP015FM)	Schools	Settings for HP	
5. If there is a malaria outbreak, clinic stats show us that and we intervene…. (AP006SD)	Clinic stats	Prioritization of HP activities	
6. Aspects of what CHWs do is HP, they give health education …. (ND002)	CHWs vs. HPPs	Working as part of one team	CHWs and the WBOT rPHC strategy
7. If there is something new we've learnt, my job is to train them [CHWs} (AP014HPP)	Train or capacitate		
8. When they [WBOTs] encounter some challenges…we go and see what the problem is…(BP007HPP)	Collaboration		

6.4 Results

In our findings, we first describe our study participants and then follow Lewin's three stages of change model to unpack the organizational change process that occurred after the introduction of the new policy initiatives.

6.4.1 Study participants

Participants were HP managers operating at different levels in the health system (39.0%, n=16), health promoters (29.3%, n=12) and facility managers (31.7%, n=13). Socio-demographic characteristics of participants are displayed on *Table 17*. About half of the participants were from the PHC level (61%, n=25/41).

Table 17: Socio-demographic characteristics of participants, *(n=41)*

VARIABLE	CLASSIFICATION	FREQUENCY (N)	PROPORTION (%)
Sex	Female	32	78.1
	Male	9	22.0
Age in years	<25	1	2.4
	25-34	2	4.9
	35-44	11	26.8
	45-54	17	41.5
	55+	10	24.4
Race	Black	39	95.1
	White	1	2.4
	Indian	1	2.4
Highest level of education	Some secondary	1	2.4
	High school)	4	9.8
	Certificate	4	9.8
	Diploma	15	36.6
	Bachelor degree	9	22.0
	Post graduate	8	19.5
Job title	Health promoter	5	12.2
	HP practitioner	10	24.4
	HP coordinator	4	9.8
	HP liaison officer	2	4.9
	Facility manager	13	31.7
	Other	7	17.1
	National	6	14.7

Job location	Province	2	4.9
	District	3	7.3
	Sub-district	9	22.0
	PHC/facility	20	48.8
	Other	1	2.9
Years worked at current job location	≤4	4	7.8
	5-6	3	7.3
	6+	34	82.9
Years worked as current job title	≤4	5	12.2
	5-6	4	9.8
	6+	32	78.1
Previous job title	None	5	12.2
	CHW/Care giver	2	4.9
	HIV counsellor	1	2.4
	HP manager	6	14.6
	Others	27	65.9

6.4.2 Stage 1: Unfreezing the status quo

6.4.2.1 HP practice and general roles and responsibilities of health promoters at PHC

Most participants identified health education as a core function of health promoters, using words like health talks, giving information, teaching, and/ or awareness giving to describe it. Health promoters play an important role in the community (where they are expected to spend up-to 80 percentage of their time) conducting door-to-door and school visits. HPPs have a role in disease prevention; statements such as *prevention is better than cure* were often used, mainly focusing on the healthy lifestyle programme. Health promoters also formulate support groups, and coordinate and facilitate health awareness events. Participants often referred to conducting community outreach as *social mobilization*. All HPPs expressed the need to establish relationships with stakeholders in one's catchment area, including participating in clinic committees. During this phase, we witness the introduction of the policy initiatives. Box 2 summarizers the general roles and responsibilities of health promoters at PHC level.

Box 2: Summary of HP practice and general roles and responsibilities of health promoters at PHC level as reported by study participants

Settings for health promotion:

- Working in communities, health promoters are not clinic/facility bound
  - visit households
    - trace defaulters
    - follow-up visits
  - schools, early development centres (ECD)/ crèches
  - churches
  - workplaces
  - public spaces e.g. bus ranks, beer halls, market places

Purpose of health promotion practice:

- Disease prevention, they work with "preventive measures" compared to curative
- Promote healthy behaviours through the healthy lifestyles programme
  - nutrition
  - physical activity
  - substance abuse e.g. alcohol and tobacco
  - salt reduction
  - safe sex (for example, condom demonstrations)
- Other programmes/topics covered include:
  - HIV/AIDS adherence to medication
  - TB (early diagnosis and adherence to medication)
  - Prevention of mother to child transmission (PMTCT)
  - Early antenatal care (ANC) booking
  - Hand washing
  - Malaria prevention
  - Promoting screening for non-communicable diseases (NCDs) i.e. diabetes and high blood pressure
  - Listeriosis *(was most recent topic during time of study)*

Health promotion roles:

- Provide health education on health topics, such early pregnancy booking, HIV, TB, prevention of mother to child transmission, nutrition, hygiene, substance abuse etc. (a core function)
  - giving information, teaching, preaching and or health awareness
- Community outreach often labeled as "social mobilization"
  - door-to-door campaigns
  - community–wide campaigns
- Campaigns/events planning
- Stakeholder engagement
  - buy-in
  - mobilize resources
  - refer patients/clients for non-health services
- Formulating and facilitating support groups
  - age- group specific,
  - gender-specific or
  - disease-specific groups
- Being part of clinic committees
- Other roles and responsibilities include:
  - behaviour change
  - outbreak response

○ clinic-community relationship building ○ understand community health needs ○ patient/client advocacy ○ strengthen community participation and community empowerment ○ distribute condoms and information, education and communication (IEC) material if available ○ manage clinic help-desk ○ participating in community meetings • Working in communities, health promoters are not clinic/facility bound ○ visit households ▪ trace defaulters ▪ follow-up visits ○ schools, early development centres (ECD)/ crèches ○ churches ○ workplaces ○ public spaces e.g. bus ranks, beer halls, market places
Sources of information for prioritizing health promotion activities:
• Community profiling • Clinic/health facility statistics • Health calendar days • Outbreaks

6.4.3 Stage 2: Change

6.4.3.1 Extent of role overlap between health promoters and CHWs

Despite HP being commonly recognised as a pillar of PHC by participants, none readily offered information about HPP role in WBOTs. Only after being specifically prompted was such information provided.

Some HPPs described how they do similar roles:

> *"….we do similar things with WBOTs. They visit households. When they visit a house, they ask if anyone has been coughing for more than two weeks. As a health promoter, you must do that.* (AP007HPP_health-promoter)

Door-to-door visits were the most common denominator between CHWs and health promoters. A provincial HP manager affirmed this view by stating:

"….a health promoter is on the ground; one of their strategies for health awareness is door-to-door? So now, HP and CHWs are both doing door-to-door." (AP016P_HP-manager)

"….when you look at the CHW programme what would you call it? It's also HP. So now, we've got duplicated HP activities within the country." (AP016P_HP-manager)

Another HP manager emphasized the importance of HP at PHC level, and expressed that, part of what CHWs do is HP:

"HP is a foundation. You can't have PHC without HP. Although we may not be formally recognized as such. But, I mean if you look at the entire CHW programme, it's the basis of PHC. Aspects of CHWs' work is HP: they are doing health education, working in communities, providing support, being mediums in which messages are disseminated. That to me is a pure form of HP, at that level and PHC can't function without that." (ND004ABC_HP-manager)

One of the district HP managers regarded the rPHC concept as not new because HP was already doing some of its aspects:

"….*re-engineering for me, it's not a new concept, except the definition of the Minister."* (BP015D_HP-manager)

Referring to how HP has always concentrated on working in communities and identifying clients in need. Therefore, change led to some role duplication.

Some participants identified the differences between the two cadres. Conversely, the change may have led to different work emphases. HPPs were reported to visit schools and

other community settings, whereas the CHWs are limited to working within households, except during community campaigns. One HP manager explained:

> *"Health promoters are more of your community facilitator type, coordinators, identifying problems, deal with issues, refer…."* (BP016P_HP-manager)

HP 'asks why health problems exist' while CHWs link patients to health services:

> *"CHWs focus more on ensuring that people are linked to services. They go out and track people that have defaulted. Instead of asking why, are people defaulting? With HP, you ask why so many people are defaulting? How can we intervene? CHWs go out and check how many households are there. But, if there is overcrowding, what is it that they do? Can they facilitate linkage with other services? They cannot. But that's what health promoters do, because they work with other sectors and link with other stakeholders."* (BP015D_HP-manager)

One HP manager explained:

> *"I see CHWs performing more clinical work, as they are the outreach programme of the clinic, following up on non-attending patients and those who have just been discharged from hospital."* (BP001SD_HP-manager)

This viewpoint was common among some HPPs:

> *"HP is only different with CHWs because they diagnose; they take vital signs [BP and sugar checks] at home."* (BP007HPP_health-promoter)

However, CHWs do not diagnose patients, rather simply record measurements, on behalf of the clinic.

6.4.3.2 CHWs receive more attention and resources

Upstream HP staff were not involved in rPHC planning or prioritization. A majority of HP managers and HPPs felt that the CHW programme had received more attention and capacity strengthening than its "HP relative":

> *"If you know you have a cadre named CHWs, and you know their functions are related to HP. When you're making changes or skilling, you should make sure that these [HP] programmes are attended to equally, but that never happened."* (BD015P_HP-manager)

Some facility managers affirmed this lack of political support for HP:

> *"….you'll notice that even our management at higher level [DoH]; they actually don't recognize HP as an important programme. It has no political will, neither is it allocated any budget."* (BP006FMAB_facility-manager)

This view, of lack of recognition for HP by the DoH, was common among all HP staff. The focus on the CHW programme highlighted how change causes discomfort among implementers.

Mid-level HP managers affirmed that the introduction of CHWs was received with high political support:

> *"….sometimes you will find CHWs being considered as a programme that is actually above the HP programme."* (AP001SD_HP-manager)

Others emphasized how CHWs were given a particular training, whilst HPPs have not received any targeted DoH training. The national DoH has not yet set competency levels for HP in South Africa. One HP manager explained:

"….but, when you look at the resources and the training that is given to these people [CHWs]. Now you ask yourself, why can't we do the same with HP and even put them at a certain level." (BP015D_HP-manager)

The feeling of HP being left out was common among HP managers in this study:

"….and now health promoters don't even have some of the skills that CHWs have, like blood pressure [measurement]." (AP016P_HP-manager)

The desire expressed by mid-level HP managers was for health promoters to perform at a level higher than CHWs. Some HP managers described some confusion brought about by the training of CHWs, who receive certificates describing their qualification as one in HP:

"CHWs are actually being registered as HP officers, what bearing does this now have on the health promoter?" (ND004ABC_HP-manager)

Such feelings point to disruption caused by change.

6.4.3.3 Anxiety among some HPPs

The introduction of WBOTs led to anxiety and trepidation among some HPPs. Mention of CHWs was met with mixed feelings among HP managers and facility-based HPPs alike:

"….*you know it brought some level of fear and uncertainty on the part of health promoters."* (BP015D_HP-manager)

This included fear of losing their jobs. The same HP manager commented:

"….r*emember when it was introduced, it was so prominent. It was pushed so hard, and pitched at a level that would undermine what already existed [HP]. So it was like is HP being phased out? It brought a level of uncertainty."* (BP015D_HP-manager)

This particular HP manager, however, described how they held meetings within their district to address this uncertainty. They explained how rPHC fitted with broader PHC goals, and clarified the concept of working in a *"ward"*:

> *"….so, at least because it's been years now and nobody has lost their job, HPPs are comfortable."* (BP015D_HP-manager)

A few mid-level HP managers did not support the introduction of CHWs, nor did they understand why CHWs were introduced. As a result, they believed that there was no need to introduce these *"new cadres (CHWs)"*, given that HPPs were already in existence, arguing that someone higher-up the DoH ranks should have advocated for more HPPs instead. Perceptions regarding the possibility of merging CHWs and HPPs under one directorate were common among some HP managers:

> *"I think they were supposed to be auxiliary health promoters instead. Like in social work, we have a social worker [and] auxiliary social workers."* (ND004ABC_HP-manager)

Since CHWs were now doing household visits, one facility manager suggested limiting health promoters' work to facilities:

> *"….now that we have got CHWs, why can't we have them focus on communities and HPPs focus on the facility?"* (BP0012FM_facility-manager)

6.4.4 Stage 3: Refreezing into 'new' practice

6.4.4.1 Working in parallel

HP managers raised the issue of HPPs and CHWs running parallel HP activities, one district HP manager commented,

> *"Now when you look at CHW duties, it's to go identify, screen and refer. But, what happens to the issues that they identify within the community? That is where HP comes in. Now you look at their reporting and how those issues are brought up. It's parallel. So, it means, a health promoter will just find a way to work and they end up addressing issues that they think are important. But, when you look at it, as we create these other structures [CHWs], we create parallel working situations whereas we want to act on issues in the same area."* (BP015D_HP-manager)

In addition, another district HP manager pointed out that the HP role of CHWs is compromised given that the facility manager and the WBOT leader are clinicians, suggesting that the refreezing may be out of kilter:

> *"…. remember when they brought in the coordinator [WBOT] at the facility, it's a nurse. This person is very much clinical. At the end of the day, they do not move on the same understanding [with HPP]. Therefore, that will make HP in the facility and catchment area run in parallel with CHWs, because these two also do not link. It's the facility manager, the health promoter here; and a WBOT coordinator there [illustration]. These two, facility manager and the WBOT leader are clinical. They would understand each other. Automatically, that would frustrate implementation of HP and how the health promoter operates."* (AP015D_HP- manager)

6.4.4.2 HPPs training CHWs

Notwithstanding the lack of clear guidelines and duplication, some health promoters embraced their role in rPHC. Facility managers regarded HPPs as critical in the initial stages of rPHC rollout. They described how health promoters had informed people in the

community about WBOTs and the CHW programme, and encouraged them to be warmly received. A HPP explained:

> *"I work with WBOTs because I know these people well. They are my patients. I started working here earlier, and I know them better. But, I was not providing them with medication [like CHWs do]. I was arranging for them to come to the clinic every month to collect the tablets. When WBOTs came, I took them around, to show them patients who are in need."* (AP007HPP_health-promoter)

Another facility manager confirmed this view:

> *"Without HPPs telling clients and the community about all the services coming with PHC re-engineering, it won't succeed. They are the ones that are supposed to go in front of us, before we can come…"* (BP003FM_facility-manager)

One common response among study participants was the in-service training of CHWs:

> "….*80% of what CHWs do may be health education and a bit of HP, but mostly health education. It should be a health promoter that guides them on how to do it."* (ND003_HP-manager)

CHWs were regarded as not having enough health information, relying on HPPs for it:

> *"CHWS don't have enough information; they rely on health promoters to train them. Some things are changing like the PMTCT; you will find that something that was true five years-ago is no longer practical now. So whenever we get new information we also give it to CHWs…."* (AP002D_HP-manager)

In this way, HPPs were enacting a facilitation and support role during the refreezing phase of the CHW programme after the uncertainty and confusion that was expressed about the introduction of the new programme.

6.4.4.3 HPPs working as part of WBOTs

At some health facilities, HPPs were reported to work as members of WBOTs, although this is informal:

> *"I am part of the WBOT. I don't do the household registrations [like CHWs]. But, I do patient follow-ups with them and visit households with CHWs when they have a problem…"* (BP002HPP_health-promoter)

One sub-district HP manager confirmed this information:

> *"HPPs are part of the WBOTs and remember they are community health workers [literal meaning]."* (AP010SD_HP-manager)

However, the involvement within WBOTs varied per health promoter. HP managers described the frequency of HPP visits within WBOTs as determined at facility level:

> *"HPPs are not always with WBOTs, depending on the needs of services at the time. Yes, there are instances whereby the health promoters and the WBOTs go together and conduct door-to-door services, but there are instances whereby they are not able to…."* (AP010SD_HP-manager)

Health promoters reported task sharing when they visit homes as part of WBOTs, their role being to give *"deeper"* health information. HPPs also regarded themselves as having a supervisory role over CHWs:

> *"….it's like we're working as supervisors of the WBOT. Even if I'm not presenting myself as a supervisor, I am working together with them. There is a lot of work, and it is easier now than before because CHWs are present on the ground with the people, and stay in that community."* (AP002HPP_health-promoter)

Many HPPs frequently cited *"stepping in"* or lending a hand when CHWs face problems in the community. They mentioned that CHWs are expected to report health-related issues they face during their work in the community to HPPs. Some health promoters were reported to sit together with the WBOT leader and go through CHWs' reports, to find where there are needs for HP interventions:

> *"She is doing households together with the WBOT. CHWs and HPP give information at households and bring patients to the facility. That makes a great improvement in case management of conditions. Because nurses will not go to households to trace [patients]. But, health promoters together with CHWs are the ones that visit households and trace patients that are not getting services, market the services and refer them to the facility."* (AP005FM_facility-manager)

Most HP staff expressed how they have grown to appreciate and embrace the presence of CHWs at PHC level, some stating that the introduction of CHWs has *"been a blessing in disguise"* because a lot of work which was on the HPPs' shoulders has been lessened, especially household visits.

6.5 Discussion

In this paper, we provide insight on how the HPPs' role has been challenged in two provinces in South Africa by the introduction of CHWs. The rPHC and the first national HP policy were introduced and implemented without clear guidelines on how health promoters were to provide support to CHWs and WBOTs. Despite considerable role overlap and the absence of formal re-orientation processes to re-align HPP roles with rPHC goals, some informal integration between HP and CHW/WBOT activities has occurred on the ground. However, there is also some role confusion, with the two cadres, and their associated

programmes, working in parallel. In *Table 18*, we use Lewin's change framework to summarise facilitators and barriers to jointly working together (Lewin, 1961, Lewin, 1947). Although change processes are iterative and do not occur in clear stages, policies and other changes initiated from the top-down can lead to unfreezing of everyday practice. Change brings about some sort of discomfort and refreezing is subject to individuals and context specific factors.

Table 18: Change in this study using Lewin's three-stage model

Stage	Organizational action that occurred	Factors for or against working together	
		Facilitators	**Barriers**
Unfreeze	Policy makers introduce rPHC and the HP policy and launch the new reform	• Health promoters know communities well	• Limited re-alignment of HPPs for new roles: o job descriptions o re-training
Change	HPPs and CHWs/ WBOTs experiment on how to work together on the ground	• HPPs as forerunners of the CHW programme	• Role overlap • More attention and resources towards CHWs • Anxiety and trepidation among HPPs
Re-freeze	Some HPPs institutionalize new change into their practice culture	• HPPs train CHWs • Working at part of one WBOT	adres, and their gement structures, working el

Staff from the HP programme were not involved in the development of the rPHC implementation guidelines. We found that the rPHC change vision was not well communicated between policy authors, national DoH, and front-line implementers - HPPs at district level; with better communication, HPPs might not have perceived CHWs as a 'threat'. Our findings are similar to a New Zealand study, which found health promoters feeling vulnerable after the introduction of a strategy to shift HP into primary health organizations (Lovell and Neuwelt, 2011). No previous local or regional research could be

found that have examined HP or its human resources relative to a PHC reform. Since implementation of the rPHC policy, there has not been any new guidance on the roles and responsibilities of HPPs, nor has the national HP directorate developed new job descriptions for facility-based staff. Our findings mirror those of Hill (2003), who examined how written policy, often fails to provide implementers with sufficient detail to perform policy change (Hill, 2003), meaning HPPs and other cadres of the health system must implement new policies with limited guidance. It is not surprising therefore, that the refreezing was not uniform but varies according to characteristics of provinces, districts and health providers (e.g. facility-managers and HPPs). Research shows that policy and guidelines are not always adequately implemented (Sakyi, 2008, Sheikh and Porter, 2010, Erasmus et al., 2014). This study adds an important piece to the puzzle, by highlighting the challenges faced by front line workers in implementing guidelines that provide insufficient 'guidance'.

In contrast, there has been tacit learning at facility level there is no mechanism for that learning to be transmitted 'up the system'. Findings from this coalface experience of HPPs could be used to inform development of new job descriptions and operational guidelines for HP practice and strengthened rPHC implementation. Examples from South Africa exist, where learning from implementing change enabled policy design for sexually transmitted infection management and antiretroviral roll-out – where policy implementers at the bottom, influenced policy-elites at the top, through continual communication and networking among policy makers, practitioners and researchers during the implementation process influencing national uptake (Schneider et al., 2006, Schneider et al., 2010). Study findings highlighted in this research represents a missed opportunity for learning from the bottom-up. We learn that some sufficiently skilled and confident health promoters have

carved out a role for themselves, supporting the CHW programme, particularly where supervision from the local facility is lacking. Our results provide further support for the hypothesis that implementation of policy change is at the discretion of front-line implementers (Gilson et al., 2014, May and Winter, 2007). However, global experiences show that combining both top-down and bottom-up initiatives is crucial for effective implementation of reforms (Ferlie and Shortell, 2001, Greenhalgh et al., 2004, Simmons et al., 2007). Research findings presented herein can also help fill these gaps by shaping policy through linearly feeding this experience/tacit knowledge up the system (Boswell and Smith, 2017).

Our findings suggest CHWs' HP activities fall by the wayside. Given that, facility managers and WBOT leaders who oversee them have primarily clinical-oriented duties. They are more likely to neglect the non-curative aspects of CHWs in rPHC. In an earlier South African study CHWs did not necessarily see themselves as "health promoters", because they did not view health education as an important service to deliver (Zulliger et al., 2014). A study in Lesotho revealed that the ability of CHWs to perform HP activities has been heavily affected by their role to increase health service access (Seutloali et al., 2018). Many HP managers would have preferred CHWs to be merged under the same HP directorate. Yet, Lehman and Gilson (2013), in their paper on power practices in implementation, describe how the provincial HP directorate in the Western Cape province of South Africa lost the battle to be in charge of the CHW programme to the provincial HIV directorate, which had access to external funding (Lehmann and Gilson, 2012). Power dynamics influence change implementation (Erasmus and Gilson, 2008). Those directorates with power over resources, for example, the HIV directorate, are more likely to be heard and respected.

Studies on rPHC in South Africa have mainly concentrated on CHWs and WBOTs. Research conducted in Gauteng and the Eastern Cape provinces found none of WBOTs under study included a HPP (Whyte, 2015, Rabkin et al., 2015). Although, the Eastern Cape study found 4 out of 9 WBOTs were supported by a HPP (Whyte, 2015). This different interpretation of a vacuum left by national guidelines show that provincial imperatives might dominate implementation.

Low investment in HP or its workforce is a global phenomenon (Vathesatogkit et al., 2011, Tangcharoensathien et al., 2008, Schang et al., 2012). A South Australian study, found unintended consequences of top-down policies to strengthen HP in PHC led to fewer opportunities for it, with HPPs reporting experiences of contradictory policy and practice environments, including funding and policy directions prioritising individual behaviour change (Jolley et al., 2014). Some countries have initiated formal educational, professional and or competency standards for HP (Melville et al., 2006a, Howat et al., 2001, Coe and de Beyer, 2014). In Guatemala, HPPs are community-based often with low levels of education (Maupin, 2011). While in others, like Australia, Canada, Israel, Botswana and Zimbabwe, HPPs have relevant HP qualifications (Sunderland et al., 2015, Melville et al., 2006a, Tapera and Sekis Moseki, 2018, Barry et al., 2009, Chideme-Maradzika, 2000), and in Mexico it's a combination of both categories (Keating et al., 2014). Given a lower than ideal supply of HPPs to deliver HP services at PHC (Alcalde-Rabanal et al., 2017), in Mexico have separated out two groups of health promoters - professional and non-professional community-based (Keating et al., 2014). This model may have relevance for South Africa. In Box 3 below, we provide some recommendations for South Africa using lessons learnt from our study.

Box 3: Recommendations from the study

Policy makers and HP managers (at the top), can learn from innovation within facilities (at the bottom) and develop formalised operational guidelines and direction for health promotion practitioners' routine practices, particularly within the primary health reform.

Role clarification of health promotion practitioners using a combination of approaches:

- Re-framing the role of HPPs to that of a more senior level, in which their role is to support, supervise and train CHWs, in line with qualifications set in the primary health reform policy;
- Developing job descriptions, including formal integration of health promoters into WBOTs and conducting patient follow-up and household visits with CHWs;
- Re-training HPPs across the health system (national to PHC) to be able to provide formal support and oversight to CHWs and WBOTs.
- Defining competency levels for the HP workforce in South Africa, to be able to train and recruit appropriate cadres to fit into the goal of the primary health reform.

There are several limitations to this study. Firstly, the research was conducted in two out of nine provinces. However, with 41 in-depth interviews, our findings and conclusions are transferrable to other parts of South Africa. Secondly, no CHWs/WBOT leaders were interviewed although; facility managers represent a neutral non-HP voice in the study. Lastly, we did not conduct focus group discussion and observations of HPP's work at facility or community level, to validate information given and to enable added triangulation of findings.

6.6 Conclusion

Our study presents a case study of what happens in the absence of proper guidelines to implement organizational change introduced through top-down initiatives, and how those at the bottom made sense of the proposed change. Some of the HPPs managed to find a role for themselves introducing CHWs, on-going community engagement, training and

supervising the CHWs. With formal role descriptions, a greater number of health promoters could take on these primary health reform roles.

DISCUSSION

CHAPTER SEVEN

"If we do not change the way we think, we will not be able to solve the problems we create with our current ways of thinking".

~ Albert Einstein ~

7. DISCUSSION

This chapter of the thesis discusses the linkages between the findings contained in each paper included in the thesis. At the time of thesis submission, two papers were published, and the third was under review. An overall discussion of the implications and significance of *Chapters 4, 5 and 6* in light of literature (*Chapter 2*) is presented. My PhD examined the institutionalization of HP capacity *(Chapter 4)*, structure *(Chapter 5)* and practice *(Chapter 6)* within the South African health system. In *Chapter 4*, I describe low levels of capacity for HP programming within the DoH (Rwafa-Ponela et al., 2020a). In *Chapter 5*, I describe and explain the structural barriers behind the low levels of HP institutionalization within the South African health system (Rwafa-Ponela et al., nd), and in *Chapter 6*, I look at the effect of lack of institutionalization on HP practice at community level in the context of a major PHC reform (Rwafa-Ponela et al., 2020b). This is an integrative chapter of the thesis that synthesizes all the various elements of my PhD to tell an overarching story. The discussion revolves around five major crosscutting themes that emerged from the three results chapters. A description of the contributions of the PhD conclude the chapter.

7.1 Summary of thesis findings and how objectives were achieved

In *Chapter 4*, I show an overall limited capacity to support and deliver HP within the South African DoH (Rwafa-Ponela et al., 2020a). This was compounded by limited situational analyses carried-out to adequately inform HP planning. The health information system was biased towards collating quantitative data, therefore omitting collection of indicators that address HP actions. However, neither did HP practitioners have capacity to develop HP specific indicators. As a result, HP reporting focused on service uptake data such as number

of campaigns. Inadequate HP training among HP personnel within the DoH was also emphasized. Coordination of HP activities across different sectors was largely absent, particularly at the national HP directorate. This gap was further widened by limited collaboration between national HP and provinces. Across all DoH levels, lack of budgeting capacity emerged as a major institutional barrier to supporting the HP programme as well as delivery of its activities (Rwafa-Ponela et al., 2020a).

In *Chapter 5*, I show that a curative-focused health system has hampered HP organization and implementation within the DoH (Rwafa-Ponela et al., nd); evidenced by limited allocation of HP budgets as indicated in *Chapter 4*, as well as redirection of HP funds to elsewhere, with the national DoH opting to outsource HP expertise from independent consultants. This was further compounded by a limited DoH HP strategic vision, with HP practice mainly focusing on providing health education. The HP programme within DoH was perceived to lack credibility and its staff were considered to have insufficient capacity. This was further compounded by inadequate HP data and evidence to inform what works. Lower-stream HP practitioners blamed the national HP directorate for lack of direction of the field. Due to the numerous challenges faced by the profession, HP staff at all levels felt demotivated and disempowered to be able to change the current status quo of the profession, and generally exhibited an external locus of control. In sum, HP in the DoH suffers from an identity crisis within the South African health system (Rwafa-Ponela et al., nd).

In *Chapter 6* of my thesis, I show how two South African national policy documents (Subedar, 2012, Department of Health, 2014), one on PHC re-engineering and the other on

HP were introduced and implemented without clear guidelines on re-aligning health promoters' job descriptions in the context the PHC reform (Rwafa-Ponela et al., 2020b). The PHC re-engineering implementation guidelines assume health promoters have higher levels of education than what currently exists (Subedar, 2012). Introduction of CHWs triggered anxiety and trepidation among some health promoters as they thought they were being phased-out. This was because of the DoH's suddenly increased attention and resource allocation towards the national CHW programme. In the absence of formal re-orientation processes to re-align their roles, and considerable role overlap between the two cadres, some health promoters have carved out a role for themselves within the reform, supporting CHWs and the PHC outreach teams. However, there is no possibility of this grassroots learning moving up the health system, so that can be 'institutionalized' (Rwafa-Ponela et al., 2020b). *Table* 19 shows how each of the three research objectives were addressed to meet the overall goal of the PhD.

Table 19: Summary of key PhD findings

Reference Chapter	PhD study objectives	Summary of key findings
Chapter 4	1. Assess collective and institutional systems capacity to deliver HP programmes and promote health across three-levels of the South African DoH.	There are gaps in promoting health and delivering the HP programme and its activities across all three levels of the DoH and domains assessed. Overall, limited HP capacity existed in the health system, indicated by a mean score of 2.08/4.00 (SD=0.83). Key findings included: ▪ No formal planning capacity, e.g. situational analyses rarely conducted ▪ Lack of HP indicators, resulting in use of service up-take data ▪ No systematic monitoring of HP activities ▪ Limited coordination across different sectors, particularly at national level ▪ Institutional constraints to HP capacity like inadequate budgets for HP programming and activities
Chapter 5	2. Examine barriers to the organization and implementation of HP within the South African health system.	A curative focused health system has resulted in limited HP budgets, resources and redirection of funds, as well as an inadequate strategic vision for HP within DoH. This was compounded by a lack of agency among HP practitioners, evidenced by an external locus of control as they view the solution to change the current status of HP to be beyond them. Key findings included: ▪ Limited collaboration within DoH, resulting in fragmentation of HP activities at national DoH ▪ Inadequate HP data and evidence due to lack of HP specific indicators in the health information system ▪ Inadequate HP training and lack of professional accreditation of dedicated HP staff ▪ Lack of perceived HP capacity and lack of credibility for the DoH HP programming, resulting in outsourcing of HP expertise at national level ▪ Role conflict among some health promoters and their facility managers, further exacerbating feelings of moral distress ▪ In sum, HP suffers from an identity crisis
Chapter 6	3. Explore how health promoters practice HP in the context of a PHC reform and the introduction of CHWs in two South African provinces.	Introduction of new policies (rPHC & HP) in South Africa, with no adequate guidelines on how to re-orient health promoter roles in an era of PHC revitalization and introduction of CHWs with similar community-based roles: ▪ rPHC guidelines assume health promoters have higher levels of education than what currently exists ▪ Anxiety among some HP practitioners as the DoH pays more attention to the national CHW programme ▪ Some health promoters collaborate with CHWs and ward-based outreach teams , depending on individual motivation, personal relationships and shared resources like office space ▪ Some HP staff continue to work parallel CHWs, compounded by separate management structures ▪ In the absence of formal guidelines, health promoters institutionalize new policy practices, for example training CHWs, however this learning is not feed up the system

7.2 Emerging themes from the thesis findings

My PhD set out with the aim of examining how HP is institutionalized within the South African health system. Factors impeding the development of a health-promoting health system in South Africa are analyzed and discussed within key themes that emerged. Findings suggest in-depth explanations as to why capacity for HP within the DoH is low, describe and explain the extent of the low levels of HP institutionalization within the South African health system. Furthermore, they explain why facility-based health promoters are having to cope on their own during a major PHC reform, as well as why lessons from the field are not being fed higher up the system to strengthen institutionalization of HP (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b).

The study demonstrates a limited collective capacity to deliver HP within the DoH, and inadequate institutional capacity to support HP activities. There is a link between insufficient HP capacity and the structural or systemic barriers faced in effectively organizing and implementing HP within the South African health system (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). The DoH and its leadership has not made a decision requiring HP qualifications for new staff nor has it systematically set up-skilling of existing HP staff. In essence, the DoH could be deliberately making this decision to save money. The position of HP as a directorate within the Social Services Cluster under PHC (Onya, 2007) results in marginalization of HP as it is not fully integrated into all clusters of the DoH nor does it have collective power to change the position and status of HP (Rwafa-Ponela et al., nd). Yet agency and effective leadership within the HP directorate could work to change the perceptions and to make a case for the positioning of HP differently within the DoH.

Furthermore, the limited communication between the local level structures and the national HP directorate (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd) means that policy and decision-makers fail to learn from what is working on the ground to help strengthen HP organization and implementation in the health system (Rwafa-Ponela et al., 2020b).

Fundamental structural factors that impede integration of HP into the fabric of the South African health system include a robust curative-focused approach (Rwafa-Ponela et al., nd). This is one of the factors that confine the strategic vision for HP within the DoH, it is further compounded by insufficient capacity in planning and setting priorities for HP (Rwafa-Ponela et al., 2020a). The fragmented system where HP at the local level results in HP addressing both issues raised by facility managers and following the health calendar. This result in some awareness-raising but lacks any sustained efforts that could address the burden of disease. This approach to HP practice is further compounded by parallel implementation of HP activities among various DoH programmes at national level (Rwafa-Ponela et al., nd). In addition, insufficient capacity to monitor and evaluate programmes means that there is limited evidence of either outputs or outcomes of HP programmes and activities in the DoH, making it difficult to make a case for HP at the highest policy levels (Rwafa-Ponela et al., 2020a). HP staff in senior positions have not been able to successfully promote the value-add of HP, consequently the financial investment towards HP activities is insufficient.

There is limited credibility of the HP programme to achieve objectives such as disease prevention and the perceptions of those in positions of power particularly at national DoH contribute to HP staff experiencing an identity crisis within the health system (Rwafa-Ponela et al., nd). Inadequate HP capacity strengthening compounds this, as well as the lack of

professional classification for the cadre of HP practitioners (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). In this context, the HP workforce within the DoH generally feel powerless to change the low status ascribed to the field, and address the numerous challenges it faces. Additionally, findings suggest there is a limited mandate given to HP which disables stakeholder coordination within DoH and multi-sectoral collaboration for HP, particularly at national level (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd).

HP senior staff have not been successful over the decades-long history of HP in the DoH to shift the mandate. Even after the introduction of the national HP policy and a major PHC reform, not much has changed on how HP is organized and implemented within the DoH. The limited vision for the role that the HP directorate could play in coordinating stakeholder activities both within the DoH and outside means that the potential role that HP could play is constrained (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). The result is HP activities that are entrenched in separate vertical programmes rather than working horizontally across clusters in the DoH.

At the local or grassroots level the findings show that health promoters have a critical role to play in PHC re-engineering, including provision of support and supervision to CHWs, ward-based outreach teams and other community-based initiatives (Rwafa-Ponela et al., 2020b). Yet these roles are not institutionalized and where they occur, it is a result of individual initiatives of HP practitioners on the ground. There is no mechanism for these learnings to be shared or to flow up the system. This further explains the weak institutionalization of HP within the DoH, and why health promoters seem to be struggling.

If an individual health promoter were to leave the PHC facility, it is possible that the coalface support that is provided to CHWs by health promoters would also end.

Five major crosscutting themes emerged from my PhD study. *Table 20* shows the coding matrix of the themes from each of the three results chapters (*Chapters 4, 5 and 6*). The themes are summarized below and discussed in more detail in *Section 7.3,* alongside broader literature:

1. Curative focused-health system, shown by limited allocation of HP financial resources, and lack of HP specific indicators;
2. Limited strategic vision for HP with DoH, evidenced by lack of distributed leadership and a narrow HP scope that is mainly focused on awareness raising;
3. Limited organizational capacity to promote sustainable health behaviours, support healthy environments and deliver HP actions;
4. Identity crisis, owing to lack of credibility of the field due to inadequate HP training and lack of professionalization; and
5. Limited coordination and multi-sectoral collaboration, both within DoH and outside hindering adequately addressing determinants of health.

Table 20: Crosscutting themes from the PhD results

Cover story	*Theme 1* Curative-focused health system	*Theme 2* HP strategic vision	*Theme 3* HP capacity	*Theme 4* Identity crisis	*Theme 5* Multi-sectoral collaboration
HP capacity assessment	▪ Limited capacity to implement health promoting systems ▪ Insufficient highly skilled staff to have a strategic vision for HP ▪ Lack of HP specific indicators ▪ Limited HP budget and resource allocation ▪ Institutional constraints to HP capacity	▪ Institutional HP mandate and operations ▪ Insufficient capacity to envision a coordinated and sustained programme that addresses issues over the medium-long term	▪ Limited situational analyses carried-out ▪ Limited use of data and evidence in priority-setting ▪ Inadequate systematic monitoring of HP activities capacity ▪ Lack of commissioning and conducting HP programme evaluation ▪ Insufficient of re-planning based on evaluation data and formative research ▪ Limited ability to design IEC materials	▪ Lack of occupational classification for HP ▪ Lack of HP specific capacity strengthening ▪ Most HP workforce at local level have no formal HP qualifications ▪ Managers often are qualified nurses or social workers with some HP training	▪ Limited vision to consider multi-sectoral collaboration as possible ▪ Insufficient capacity to demonstrate leadership across sectors ▪ Limited capacity for stakeholder coordination ▪ Lack of vision for how HP directorate could lead HP quality assurance
Factors impeding institutionalization of HP	▪ Curative-focused approach ▪ Structure of DoH organised around diseases and health issues e.g. NCDs, HIV/TB, Maternal, child and women's health ▪ HP directorate located within the PHC cluster, without a HP-specific chief director ▪ Limited HP specific budgets and resources ▪ Re-direction of HP funds to elsewhere ▪ Lack of HP data and evidence	▪ Limited vision for HP within the DoH ▪ Lack of vision for a strategic role for HP practitioners ▪ In practice, HP with DoH is mostly health education ▪ Inadequate leadership to steer the HP agenda	▪ Institutional capacity has gaps and weaknesses ▪ Insufficient collective capacity of HP overcome or change the position of HP within DoH ▪ Outsourcing of HP expertise at national DoH	▪ Lack of HP occupational class ▪ Recruitment and appointment of staff without a HP-specific qualification ▪ Limited ongoing and sustained in-service HP capacity strengthening ▪ Lack of HP programme uniformity in provinces ▪ HP staff have external locus of control ▪ Role conflict with facility managers ▪ Feelings of moral distress ▪ HP's identity crisis	▪ HP activities embedded in separate vertical programmes ▪ Health in all policies would require collaboration outside of DoH – currently no mechanisms for this ▪ Limited collaboration and multi-sectoral action

Health promoters in the context of CHWs and PHC revitalization	▪ CHWs receive more attention and resources from the DoH as they are involved in activities such as referrals to clinics ▪ No mechanisms for feedback from the ground to inform priorities or decision-making	▪ Some evidence of priority-setting based on community needs ▪ Health promoters know communities very well ▪ Parallel HP and CHW management structures	▪ Health promoters train CHWs ▪ Health promoters providing support and oversight to CHWs and PHC outreach teams ▪ Health promoters should be working as part of PHC outreach teams but this has not been formalised	▪ Extent of role overlap between health promoters and CHWs ▪ Role confusion comparing to CHWs ▪ Feelings of anxiety and trepidation among some HP practitioners	▪ Some local inter-sectoral collaborations occur on the ground ▪ HPs work with some community-based organisations outside of the health sector e.g. early childhood development centres and schools

7.2.1 Theme 1: A curative-focused health system

In *Chapter 5* of my thesis, I show that a dominant curative-focused approach continues to affect the institutionalization of HP in the South African health system (Rwafa-Ponela et al., nd). A curative-oriented model is defined as an approach to clinical medicine that narrowly focuses on treatment goals (Fox, 1997). The reason behind the HP programme remaining a vertical programme within a cluster under PHC at the DoH may be partly be the result of limited capacity among senior HP staff to make a case for why it would be more effective if it were fully integrated within the health system (Rwafa-Ponela et al., nd). The current structure means that the HP programme does not participate in higher-level executive meetings and has to rely on a non-HP Chief Director to make a case for HP. The absence of HP from the National Health Insurance is an example of how HP is currently not considered as an integral part of the South African health system (Freeman et al., 2020, Department of Health, 2019). In this regard, having the most senior person of the HP programme at the level of a Chief Director would enable greater influence and to contribute to the overall departmental strategy. In that way, the integration of HP would be facilitated.

Policy documents on HP and the PHC reform are not specific enough on the roles of HP in revitalizing PHC, and practices on the ground differ from one health facility to another (Rwafa-Ponela et al., 2020b). The HP directorate reported not being consulted in the drafting of the PHC re-engineering or reform guidelines. On the other hand, some external HP stakeholders reported not being consulted in the development of the national HP policy. Although those outside the DoH might not a “right” to be consulted, this could have been beneficial. Additionally, it is not clear whether other directorates or programmes within the DoH were consulted in the process. It is important to note that provincial imperatives may

dominate, as seen in differences in structure and adoption of the HP programme in the various provinces (Rwafa-Ponela et al., nd). This is as a result of decentralization in the South African health system, where national DoH develops policies and provides overall guidelines while provinces are responsible for implementation (Plaatjies, 2008, Gilson, 2012a). In the case of HP, the budget is largely disbursed to provinces leaving the national directorate with very little. This impact on the ability of the national office to coordinate and communicate with provinces.

The case for greater integration of HP would require an evidence base of both the need for HP as well as the effectiveness of its programmes within DoH structures. Without an evidence-base and data to inform HP practice (Rwafa-Ponela et al., nd), and limited monitoring and evaluation of programmes to show whether objectives are being met (Rwafa-Ponela et al., 2020a), there is a limited chance for policy-makers to use so as to make an investment case for the HP programme within DoH. HP staff capacity needs to be strengthened to be able to conduct situational analyses, interpret data, monitor and evaluate programme activities. Increased capacity in these areas would be required at all levels of the health system.

Emphasis on curative services by policy and decision-makers within DoH is based on evidence of improvement in the mortality and morbidity rates that have been shown in some programmes, such as prevention-of-mother to child transmission of HIV (Goga et al., 2015), and roll-out of anti-retroviral treatment for HIV (Fatti et al., 2010). It is much harder to generate such data and evidence from HP activities. This is because HP addresses underlying determinants that are further away from health outcomes, such as getting

mothers to attend antenatal care earlier during their pregnancies or the promotion of breastfeeding, as well as formulation of support groups for people living with HIV and other chronic conditions (Rwafa-Ponela et al., 2020b). These HP activities could be contributing to the prevention of mother-to-child transmission of HIV, but there is no way to quantify the contribution of the HP programme as no systematic data is being collected, collated and used to evaluate these activities. This may be one of the reasons why HP lessons from the local-level do not flow up the system (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). Another explanation for why HP learnings at the coalface may not be fed higher up could be due to lack of HP recognition in the system among those in positions of power, as well as inadequate HP leadership with limited agency to advocate for the programme at strategic level. Outside of government and the DoH, non-governmental organizations in South Africa have produced evidence to show the impact of HP interventions and activities (Goldstein et al., 2005, Le Tape et al., 2019, Robins, 2008).

As mentioned in the literature review (*Chapter 2*), despite efforts in recent years to strengthen health systems to be more health promotive, and a wide acceptance of the philosophy underpinning the importance of HP in achieving significant health gains, substantial challenges remain (Kumar and Preetha, 2012, Coe and de Beyer, 2014, Murray et al., 2013, European Commission, 2019). A recent 2018 assessment of HP in 21 European countries, indicated that while the majority of countries had adopted approaches to address social determinants of health, in some countries there is still a predominant focus on curative approaches (Barnfield and Savolainen, 2019), which is similar to the current South African context. Findings from this PhD build on existing global evidence that HP largely remains on the margins of health systems (Frankish et al., 2006, Wendimagegn and

Bezuidenhout, 2019, Bezerra and Sorpreso, 2016). In addition, it highlights an important question about whether the current HP configuration and capacity would be sufficient if there was a policy decision to shift towards a health-promoting health system. The PhD highlights that due to the numerous capacity gaps and structural limitations that exist at all levels of the current HP system (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b), it would not be able to provide the strategic vision that would be required to support a change towards a health-promoting health system. A HP Foundation that could provide the leadership and direction for the DoH may be one option to overcome these challenges.

7.2.1.1 Financing to support HP activities

Results from my PhD study showed that a curative-focus of the health system hampers allocation of resources and budgets to HP programming across all levels of the health system (*Chapters 4 and 5)*. In addition in some instances where a budget was allocated at the provincial level, there was redirection of funds to other programmes, mostly to curative services (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). These findings further support the idea that a dominant curative approach absorbs the majority of the resources within the health system (Lantz et al., 2007, Mahmood, 2015) and as a result health promoters have to deal with limited budgets to run the programme and related activities. These further points to the limited institutionalization of HP in the health system. Progress towards revitalizing health practices from curative services to focusing on community-based and preventive services has also been hindered by the reluctance of leaders to align policies and financing to support HP efforts (Cueto, 2004). There seems to be an inevitable conflict over resources between curative services and health promotive programmes.

Availability of sustainable budgets to the current structure of the HP directorate and its sub-directorates raises some unanswered questions. For example, given that the PhD indicated limited capacity to budget funds among DoH HP staff as they were usually not readily available for them to do so (Rwafa-Ponela et al., 2020a). In this regard, it is critical to ask whether the DoH HP programme has sufficient capacity to manage the budget if it were allocated. Would the budget be linked to strategic work plans? Alternatively, would it enable buying of promotional material like t-shirts for use during awareness campaigns? A possible solution alongside establishment of a HP Foundation would be to strengthen the capacity to budget funds among DoH HP staff through in-service training.

In *Chapter 6* of the thesis, HP staff showed perceived dissatisfaction about DoH's financial neglect of the HP workforce and sudden financial injection and commitment towards the national CHWs' programme (Rwafa-Ponela et al., 2020b). CHWs mainly assist in managing and monitoring chronic conditions, and delivery of medication to patients in communities, (Ndou et al., 2013, Tsolekile et al., 2014, Nxumalo et al., 2016). These elements are geared more towards clinical improvement than HP. The push towards integration of CHWs in the South African health system is due to the availability of evidence from the international community, other LMICs and locally on the capacity of such programmes to improve health at local level as well as political will (Ozano et al., 2018, World Health Organization, 2007a, Tseng et al., 2019). Low investment in HP has been attributed to the 'non-urgent' nature of the field, when compared with curative services (Ziglio et al., 2000). This study found perceived lack of HP capacity by those in power within the DoH as one of the reasons for low investment in the HP programme (Rwafa-Ponela et al., nd). However, it should be noted that while institutional challenges remain in many countries, such as budget cuts and

relative reduction of health sector funds by governments (Collins and Hayes, 2007). South Africa is an exception with improvements in health expenditure over the years (Conmy, 2018, James et al., 2018).

Other countries have established HP Foundations (*see Section 2.5.4.1* in *Chapter 2*) to help curb challenges of HP financing as well as increase levels of HP integration in the health system (Bayarsaikhan, 2008, Bayarsaikhan and Nakamura, 2015, Prakongsai et al., 2007, Tangcharoensathien et al., 2008, Schang et al., 2012). In South Africa there has been a push for a HP and Development Foundation (Perez et al., 2013, Munodawafa, 2011), largely from outside of government, but barriers have been encountered with resistance from Treasury to ring-fence taxes collected on alcohol, tobacco and sugar for a HP Foundation (Health Promotion and Development Foundation, 2018). This may be further limiting the opportunities of institutionalizing HP into the fabric of the health system. Establishment of a HP Foundation could help close HP budget capacity gaps, and among HP staff through managing HP funds for the all levels of the DoH, including facility-based HP activities within the current PHC reform, other sectors and civil society (Mouy and Barr, 2006). Efforts to set up a HP and Development Foundation should be intensified in order to ensure that there is a protected and sustained financing for HP in South Africa to enable institutionalization.

7.2.2 Theme 2: Limited strategic vision for HP within DoH

In *Chapter 5* of my thesis, I show the limited vision, commitment and strategic role for HP within the South African DoH (Rwafa-Ponela et al., nd). This is further constrained by the limited capacity to support HP implementation and to institutionalize what is working on the ground. The DoH could be strengthening its HP programme and activities, particularly

given the PHC reform instead of focusing mostly on curative services (Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). While the HP strategic plan (2015-2019) refers to activities such as good nutrition and exercise among the South African population (Department of Health, 2014), activities from the HP programme within the DoH seem to have little or no impact at population level. One provincial HP manager reported that *"we are not reaching tens of thousands of people",* as only small groups of people are actively participating in HP activities like support groups, food gardens and physical activity for the elderly and patients with chronic diseases (Rwafa-Ponela et al., 2020b). The health benefits might be different for specific groups of people, and some are reactive-based activities such as targeting those already with disease. Therefore, the next iteration of the national HP strategy needs to be more ambitious than the earlier (2015-2019) version. It should be focused on changing health and well-being at a population level to enable a shift towards a health-promoting health system.

South Africa could learn from how some industrialized countries have developed a bigger vison for HP and consider how the vision could be adapted to fit its specific context. While, intensive strides have been made in developed countries to position HP to address determinants of health and health inequalities (European Commission, 2019), major challenges remain, including questions related to frequent lack of commitment among decision-makers to allocate the necessary attention and resources to the field of HP (Kessler and Renggli, 2011). There is need for the HP staff within the DoH to rethink the 'small group strategies' and consider how to approach population-based HP activities, like facilitating community-wide park-runs or advocating for healthier foods to be made more available and cheaper. This requires multi-sectoral collaboration with different stakeholders across all

levels of the health system. If there was a shift in thinking towards health-promoting health systems as envisioned by my PhD, one question to ask is would the current HP practitioners and structure have capacity to enable population-level health gains and well-being? Data from the PhD show that this is currently unlikely. Therefore, there may be need to consider what cadre of HP practitioners would better capacity to perform such activities to enable a health-promoting health system? This approach may mean that there would be a need to employ a new batch of HP staff. The DoH HP programme is currently run by most senior staff with qualifications in social work or a nursing background (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd), therefore, would not be able to ensure a whole systems change for HP by themselves.

While there has been a push globally for Health in All Policies and attempts made to have a bigger strategic vision for HP programming rather than having HP as a fragmented programme area (World Health Organization, 2014a), there is difficulty in implementing this agenda. One explanation is a strong tendency to "medicalize" health problems, as policy-makers view health as the purview of health departments resulting in limited focus on the Health in All Policies agenda (Lantz et al., 2007, World Health Organization, 2014a, Mahmood, 2015). Effective integration of HP within health systems requires a strengthening the HP function at a broader political and policy level (European Commission, 2019). South Africa is typical of other countries, which lag behind on the organization and implementation of HP within the DoH structures due to a limited vision and investment in the programme and failure to see a bigger picture in the potential of HP interventions to reduce burden of disease, and improve population health gains and well-being (Rwafa-Ponela et al., nd). However, from the literature it is not always the case that high-income

countries have a bigger HP vision. Some middle-income countries are further advanced and have a clear and well-developed vision and strategies for HP, such as Bhutan, China and Brazil (Kind and Ferreira-Neto, 2013, Barry and Battel-Kirk, 2011, Watabe et al., 2016, Mahmood, 2015). It is also the case that some countries are not doing that well on their vision for HP, for example Sudan (Elsubai, 2007). This may be linked to prioritisation of different competing issues and the general weaknesses in the health system. Hence, HP programming is ascribed a low status and the extent of its institutionalization within the fabric of the health system remains weak. As a result this reduces implementation of the Health in all Policies approach (World Health Organization, 2014a). This is a common phenomenon among many other African countries. HP activities in many African settings like in South Africa have a narrow implementation focus (Freeman et al., 2020), with social determinants of health being virtually ignored (Ndjepel et al., 2014, Tapera and Sekis Moseki, 2018). An example of this is in Cameroon, where HP activities were found to be is insufficiently implemented, despite the presence of a ministerial body in-charge of its programming and activities (Ndjepel et al., 2014).

My PhD data indicated that what is generally understood as HP practice within the South African DoH is health education, information and awareness raising (*Chapters 5 and 6*) (Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). While, health education is important, it needs to be understood as one of many strategies for HP (Kessler and Renggli, 2011), and not the only focus of the HP field. In the context of PHC reform, CHWs could take up most of the role of providing door-to-door health education and awareness in communities to avoid duplication of roles among health promoters and CHW cadres (Rwafa-Ponela et al., 2020b). Given the importance of community-based approaches, and the difficultly involved in

engaging with communities, particularly as CHWs are from the communities they work in, they may not have the authority that some health promoters have. Facility-based health promoters and their managers could then be responsible for a more strategic direction of community-based HP interventions, such as designing appropriate behaviour change communication strategies and interventions based on theory as well as according to specific local or community needs and provision of support to CHWs. Thus, CHWs and ward-based outreach teams need input from both nurses and health promoters in collaborative supervision.

While, HP is mostly viewed as synonymous with health education within the DoH in South Africa, this is not the case of HP globally. Depending on how the HP concept is interpreted, attitudes of health professionals towards HP practices will differ (Johansson et al., 2009). This study showed how some facility managers value the presence of health promoters at community level within clinic-facilities, with some having a greater understanding that HP practitioners have a bigger role to play in population health and contributing to health gains (Rwafa-Ponela et al., 2020b). There is reasonable evidence from this PhD that health promoters do more that provide health education, where they are actively working in communities, and serving as patient advocates in clinics, gatekeepers as well as provide support structures for clients (Rwafa-Ponela et al., 2020b). Additionally, most participants described the role of health promoters in community outreach, although this was labelled as “social mobilization”. As previously mentioned, delivery of such activities could be strengthened through capacity strengthening initiatives to enable reaching more people in the country than small groups. One important question raised by this thesis is whether South Africa’s status as a LMIC is the reason why there is a limited

vision for HP within the DoH? Certainly, countries which have a bigger vision for HP are industrialised countries, largely in the global north (European Commission, 2019). Exceptions in this pattern among LMICs include Thailand and South Korea (Watabe et al., 2016, Nam and Engelhardt, 2007).

7.2.3 Theme 3: Limited capacity and agency for HP

Research findings in *Chapter 6* revealed that HP capacity within the South African DoH is limited (Rwafa-Ponela et al., 2020a). This is was compounded by a limited agency among HP staff to act beyond what they currently know about the programme (Rwafa-Ponela et al., nd). Le and colleagues have argued that when conceptualizing capacity, it is important to be clear on '*capacity to do what, by whom'* (Le et al., 2014). In my PhD, I focused on the collective capacity to develop, deliver and evaluate HP activities, within the national HP directorate and sub-directorates at provincial and district levels, and the broader DoH institution or context. Although still a developing concept, HP capacity has received significant international attention in recent years (Ebbesen et al., 2004). There are variations in HP capacity between and within countries, even in LMICs.

Data from the PhD shows that capacity strengthening alone among HP practitioners may not be sufficient to address challenges faced by the programme. Limited agency among HP staff is as a result of structural constraints such as a limited vision for HP within DoH, limited resources and fragmentation of activities which leads to limited clarity on roles for the HP staff (Rwafa-Ponela et al., nd). Therefore, if HP staff had greater capacity would anything change? Given that HP practitioners do not have the agency to bring about change to decades-long practice and organization of the programme within DoH (Rwafa-Ponela et al.,

nd). What about changes required by a broader health-promoting health system? Learning new skills when one feels constrained in their work environment to be able to implement activities differently because structures and processes have been set up in a particular way, and do not have power to change the system reduces potential gains from the institutionalization of HP within the health system. This justifies the importance of addressing the structural challenges in order to strengthen institutionalization of HP. Among LMICs, countries with limited HP capacity like South Africa include Peru, where HP capacity maps of local-level health areas showed gaps in financing, external health sector collaborations and information systems (Cosme Chavez et al., 2017).

Medium-to-high HP capacities were found in Thailand (Pumyim and Lertmaharit, 2008) and across Western Pacific countries (Lin and Fawkes, 2005). However, the Western Pacific capacity maps aggregated scores across eight different countries and as a result gaps in some countries were masked by high levels of capacity in other countries, especially in the domains of professional development and information systems (Lin and Fawkes, 2005), which also present a huge capacity gap in the current South African situation.

South Korea was shown to have a well-developed, stronger HP capacity map. Yet the capacity assessment had a broader scope comprising of both the Ministry of Health and non-governmental organizations (Nam and Engelhardt, 2007). Future capacity studies in South Africa could consider including non-governmental organization that conduct HP activities as well as part of the assessment. However, this may mask HP capacity gaps in the health system as described earlier (Lin and Fawkes, 2005). While, specific HP financing capacity challenges seem to be a global phenomenon (Cosme Chavez et al., 2017, World

Health Organization, 2010, Lin and Fawkes, 2005), an exception was the independent HP budget in South Korea. Its HP funding was reported as one of the largest globally (Nam and Engelhardt, 2007). It should be noted that the capacity mapping was conducted a decade ago and there is no current evidence of whether this has been sustained. In South Africa, limited HP funds particularly in the context of the introduction of CHWs during a major PHC reform led to some health promoters' feeling anxious about being phased out of the health system (Rwafa-Ponela et al., 2020b). Sufficient resource allocation for HP that create and sustain effective structures and strategies are critical in institutionalizing HP (Mahmood, 2015). Thus, a dedicated HP budget creates a supportive environment in which capacity could be strengthened.

Given limited resources and an evidence-base, the HP workforce could attain a sense of agency and capacity through ongoing processes of constantly defining and redefining organizational HP capacity and shifting social structures (Rod, 2015), instead of waiting for external bodies to come to their rescue. In addition, capacity assessment experiences can themselves strengthen capacity (Lê et al., 2014), as well as the increased agency among practitioners and the systematic incorporation of lessons learnt in improving performance. My PhD found that participants who participated in the capacity assessment workshops indicated that the process was positive as it allowed then to debrief and reflect on their current HP practices and challenge the way they were organizing and implementing activities (*Chapter 4*) (Rwafa-Ponela et al., 2020a).

7.2.3.1 Inadequate HP evidence-base to inform practice

My PhD found that there is insufficient evidence generated to inform HP interventions or the effectiveness of the HP programme in the DoH (*Chapters 4 and 5*). Indicators are for curative health services and outcomes with no HP-specific indicators monitored within the health information system (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). While the value of a HP evidence-base on effectiveness of interventions cannot be ignored, some authors argue that challenges of collating such information should not be underestimated (Nutbeam, 1999, Collins and Hayes, 2007). These include the capacity needed to generate such evidence, which was found to be limited among HP practitioners across all levels of the HP system and the complexity of producing HP evidence which requires commitment and resources (Collins and Hayes, 2007). Solutions that have been put forward, include use of a combination of quantitative and qualitative information during the data collection process (Wong, 2002). However, this is only a solution if data is being collated, which is not the case yet in South Africa. There also needs availability of skills to be able to collect, analyse and interpret HP evidence or data. This study showed limited collective capacity to do this among HP staff as well as limited institutional capacity to support it (Rwafa-Ponela et al., 2020a). This evidence may provide further reasons for policy and decision-makers to keep HP on the margins on the health system. Furthermore, the role of behaviour change theory in monitoring and evaluation has received little attention in the debates about evidence-based HP practice and measurement of intervention effectiveness (Green, 2000). In this PhD, I found lack of capacity to use behaviour change theories to inform the development of HP activities and planning (*Chapter 4*), among HP practitioners at all levels (Rwafa-Ponela et al., 2020a).

7.2.3.2 HP training and competencies

My PhD shows that HP practitioners have inadequate training (*Chapters 4, 5 and 6*) and most entered the profession without formal qualifications, and there is no professional accreditation for the field as yet (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). The DoH system does not require health promoters to be trained. This diminishes capacity to implement HP activities, increases perceptions that health promoters are similar to the CHWs, and raises concerns for proposed changes towards a health-promoting health system. In many countries, formal HP qualifications or a related discipline is the minimum entry requirement for a HP position, it is recognised that there are practitioners who entered the field without formal qualifications like in South Africa (Dempsey et al., 2011). In 2008, to address this challenge, and develop a competent HP workforce, core competencies for HP were identified (Barry et al., 2009, Battel-Kirk et al., 2009, Dempsey et al., 2011). The main purpose of the HP competencies was to inform training, practice, standards and accreditation of full HP courses in various countries (International Union for Health Promotion and Education, 2016, Melville et al., 2006a). While the competencies have been developed in countries with formal education, professional and policy infrastructures for HP, little action has occurred in countries with less infrastructure for HP such as South Africa, even among developed nations (Melville et al., 2006a). There is limited evidence on how such HP competencies and professional standards have been adapted for use in African contexts. This could health inform institutionalization of HP in the region.

7.2.4 Theme 4: Professional identity crisis and health promotion

Another important finding from the PhD was that HP practitioners and their leadership suffer from a professional identity crisis and feel like *"outsiders"* (Rwafa-Ponela et al., nd). This is due to inadequate recognition in the health system and lack of qualifications and inconsistent efforts to strengthen capacity (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., 2020b). Efforts that have been put towards qualifications and capacity strengthening for HP staff were largely short-term and structures did not change, even in provinces where the capacity strengthening occurred (Van den Broucke et al., 2010, Wills and Rudolph, 2010). This means that HP staff ended up going back to doing what they were doing since the inception of the programme in the DoH, rather than implementing new skills.

The uncertainty about what the concept of HP means poses a challenge to its organization and implementation (Johansson et al., 2009). *"Friends, acquaintances and politicians can easily understand our professional role when they inquire if we are nurses, doctors or physiotherapists. However, explaining what we do for a living is a challenge for many health promotion professionals"* ((Howat et al., 2003b), pg. 82). In my PhD, identity crisis among HP staff was evidenced by experiences of role conflict at the local level (*Chapter 5*), where health promoters seem to be aware of what they need to do, although this is within a limited scope of HP practice. While on the other hand some health workers, particularly nurses are not aware of what the roles of HP practitioners' are at PHC level (Rwafa-Ponela et al., nd). Role conflict is as a result of people being faced with incompatible demands (Biddle, 1986, King and King, 1990) such as facility managers requesting health promoters to make tea, do clerical work, stay within facilities as well limited agency among some health promoters on what they need to be doing (Rwafa-Ponela et al., nd). There is an exception in

tobacco control legislation and policy, which was one area in the national DoH, where there was historical clarity of a role for the HP directorate (Rwafa-Ponela et al., nd). In addition, tension and feelings of role confusion, among some facility-based health promoters were experienced during the introduction of CHWs with similar community-based roles to themselves, further compounded by limited clear communication and inadequate guidelines as well as re-definition of health promoters' roles from national DoH managers (*Chapter 6*) (Rwafa-Ponela et al., 2020b). The proposed role for facility-based health promoters in the ward-based outreach teams was never actioned and there was no retraining or revising of job descriptions to reflect their role in the PHC reform.

Reasons for role conflict and confusion for HP practitioners could originate from the philosophy of the concept of HP being poorly understood both among the practitioners themselves and among other health workers like nurses and facility managers. This includes inadequate guidelines and unclear objectives that could guide HP practice, especially in developing nations like in the case of roles of health promoters in PHC revitalization (Johansson et al., 2010, Ndjepel et al., 2014, Rwafa-Ponela et al., 2020b). As described in *Chapter 2*, HP has a range of interpretations and crosses multiple disciplines, as a result it continues to suffer a professional identity crisis (Howat et al., 2003b). An identity crisis hampers the development of HP as a recognized professional discipline, thereby reducing the extent of its institutionalization in the broader health system (Hale, 2005). As mentioned earlier, some health workers could not differentiate between health promoters and CHWs, including presence of tension as some health promoters felt threatened by the introduction of CHWs in the system (Rwafa-Ponela et al., 2020b). In this context, another explanation is that while the PHC reform and health system strengthening need HP, it is unclear to some

HP practitioners why CHWs were introduced. This could be due to how CHWs were emphasized by the DoH, including a trip to Brazil in 2011 to learn about the PHC revitalization model (Department of Health, 2011). However, the importance of managing role conflict in such situations is often ignored.

Success or failure of professional socialization lies in *"a suitable, subjectively internalized professional identity,"* ((Costello, 2005) pg. 23). If there is limited ability to carry out roles and be recognized as a competent professional developing a professional identity will be limited too (Sullivan, 2007, Costello, 2005). This is the case of the HP programme within the DoH in South Africa (*Chapters 4, 5 and 6)*, which lacks credibility and recognition and leaves most of its staff feeling powerless, experiencing moral distress and blaming external factors for their situation (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). This is linked to perceptions of limited capacity among HP practitioners by those in positions of power and influence within the DoH. Limited capacity is to some extent the result of lack of specific HP training. This leads to outsourcing of HP expertise at national DoH as a solution to the problem, further pushing the HP programme to the margins.

7.2.5 Theme 5: Limited coordination and multi-sectoral collaboration for HP

My PhD found that HP at the national and provincial levels provided limited coordination of HP activities within the DoH across different clusters (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). In addition, there was no systematic communication between the national HP directorate and provinces. The limited opportunities for meetings between national and provincial managers meant that what HP staff were doing at the local PHC level was largely informed by the needs as identified by clinical facility managers, instead of implementing

the HP strategic plan in a systematic and coordinated way. In this context, it is difficult to have a health-promoting health system, if two levels of management fail to communicate with each other. Joint supervision of facility-based health promoters by facility managers and sub-district coordinators may be difficult to achieve because of different reporting lines. In addition, how health promoters and nurses engage and work together is important, particularly at PHC level.

In addition, there was very limited evidence of multi-sectoral collaboration with other departments within government as well as civil society (*Chapters 5 and 4)*, particularly at national level (Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020a). Up-to-date effective HP interventions require constant communication among stakeholders, as is the case of collaboration among some health promoters and CHWs. HP programming is not like other directorates such as non-communicable diseases, whose actions may remain consistent overtime. The current extent of HP institutionalization may not be able to shape the status of a health-promoting health system that enables population health gains. It would take re-modelling the entire system to be able to change perceptions, practice and the organization of HP towards this for the future.

There is international consensus that multi-sectoral partnerships can achieve better outcomes in promoting population health and addressing social determinants, than working in silos (World Health Organization, 2014a, Jones and Barry, 2011, Jones and Barry, 2018). Furthermore, better coordination of HP activities within DoH is required rather than the running of vertical HP activities among different programmes with more resources and the systematic exclusion of the HP programme in the planning processes (Rwafa-Ponela et al.,

2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). Given an earlier description that HP may mean different things to different groups of people, itis the possible that some parallel HP activities and positions within government might not be framed as HP or include the term HP, such as advocacy, communication and social mobilization within DoH (Dempsey et al., 2011). This further limits the potential of a more unified health-promoting health system. Another implication is that challenges exist in creating and sustaining collaborations, particularly across sectors, which may be the case of a poorly resourced HP programme (Jones and Barry, 2018). Failure to create and sustain multi-sectoral collaborations for health may also be attributed to different interests and inter-governmental tensions concerns of 'health imperialism' by non-health sectors or mistrust in power-sharing among stakeholders in collaborations (Collins and Hayes, 2007, Jones and Barry, 2018). Some scholars argue that there is little research into trust and mistrust issues that primarily affect effective collaborations (Jones and Barry, 2018). Further research is required to explore this aspect in the institutionalization of HP in South Africa or elsewhere. A recent 2018 scoping review of international literature identified nine core elements to inform positive collaborative functioning (Corbin et al., 2018). While, tools to monitor collaborative processes among stakeholders have been developed; complexity, dynamism and contextual factors limit their representativeness in various settings, particularly for Africa (Joss and Keleher, 2011). Despite the aforementioned, results from this current study showed better stakeholder engagement at local level, including health districts and in communities and at PHC facilities (*Chapter 6*). There was evidence of some collaboration between facility-based health promoters and CHWs and/ ward-based outreach teams and the school health programme in efforts to revitalize PHC in South Africa as well as health promoters being tasked with linking PHC and communities (Rwafa-Ponela et al., 2020b).

However, new questions arise from the PhD, for example - if DoH decided to adopt health-promoting health systems approach rather than the current curative approach, would HP staff at all levels actually be able to provide leadership and strategic thinking to enable this? Data from the findings suggests that they are not, as their capacity is not sufficient and the structure to enable a health-promoting system is not in place. These gaps provide a stronger case for why a HP Foundation may be critical for the South African context to lead the HP agenda.

7.3 Conceptual relevance: a vision for health-promoting health systems

My PhD study was guided by a conceptual framework (*Figure 6 in Chapter 2*), which focused on critical conditions required to integrate HP within the health system. While, there is an increased recognition that curative-focused approaches alone are not sufficient to address the growing global burden of disease and to bring about improvements in health and well-being at a population level, many countries have not yet achieved this goal (Kumar and Preetha, 2012, Coe and de Beyer, 2014, Murray et al., 2013, European Commission, 2019). Likewise, South Africa is far from reaching the health-promoting health system goal, as HP is not yet fully integrated within the fabric of its health system. My PhD focused on the capacity, organization and implementation of HP within the DoH structure. Evidence from the study show that currently there is little commitment and political will for the HP programme and its activities within the DoH and limited chances for it being fully institutionalized.

Limited resources inhibit the ability of the HP programme to effectively drive, coordinate and control HP activities within DoH or across government and outside it. Inadequate financial resources persistently hinder HP strengthening efforts at any level of the health system (Munodawafa, 2011). It is important to note that insufficient institutionalization of HP in South Africa is happening in a context of health systems strengthening, and revitalizing of PHC, as well as the proposed National Health Insurance, strategies that are supposed to ensure the full integration of HP within the health system for more health gains. Yet, the economic sphere of budget and resource allocation within the DoH continues to systematically side-line HP (*Chapters 4, 5 and 6*) (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). My PhD study shows a clear evidence of a HP financing challenge in the South African context. Therefore, establishment of a HP and Development Foundation mechanism as proposed by external stakeholders in the country is necessary to help drive the HP agenda, both within and outside government and institutionalize it (Perez et al., 2013). Additionally, mechanisms to invest financially in HP need political will; currently the National Health Insurance Bill is silent on financing HP. A narrow strategic vison for HP within the DoH makes South African policy-makers fail to see the potential HP institutionalization within the health system has to improve the fighting chance for the National Health Insurance in the country (Freeman et al., 2020).

Decision-makers give in to social demands of paying more attention to curative services (*Chapter 5*), as opposed to investing more in HP, which promises greater gains in population health and well-being due to limitations such as lack of credibility, capacity and evidence (Rwafa-Ponela et al., nd). Therefore, social demands to invest in HP may emanate from civil society members, through organizations like the HPDFNet that is pushing for the greater

investment in HP in South Africa. The HP programme within the DoH in its current set-up is just a tick box, to say we have health promoters and HP activities within the health system. In the same South African context, money for HP has been was reported to be spent on superficial and untested health information and education campaigns with little impact, further reflecting the narrow view of HP that is held by many in positions of power within the DoH (Freeman et al., 2020). Thus, the current format of the HP programme within South Africa's DoH does not seem to meet the five action areas of the Ottawa Charter (World Health Organization, 1986). Another challenge may be that people do not actually know how to implement the Ottawa Charter and/or that the multi-sectoral collaboration required is hugely difficult.

An important question to raise is whether DoH HP staff are health promoters or health educators? A study from one district in Gauteng Province, South Africa found that health promoters spend most of their time delivering health education talks in the clinics as compared to the community (Hattingh and Janks, 2012). However, most DoH participants during this PhD study reported that health promoters spend most of their time outside the clinics (*Chapter 6*), in communities providing health education and other services (Rwafa-Ponela et al., 2020b, Rwafa-Ponela et al., nd). However, it is challenging to make such a claim using qualitative methods. Therefore, further quantitative research is needed to substantiate this finding. The focus of the health talks among health promoters are governed by a 'HP calendar' (Hattingh and Janks, 2012), that suggests a health topic to cover for the day, week or month (*Chapter 6*) (Rwafa-Ponela et al., 2020b). The result of the calendar is that activities are not sustained for any length of time as the focus changes from

one issue to another. There is evidence to suggest that once-off HP activities have limited effect (Corbin and Mittelmark, 2008, Kumar and Preetha, 2012).

There is a view that all health workers should be doing HP, rather than it being the responsibility of a small number of staff who are labelled as health promoters (Johansson et al., 2010, Geense et al., 2013, Raphael, 2008). If all health workers were responsible for HP, it would potentially reduce the need for HP-specific staff. However, this raises the concern that if all HP practitioners were removed, particularly from local levels, HP will be further neglected, in a context where there are heavy workloads among clinicians and long clinic queues (Rwafa-Ponela et al., nd).

Most of the health-promoting health systems theory domains considered during this study show substantial gaps for what is absent in terms of HP within the DoH in South Africa (*Figure 18*). In this context, what is the future of HP within the current health system?, given that there are limited opportunities to comprehensively show what HP can achieve within the DoH structure in South Africa, especially on a large scale (Freeman et al., 2020). Furthermore, despite global evidence for HP effectiveness in increasing population health and well-being (Baum and Fisher, 2014, Keleher and Armstrong, 2006, Petersen and Kwan, 2004), there are concerns that much of the evidence of what works is not locally generated nor is it from countries with similar characteristics to South Africa (Freeman et al., 2020). Examining the effectiveness of the current HP activities and the HP programme within the South African DoH structure was beyond the scope of this PhD. However, I propose that further research be conducted to cover this shortfall.

7.3.1 Revisiting domains of the conceptual framework

An adapted conceptual framework for how to institutionalize health-promoting health systems guided this PhD. Results of participants' views from the study may be interpreted in light of the conceptual domains to make sense of the data that emanated from the research question*, how is HP institutionalized within the South African health system?* Data from the PhD provides in-depth explanations as to why capacity for HP within the DoH is low and explanations why the extent of HP institutionalization is low, including the effect of this at PHC level during a major health system reform. *Figure 18* summarizes the synthesis of the PhD findings using the domains of the conceptual framework. Some findings overlap across various domains. Key findings and implications for the institutionalization of HP in the South African health systems using each domain of the PhD framework are as follows:

a) *People-centred approaches*: In *Chapter 6* of my thesis, I show that HP staff have a role to play in PHC revitalization; due to their community-based role and in-depth knowledge of populations they work with in strengthening opportunities for institutionalization of HP in the health system (Rwafa-Ponela et al., 2020b).
b) *Leadership and governance*: In all three results chapters, I found that there is a limited strategic vison for HP within the DoH, particularly at national level (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). Inadequate HP leadership shown in *Chapter 5* provides further shortfalls to envision change towards a health-promoting health system (Rwafa-Ponela et al., nd).
c) *Organizational structures*: In all results chapters of my thesis, I found that HP capacity and implementation is hindered by a curative-focused health system (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). Moreover, results from

Chapters 4 and 5 further show HP structural and organogram disparities among provinces (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). These structures may require a re-visit in order to strengthen institutionalizing change.

d) *Financing and resources*: Results from all three results chapters of the PhD show that there is limited financing and allocation of resources towards HP, which hampers HP implementation and elicits feelings of neglect for the field among HP staff further pushing HP to the margins of the health system (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b).

e) *Workforce*: In *Chapter 4 and 5* of my thesis, I found that there is inadequate HP specific training among designated HP staff and lack of professionalization of the field within government human resources systems (Rwafa-Ponela et al., 2020a). *Chapter 5* showed that this is compounded by HP staff who have a limited sense of agency, evidenced by an external locus of control and suffer from an identity crisis (Rwafa-Ponela et al., nd). However, *Chapter 6* highlights how some health promoters have found a role for themselves among ward-based outreach teams and CHWs, despite feeling threatened by their presence (Rwafa-Ponela et al., 2020b). These lessons strengthen possibilities for community-based institutionalization of HP amid a major PHC reform.

f) *HP capacity*: In *Chapter 4* of my thesis, I found that there is limited collective HP capacity among HP staff and well as capacity to promote health within the institutional system of the DoH (Rwafa-Ponela et al., 2020a). *Chapter 5* showed this is further compounded by HP staff who are perceived to lack capacity at individual level, as well as lack of credibility that investing in HP improves health gains, diminishing the institutionalization of HP in the health system (Rwafa-Ponela et al., nd).

g) *Development of a HP evidence-base*: *Chapters 4 and 5* show that there is lack of HP specific indicators within the health information system (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b), which compounds generation of adequate data and evidence of what works for HP within DoH, as well as lack of effective monitoring and evaluation of activities (Rwafa-Ponela et al., nd). In *Chapter 4*, I show that this is compounded by lack of adoption of what works by the HP directorate from other HP related programmes within the DoH (Rwafa-Ponela et al., 2020a). Furthermore, *Chapter 6* indicates that policy-makers and national HP leaders are not taking what seems to be working at coalface in PHC re-engineering to feed-it up the system to strengthen institutionalization of HP (Rwafa-Ponela et al., 2020b).

h) *HP service delivery*: In *Chapter 5* of my thesis, I found that there is a narrow definition to what HP means within the DoH. This speaks back to the limited strategic vision for the field within the South African DoH, which pushes it to the margins of the system. (Rwafa-Ponela et al., nd). *Chapter 6* describes a case for the role of health promoters at community-level in PHC re-engineering, other than provision of health education and lack of re-alignment of their roles with the PHC reform (Rwafa-Ponela et al., 2020b).

i) *Multi-sectoral collaboration*: All three results chapters show that there is inadequate co-ordination and multi-sectoral collaboration for HP within DoH, particularly at national level, evidenced by vertical implementation of HP activities across various programmes (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). As described earlier, *Chapter 6* shows collaborations between health promoters and CHWs at PHC levels, as well as engagement with other stakeholders, which is critical in institutionalizing change for a health-promoting health system (Rwafa-Ponela et al., 2020b).

j) *Country specific context*: In *Chapter 6*, the role of HP practitioners in the context of PHC revitalization in South Africa is shown, as well as within communities and at PHC level, and the commitment of the South African government to HP, through publishing the country's first national HP policy after years of being in draft (Rwafa-Ponela et al., 2020b). Furthermore, the commissioning of the National Health Insurance also provides a great opportunity for a South African country-level context to strengthen the capacity, organization and implementation of HP in the health system (Freeman et al., 2020, Department of Health, 2019, Department of Health, 2017c).

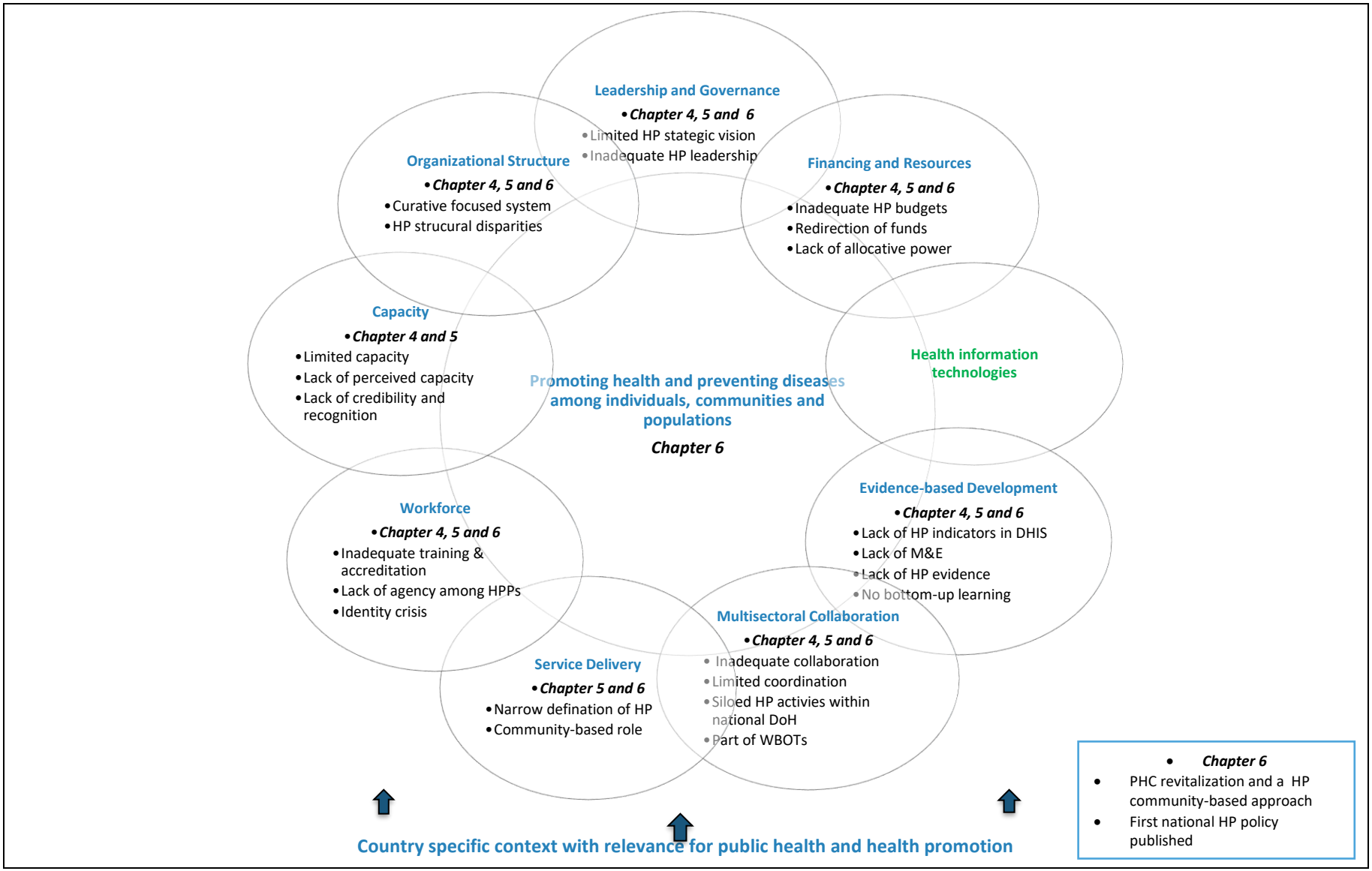


Figure 19: Synthesizing PhD findings using the health-promoting systems theory, Adapted (Aluttis et al., 2014, World Health Organization, 2009e)

7.3.1.1 Health information technologies

My PhD found that HP, as practiced within the DoH, consists mostly of health education and awareness related activities (*Chapters 5 and 6*) (Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b). A gap in practice and in the conceptualisation of my PhD was investigating what role health communication and health information technologies have in HP practice. This aspect may need to be added to the health-promoting health systems theory to further modify and strengthen it as the eleventh critical condition required to promote population health within health systems.

Health information technologies include use of media channels and services to enhance health care, assist with consumer-provider communication, inform health behaviours, prevention, and HP (Office of Disease Prevention and Health Promotion, 2020). Health messages are shared through media such as mass media, social media, mobile phone applications, and text messaging (Socha and Eber-Schmid, 2012). New advancements in telecommunications have an increased capacity to transmit volumes of health information, thus serve as a great potential for improvements in individual and population health (Bukachi and Pakenham-Walsh, 2007). In this regard, health communication and health information technologies are central to the way health is viewed among communities and populations (Stead et al., 2019), as with increased access to mobile phones, and the internet, there is a lot of health information at people's disposal. Health information technologies enable both health workers and people to search for, understand, and use health information to significantly impact health decisions and actions (Office of Disease Prevention and Health Promotion, 2020). Therefore should be considered in institutionalizing health-promoting health systems.

At the same time, policy-makers, practitioners and researchers need to think about the people and their capacity to navigate information technology systems; such that there is an increased ability to use, the challenges faced to improve HP activities and help people go through such information. In this regard, health literacy is a critical element in maintaining public health and well-being (Nutbeam, 2000, Nutbeam, 2008). Health literacy an important element of HP is the ability to navigate and use health information strategies to inform and influence one's choices about their health (Kreuter and Wray, 2003). However, how does one know that people are using DoH health information platforms that are available for example, and using them accurately? Further research needs to be conducted to investigate how people access health information and which media they use more frequently to be able to strengthen this within a health-promoting health system.

The current context provides a great opportunity to assist strengthen people to navigate through volumes of health information, and help them with skills on what they can pay attention to or ignore. As complex as this may sound, it is necessary to build personal skills on how to tell what is misinformation from what is real, as well as how to interpret health information one needs to believe, in addition to what they already know. Yet, it has to be noted that there is limited access to health information technologies due to poor telecommunication infrastructure in some contexts, such as Africa particularly among rural communities (Bukachi and Pakenham-Walsh, 2007, Kamba, 2009), and South Africa is no exception.

7.4 Strengths and limitations of the study

My PhD was conducted in two South African provinces. While, findings from this PhD may be transferrable to the other districts and provinces in the country, it also raises questions of possibilities of social desirability bias. Study participants might have answered questions in ways they thought the researcher wanted to hear. The study used purposive sampling at the different levels of government to recruit its study participants, which was relevant to a case study approach. This technique has the likelihood of introducing selection bias, and non-sampled districts or provinces might have had important viewpoints on the topic, which may have been missed. However, the research was conducted across multiple health system levels, including the inclusion of facility managers and key HP stakeholders who respectively provided a non-HP and non-DoH voice to study findings; including a mixed and multiple methods of data collection to enable triangulation of data across various sources; therefore has good general methodological quality. However, conducting observations of facility-based health promoters doing their HP work in the community would have helped to strengthen the research methodology.

While workshops enriched the process of data collection, another possible limitation in this study may be attributed to the type of capacity assessment tool used. The tool was developed for the assessment of social and behaviour change communication collective capacity among HP staff in Malawi (Jana et al., 2018). Some researchers may query if it is fair to assess HP staff against a social and behaviour change communication tool, even though it was adapted for use in South Africa and was also administered among HP practitioners in Malawi (Jana et al., 2018). Some questions such as *'do you develop*

indicators for HP programmes that are linked to your communication objectives' did not seem applicable to HP staff at district level, while some like, '*do you have systems in place to oversee/ monitor your budgets,* were not applicable at any level, as the HP programme does not necessarily have a budget to monitor, except salaries. Furthermore, the HP directorate or is sub-divisions do not produce any information, education or communication material. The Communication directorate within DoH has this mandate and other programmes like HIV&TB produce their own materials as they have funding. The HP programme relies on other programmes or non-governmental organizations for material supplies across all levels. It is important to note that there may be capacity among HP staff that was not measured or captured by the capacity assessment tool. The limitation of the tool is it could only pick up what is in the tool. There were no questions such as, what would you say you did well as HP? However, some aspects of HP successes were covered in the one-on-one interview guides. For example, good relationships and collaboration existed at the community level for facility-based health promoters.

This indicates that the HP capacity assessment tool might have been inadequately adapted to reflect the South African context. While I acknowledge failure to specifically adapt the capacity assessment tool enough for the study, the domains assessed overlapped substantively with the WHO global HP capacity-mapping tool and the international HP core competencies. These domains are as follows: leadership and HP policy development; needs assessments for planning; programme implementation; multi-sectoral collaborations; information systems; workforce skills and training; and HP financing (World Health Organization, 2010, Barry et al., 2009). Capacity sub-domains sometimes overlapped in the HP capacity assessment tool, such that the discussion of HP budgets and its allocation of

resources was covered under two different sub-domains, namely institutional systems, and plan and design domains. In some instance, some participants alluded that they had previously discussed the budget and financing issues or had nothing more to discuss on the matter. It is also critical to note that HP staff had never had an opportunity to reflect on HP before with an outsider. Therefore, it may have been easier to talk about HP frustrations and negatives than actual positives related to the programme. The research could have opened a window to complaints about HP to the researcher than what is working well. Some participants may have found it easier to talk about their limited perspectives and negative experiences. There were also limited opportunities to have outside-of-HP perspectives within the DOH. For example, only two national DoH managers were outside HP were interviewed. Active selection more participants within the DoH that know about HP, at various levels of the health system that are beyond the level of facility managers could have worked better.

7.5 Contributions of the research

My PhD research has several contributions to literature. Generally, it extends our knowledge of how HP is organized and implemented within the South African DoH. The study investigates key issues related to the health systems' health-promoting role. A number of gaps in HP literature, and health systems and policy research are addressed (*Chapter 2*). Specifically, scientific research on collective and institutional systems capacity to deliver and support HP in South Africa was missing. Information dearth existed on how structure and agency impede HP organization and implementation in the DoH; and how HP is practiced among health promoters at coalface in an era of PHC revitalization and the

introduction of CHWs in South Africa was unknown before my PhD. However, broader question remain to address HP still exist, such as what is the extent to which WHO has a role if at all in driving HP. For example, structures within WHO seem to deal with HP separately from the overall health system. *Table 21* shows a summary of the contributions of the overall thesis. The PhD makes the following contributions to scholarly literature:

- Endeavors to contribute to the discipline of integrating HP into the fabric of health systems, through its investigation of how HP is institutionalized within the South African DoH structure. Specifically, it provides essential evidence on factors that hinder health-promoting health systems based approaches and how these may be strengthened to improve institutionalization;
- Contributes to the international HP capacity mapping initiative and extends the baseline knowledge on institutional systems and collective HP capacity assessment, by providing evidence from a middle-income African setting. HP capacity assessments conducted elsewhere in the world mostly focus on collecting quantitative data. This study goes a step further, to explore the reasons behind the numeric capacity scores;
- Describes experiences of health promoters in the context of the introduction of CHWs and the tension that result between the two cadres. Additionally, it examines how these two street-level bureaucrats or policy implementers are working together on the ground, in the context of a national community-based PHC revitalization strategy. These lessons of frequent integration of cadres on the ground mean policy-makers can learn from them, and need to be fed up the health system to strengthen the institutionalization of the DoH HP programme;

- Describes barriers and dynamics that shed light on why HP is ascribed a low status and investment in the health system as well as why HP capacity is low within the system. Analyzing how structure and agency have interacted to impede the implementation and organization of an effective HP agenda within the DoH provides baseline evidence on where to mitigate; and
- Lastly, the thesis provides practical policy and practice recommendations to policy-makers, researchers and health practitioners in terms of current gaps to address in HP and health system strengthening and proposals for future research on how to strengthen health systems' health promoting role, including highlighting missed opportunities.

Table 21: Contribution of the thesis and data slicing of the three results chapters produced from the PhD dataset, Adapted (Kirkman and Chen, 2011)

	Objective I: Chapter 4	Objective II: Chapter 5	Objective III: Chapter 6
Research questions	What capacity is available to deliver and support HP programmes across levels of the DoH?	What factors hinder the organization and implementation of HP within the DoH system?	How do health promoters practice HP in the context of PHC revitalization and introduction of CHWs?
Theories/tools used	HP capacity assessment tool	Structuration theory	Organizational change model
Constructs/domains	Plan and design; implement and monitor; evaluate, scale and sustain; coordinate and institutional systems	Structure and agency	Unfreeze, change, and refreeze
Theoretical Implications	HP capacity gaps existed across all three levels of the DoH. Capacity gaps occurred in all domains assessed and were compounded by serious structural divides between national and provincial HP levels. Qualitative findings largely aligned well with the collective capacity scores in each domain, except for institutional capacity scores that suggested greater capacity with qualitative data revealing substantive barriers.	Structural constraints interact with the general limited sense of agency or power among HP staff. The result is that the discipline lacks recognition and what is understood as HP within DoH is mostly health education. HP activities are outsourced. HP staff at all levels feel demotivated due to the numerous challenges faced. In sum, HP suffers from an identity crisis, as its potential contribution in the health system is undervalued.	Facilitators and barriers to jointly working together between health promoters and CHWs exist on the ground exist. Although change processes are iterative and do not occur in clear stages, policies and other changes initiated from the top-down can lead to unfreezing of everyday practice. Change brings about some sort of discomfort and refreezing is subject to individuals and context specific factors.
Policy implications	A national strategic coordinating body needs to be established to help drive the HP programming, coordinate and control HP activities within the DoH and outside government and financially support HP activities at any level.	Establishment of an independent HP Foundation is necessary to drive the HP agenda and spearhead multi-sectoral collaboration. In order to gain agency and find its identity, strategic oversight of the HP agenda needs to be driven independently of the curative structures of the health system.	Policy-makers and HP managers need to learn from to feed experience/ tacit knowledge at PHC-level up the system, and develop new jobs descriptions that formally integrate health promoters into their PHC revitalization roles.
Practice implications	There is need to strengthen HP capacity in the system and among HP staff, for example skills building across the different levels through capacity strengthening using in-service trainings, and development of indicators that specifically focus on HP.	A skilled cadre of HP who is sufficiently resourced is required at every health system level to support other health workers and programmes, as well as facilitate multi-sectoral collaboration for HP.	HP practitioners need to provide support and oversight to CHWs and PHC outreach teams through providing up-to-date health information, jointly discussing how to assist with problems in the community; advice on patient follow-ups and household visits.

CHAPTER EIGHT

*"We currently have a system of taking care of sickness. We do not have a system for enhancing and **promoting health**."*

~ Hillary Clinton ~

8. CONCLUSION AND RECOMMENDATIONS

In this chapter, I present the conclusion drawn from the integrated components of the PhD and provide relevant recommendations from the findings of my PhD study, including their relevance to the gaps identified prior conducting the research and during the review of literature. Contributions of the research are also emphasized. The chapter describes implications for policy, practice and future research; as well as proposed next steps for advocacy for HP. A final reflection on the PhD ends the chapter and overall thesis.

8.1 Conclusion

At the beginning of this PhD, I posed the question, *how* is HP institutionalized within the South African health system? By analyzing HP programming across levels of the DoH, my PhD has shown that *'HP within the South African health system is insufficiently institutionalized'*. After examining the capacity, organization and implementation of HP, I conclude that the curative-focused structure of the DoH results in low levels of HP integration into the fabric of the health system at all levels. My PhD findings suggest that in general HP programming within the DoH is pushed to the margins.

Weak institutionalization of HP in the South African health system occurs through multi-faceted barriers, such as a narrow strategic vision for HP, which limits institutional capacity to effectively support the programme, for example inadequate finances and other resources necessary to deliver its activities. Insufficient commitment to the HP programme by those in positions of power and influence at the DoH is coupled by very limited and insufficient use of HP evidence in planning and evaluation. There are no systematic systems for generating

evidence to show whether strategic objectives are being met, or not, through monitoring and evaluation systems, which makes it difficult for policy and decision-makers to make an investment case for the programme or its activities. This is further exacerbated by limited capacity and agency among dedicated HP staff, which partly is a result of having a cadre of workers without adequate qualifications and an identity crisis where health promoters themselves do not have a clear career path. All this is happening in in the context of an institutional environment, which needs necessary structures and leadership for a health promotive agenda.

Effects of the low levels of HP institutionalization within the health system also mean that facility-based health promoters have to cope on their own with the implementation of a major PHC reform. There are no mechanisms for lessons at coalface to be fed up the system to enable policy-makers to base policies and decisions on what has worked on the ground. This may be as a result of limited levels of both collective and institutional systems capacity for HP, as well as the presence of gaps in the system to be able to adapt to change where formal processes are absent. The result of these individual and structural limitations further affect the ability of the HP programme to work multi-sectorally and be involved in collaborations with other clusters within the DoH and across other government departments and other sectors to address social determinants of health. The one exception to this is the historical role that senior HP staff played in tobacco control legislation and policy at national level.

Consequently, HP within the DoH does not adequately address population health and well-being. Based on the evidence generated through my PhD, I propose that HP be fully woven

into the fabric of the health system at all levels. Strengthening of the HP capacity, structure and practice, particularly within PHC revitalization efforts needs to be in place in order to enable a health-promoting role of the South African health system that will help achieve universal health coverage. The commitment to HP within the DoH in South Africa has not yet been adequately translated to improved capacity, organization and implementation. Without a change commitment for HP to be more central throughout the health system, it will always be a Cinderella service that loses "*the scramble for attention and resources"* to its curative service counterpart, thereby diminishing the potential for population health gains offered by effective HP programming as well as any of the recommendations proposed from this PhD thesis to be implemented.

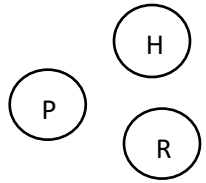
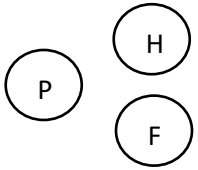
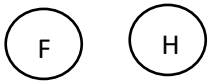
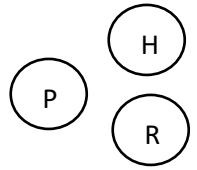
8.2 Recommendations and implications of the study for policy, practice and research

The quadruple burden of diseases faced by South Africa and high levels of health inequalities demonstrate that it is necessary for HP approaches to be integrated within the health system and become a national priority. Given the country's National Health Insurance context, policy and decision-makers have to open up to the vision and promises offered by a health-promoting health system as envisioned by the PhD. Findings from this research suggest a number of significant recommendations for the field of HP and health system strengthening in South Africa. However, it is important to note that while change in any system may be necessary, it may bring discomfort. Therefore, while changes proposed by this PhD may need to be made, their implementation has to be gradual in the health system and be based on specific needs and contextual conditions of the country and/ or province or district (Ndjepel et al., 2014). Recommendations from the study are informed by study

findings, some unresolved questions using some of the gaps identified during the literature review that was conducted (*Chapter 2*) as a foundation to build on. *Table 22* summarises these recommendations as well as the proposed role players needed to take responsibility of the various actions, namely policy and decision-makers, facility managers, HP practitioners and/or researchers. More details on the recommendations and implications of the study are discussed in the sections below.

Table 22: Recommendations from the PhD study, Adapted (Hatcher, 2017)

Gaps at the beginning of PhD	PhD study key findings	Immediate recommendations	Long-term recommendations	Target audience for proposed action KEY: - Policy-makers (P) - Facility managers (F) - HP practitioners (H) - Researchers (R)
1. Factors that help explain why HP is not on the agenda	Curative-focused health system	An integrated model, having HP cadres in every cluster at DoH who report to the HP directorate, versus a vertical structures, which currently exist and every health worker to provide HP	Establish an entity to think strategically, drive and facilitate integration of HP in the health system and across other sectors as well as influence HP in a way that enables health wins	P
	Limited HP strategic vision/current DoH structure undermines HP	The capacity of the national HP directorate needs to be strengthened, such that they may begin providing leadership and functioning at a strategic planning level for the profession	Set HP up at a level equivalent to a cluster to be able to work effectively at national level. Currently, it looks like a local-level issue	P
	Limited of HP specific budgets	Allocation of funds and resources on the budget towards HP activities that are not later re-directed to somewhere else, usually curative	Collection of hypothecated tax for HP activities through a HP Foundation or an entity that represents one	P F
	Lack of evidence based HP practice	Consultations with HP experts to assist the HP directorate to develop HP indicators that are able to measure performance including the understanding of choice of indicators and their future role	Collating of HP specific indicators within in the district health information system, that will be interpreted by HP practitioners and used to inform practice	P H R

2. Limited scholarly literature on capacities available to deliver and support HP in LMICs	Limited organizational HP capacity and opportunities to reflect on practice	Future HP capacity assessments need to focus on assessing capacity at individual level	Systematically running of capacity assessment workshops to monitor HP progress and strengthen practice	
3. Rationale for advancing the recognition of the need for the dedicated HP workforce	Inadequate HP training and limited qualifications	In-service training of current HP practitioners to up-skill them	Development or adoption of the international core competencies for HP used to train the HP workforce in other countries and guide practice	
	Lack of HP professional accreditation	Advocacy for HP training and accreditation of the profession	Accreditation of full HP courses and registration with a professional body	
	Insufficient motivation among HP practitioners	Advancing recognition of work done by HP staff within the DoH	Creation of a career path in the profession	
	Community-based role of health promoters and in PHC reform strategies	HP practitioners should be liberators were they act as community activists, doing needs assessments and changing ways in which communities operate for the benefits of health	Skilled HP practitioners who are able to identify determinants of health factors, health inequalities and effectively use evidence to help inform what works	
4. Progress towards addressing determinants of health and Health in All Policies	Inadequate co-ordination and multi-sectoral collaborations for HP	HP staff need to take a leading role in creating and sustaining collaborations at all levels of the system and across various sectors	If a HP Foundation is established it can take over the role of HP coordination across the different levels of government and sectors	

8.2.1 Implications for policy

Based on the findings from my PhD, it is particularly evident that there is need to strengthen investment in HP within the DoH. Decision-makers should consider, through policies mainstreaming HP within the health system in South Africa, as well as instituting ways of driving an effective HP agenda and addressing determinants of heath. This may be achieved through means of an independent HP and Development Foundation (Perez et al., 2013, Munodawafa, 2011). This will enable South Africa to align itself with the call for HP technical bodies that can provide expert input, mechanisms for local community input and dedicated research and training infrastructure for HP (European Commission, 2019). Experiences from other countries show how governments establish HP Foundations for the primary purpose of promoting health (Bayarsaikhan, 2008, Bayarsaikhan and Nakamura, 2015, Prakongsai et al., 2007, Tangcharoensathien et al., 2008, Schang et al., 2012, Mouy and Barr, 2006). As highlighted throughout the thesis, policy-makers in South Africa need to consider introducing a HP Foundation as advocated by external civil society groups in the country (Perez et al., 2013). If established the Foundation could be responsible for ensuring strategic HP planning across all levels of the DoH, other government departments, sectors and among non-governmental organizations. This will include coordination of HP activities in the country and multi-sectoral collaborations for HP, HP capacity strengthening, development of HP specific indicators as well as a monitoring and evaluation system, research to generate systematic evidence for HP practice, and sustainable HP budgeting (Perez et al., 2013, Munodawafa, 2011).

I recommend several options that the government may consider in institutionalizing HP into the fabric of the health system if an independent HP Foundation is put in place. One of the possible options includes re-structuring the HP directorate at the national DoH, given that there is inadequate leadership for HP and limited multi-sectoral collaboration capacity at that level (Rwafa-Ponela et al., 2020a, Rwafa-Ponela et al., nd). In this model, dedicated HP personnel will be required to be present in each cluster at national DoH (e.g. communicable diseases, non-communicable diseases, HIV&TB). The HP Foundation will then guide implementation of HP activities within the DoH, with HP practitioners in each cluster managing the programme and reporting to the Foundation. However, in this model the HP structure as district level will need to be maintained, as they are the implementers of HP at PHC level and therefore should be responsible for micro planning of HP and tailoring activities based on local needs. The HP Foundation would need to engage/assist health promoters on the ground to be able to work more effectively through provision of ongoing capacity strengthening initiatives, support and strategic oversight, as well as enable HP learning on the ground be fed up the system through research and establishment of HP indicator tracking and set-up of systematic feedback systems and running of regular workshops. The HP Foundation will also be responsible for driving the HP agenda in other government departments, sectors among non-governmental organizations, whom in turn will too interact with district HP to strengthen implementation and reduce duplication of HP activities in the communities.

Another option I suggest would be to maintain the national HP directorate as it is currently. However, the current DoH HP model favours parallel implementation of HP activities,

particularly at the national level (Rwafa-Ponela et al., nd). In this context, the independent HP Foundation would need to make sure that HP activities are not implemented in silos, but integrated in the system including those within the DoH and outside it through establishing and maintaining multi-sectoral collaborations. It is also important to note that in the context of the implementation of the National Health Insurance, provincial HP may disappear together with other provincial structures, as they are proposals for a health technology assessment (HTA) system. This would be used to inform policy and decision-making processes in setting priorities within the health system, and this would include HP programming within the DoH (Department of Health, 2017c, World Health Organization, 2015). Therefore, if with a decision is made to establish a HP Foundation in South Africa, there would be a need to consider theoretical concepts vs. practice, particularly around the availability of sustainable HP funds from Treasury (Mouy and Barr, 2006). If an independent HP and Development Foundation does not materialize, as the issue has been under political debate for nearly a decade (Perez et al., 2013, Health Promotion and Development Foundation, 2018). HP programming within the DoH and outside could be financed directly under the National Health Insurance fund, like its curative counterpart (Department of Health, 2019, Freeman et al., 2020). This would involve having a specific HP budget for all levels and sectors. However, it is important to acknowledge that some challenges in the South African health system are generic, for example, institutional barriers to HP organization and implementation, such as budgets are not unique to HP alone.

8.2.2 Implications for practice

HP is about changing people's behaviours so they feel positioned to change their health. Based on findings from my thesis including activities that health promoters do well, such as support groups and building trust with community members (Rwafa-Ponela et al., 2020b). Further critical questions to ask include that have health promoters been groomed or trained differently such that they are more approachable by community than clinical staff, as nurses may be more judgemental. This characteristic of health promoters may need to be strengthened through routine in-service training and be considered in the future training of HP professionals. HP practitioners should also consider strengthening parts of their practice that are well-conducted to maintain relevance and increase their visibility and recognition in the health system, for example provision of support to CHWs at PHC level. There may be need to re-think the small group approaches currently used in the delivery of HP activities at local levels, as well as the high focus on health education sessions in clinics and communities, to population based HP activities that target larger of people groups and creation of supportive environments that enable positive health behaviour (*Section 7.2.2*). This would involve training cadres of HP professional that are a level higher than CHWs. Additionally health promoters have a longer record of accomplishment in the community, have been there longer in the system or do not have as many expectations as CHWs do (Rwafa-Ponela et al., 2020b).

Going forward, policy and decision-makers need to also consider lack of formal training and accreditation of HP staff as a major factor that drives lack of capacity to deliver effective HP programming within the DoH and limited agency among practitioners (Rwafa-Ponela et al.,

2020a). In *Chapter 5*, I learnt that inadequate training of HP staff, leads to lack of recognition and credibility of the profession by other health workers including those in positions of power like senior and facility managers within the DoH (Rwafa-Ponela et al., nd). In this regard, processes for future training and accreditation HP professionals need to be put in place by the national HP directorate and the DoH in consultation with academia. This could be done by borrowing and adapting guidelines of practice from the already defined international core competencies for HP (Barry et al., 2009, Dempsey et al., 2011, International Union for Health Promotion and Education, 2016), and tailoring make them to be context-specific to South Africa. As described earlier, in training HP professionals there would be need to make sure that, health promoters are different from CHWs. Meanwhile, HP practitioners currently in the system without proper HP training and qualifications could be up-skilled through in-service training and routinely conducting capacity assessments to help monitor progress for set HP goals and targets (Lê et al., 2014). Additionally, policy-makers need to learn from experiences on the ground, formally up-date job descriptions of HP staff, particularly facility-based health promoters to reflect their roles with CHWs/ ward-based outreach teams and the school health programme. In this context, health promoters seem relevant and need to be maintained in the system to help achieve PHC revitalization goals and efforts to improve health system performance.

Another important question to ask is does the HP discipline need a strategic level at national DoH? In my view, it does so that HP does not fall on the wayside. HP is not functioning at a strategic position. However, if the HP directorate is maintained there is need to strengthen

their strategic role in the system through in-service training as well and routine capacity strengthening workshops. There seem to be insufficient evolution of HP over time within the DoH, for example, an inadequately trained HP workforce is historical, as well as constrained roles. In this context, some people may ask if it is justified to maintain health promoters and their leaders in the different kinds of meanings they currently hold and not uniform structures. Lack of distributed leadership was evident throughout the thesis. Instead of having a shared or collective agency and capacity to change and improve the status of the programme within DoH, HP practitioners are too busy looking up and elsewhere for solutions. Findings also showed lack of reflective learning, as there is no data to change perceptions held about the HP programme within DoH as well as an identity crisis (Rwafa-Ponela et al., nd). Job descriptions of what HP practitioners are expected to do at each level need to change, given the PHC revitalization context and training needs to be specific for the level of position held in the system (Rwafa-Ponela et al., 2020b). While the HP within the DoH seems to face similar challenges to other health systems, like budgets (Rwafa-Ponela et al., nd, Rwafa-Ponela et al., 2020b), HP practitioners and its leadership need to think about strengthening organization and implementation of its activities. This includes making the programme visible at all levels through generation of a HP evidence-base on impact of activities as well as systematic reporting, monitoring and evaluation of the activities. One potential challenge to implementation of these activities is the lack of capacity about HP staff (Rwafa-Ponela et al., 2020a). HP practitioners may need to be trained in developing HP indicators, how to systematically collect data as well as interpretation of that data and use in strategic planning.

8.2.3 Methodological considerations and tips for future research

My PhD has raised many critical questions that require further investigation. For example, research is needed to determine the effectiveness of the DoH HP programme, the relationship between the South African HP policy and practice, as well as broader investigations of the causes of a limited vision for HP in the African region or among other LMICs. Limitations described in *Section 7.4*, in the discussion chapter may be also be addressed in future research studies to strengthen HP capacity, organization and implementation particularly within the context of health systems strengthening. Future studies in this area need to consider the following specific methodological tips:

- *Inclusion of other participant groups*: Future research should take into account views of CHWs, ward-based outreach team leaders as well as community members and other cluster managers. These potential participants were not part of this study and could enrich future HP studies, as well as health systems and policy research in the area.
- *Employing other data collection methods*: future researchers may need to conduct focus group discussions, with (a) health promoters, (b) facility managers, (c) sub-district HP managers, (d) district HP managers, (e) provincial HP managers, and (f) national HP directorate staff to yield a richer in-depth understanding of perceptions about HP programming and its staff in the South African context. Observations or ethnographic approaches, particularly of facility-based health promoters as well as use of reflective diaries among participants to assist in capturing more in-depth information of what they do on a day-to-day basis to help fully conceptualize the role of HP staff within the health system, as well as their demographic profiles.

- *Capacity assessments*: Future studies on HP capacity assessments need to focus on assessing capacity at individual level. As previously, stated, capacity workshops could be used as a way to account for HP support and delivery within the DoH and for HP practitioners and their managers to reflect on the programme and its activities as an on-going process. If these exercises are conducted systematically, it will allow strengthened monitoring of HP progress in the country.

8.2.4 Other remarks

In light of findings from this study, HP advocates should consider the necessity of advocating for the full integration of HP within the South African health system. HP practitioners and other stakeholders, namely researchers need to advance the recognition of the need for a dedicated HP workforce, particularly within the DoH structures. This can be through continued research, reflective learning and building a sustainable HP evidence-base of what works for the programme in the country to increase political buy-in and strengthen institutionalization of HP capacity, organization and implementation in the health system.

8.3 Final reflection on the thesis

My PhD study is relevant to the field of HP and health systems and policy research, as both elements are vital for health systems strengthening and achieving improved health gains (World Health Organization, 2012, European Commission, 2019). It contributes to the empirical evidence that is limited in South Africa and limited among LMICs. The study sheds light on that

important factors policy and decision-makers, practitioners and researchers need to concentrate on to influence reframing, repositioning and renewing efforts of strengthening the health promoting role of the health system (Wise and Nutbeam, 2007). In my view, findings from this study could be considered transferable to other districts, provinces or countries that have similar socio-economic backgrounds, structures, HP workforce cadres and experiences. The study has important implications for other parts of South Africa with similar levels of HP capacity, structural and agency barriers to the institutionalization of HP, as well as the enablers of collaboration between health promoters and CHWs in PHC revitalization. This information is essential in making forging a way forward for the integration of HP within the South African health system. Therefore, it shows that we need to change the way we have been traditionally approaching health in our societies and health systems.

THESIS

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APPENDICES

10. APPENDICES

10.1 APPENDIX A: ETHICS APPROVAL CERTIFICATE

R14/49 Teural Rwafa

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170634

NAME: (Principal Investigator)	Teural Rwafa
DEPARTMENT:	School of Public Health Carltonville, Leratong and Sterfontein Hospitals
PROJECT TITLE:	Health Promotion: A Critical Analysis of how its Policy, Structure and Practice is Institutionalized within Different Levels of the South African Health System
DATE CONSIDERED:	30/06/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Prof J. Goudge, Prof J. Eyles and Prof N. Christofides
APPROVED BY:	Professor P. Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	06/12/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd floor, Phillip Tobias Building, Parktown; University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit to the Committee. I agree to submit a yearly progress report. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially review June and will therefore be due to the month of June each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature — Date: 07/12/2017

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

10.2 APPENDIX B: NDOH PERMISSION TO CONDUCT RESEARCH

DIRECTOR GENERAL
HEALTH
REPUBLIC OF SOUTH AFRICA

PRETORIA
Private Bag X828, PRETORIA, 0001. 27th Floor, Room 2710, Civitas Building, Cnr Thabo Sehume & Struben Street, PRETORIA, 0001 Tel: 012 395 8090, Fax: 012 395 8422
CAPE TOWN
P.O. Box 3645, CAPE TOWN, 8000, 8th Floor, Room 817, 103 Parliament Towers, Plein Street, CAPE TOWN, 8000 Tel: 021 461 2040, Fax: 021 461 8864

Ms Teurai Rwafa
The Centre for Health Policy
University of the Witwatersrand
3Floor New School of Public Health Building
27 St Andrews Road
PARKTOWN
2193

Dear Ms Rwafa

PERMISSION TO CONDUCT RESEARCH WITHIN THE DIRECTORATE: HEALTH PROMOTION IN THE NATIONAL DEPARTMENT OF HEALTH

The National Department of Health (NDoH) acknowledges receipt of a request for approval to conduct a study on "Health Promotion: A Critical Analysis of How Policy, Structure and Practice is Institutionalised within different Levels of the South African Health System" at the NDoH dated 16 August 2017.

In response to your request to conduct capacity assessments and in-depth interview of Health Promotion Managers at the NDoH, permission is provisionally granted. Approval is granted on conditions that the:

- Research Ethics Committee approval/ Research Ethics Clearance Certificate is submitted to the NDoH before the commencement of the study;
- Permission to present or publish findings of the study is sought with the NDoH first.

Submission and presentation of the final report of the study with recommendations to the NDoH is also required, as feedback.

Yours sincerely

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH
DATE:08/9/2017

10.3 APPENDIX C: PERMISSION TO CONDUCT RESEARCH (1)

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel : +27 (13) 766 3429, Fax: +27 (13) 766 3408

Lilko Latempilo | Departement van Gesondheid | UmNyango WezeMpilo

Enquiries, Research (013) 766 3511/3429/3408

Ms Teurai Rwafa
NO. 16 ROYAL PALMS COMPLEX
Johannesburg
2194

Dear Ms Rwafa

APPLICATION FOR RESEARCH APPROVAL: HEALTH PROMOTION: A CRITICAL ANALYSIS OF HOW ITS POLICY, STRUCTURE AND PRACTICE IS INSTITUTIONALIZED WITHIN DIFFERENT LEVELS OF THE SOUTH AFRICAN HEALTH SYSTEM

The Provincial Health Research Committee has approved your research proposal in the latest format that you sent.

PHREC REF: MP_2017RP58_148
Approval Valid for 1 Year
Data Collection Period: October 2017-February 2018
Approved Facilities: Provincial Health Promotion Personnel

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

MS TZ MADONSELA
MPUMALANGA PHRC

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
PLANNING & INFORMATION
2017 -10- 23
PRIVATE BAG X 11286
NELSPRUIT 1200

2017/10/23
DATE

MPUMALANGA
THE PEACE OF THE RISING SUN

10.4 APPENDIX D: PERMISSION TO CONDUCT RESEARCH (2)

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (PI)	Prof Jane Goudge, Prof Nicola Christofides & Prof John Eyles
Organization / Institution	Wits
Research Title	Health Promotion: A critical analysis of how its policy, structure and practice is institutionalized within different levels of the South African health system.
Contact number	Contact no: 0117173425 – 0117172566 & 0117172200 Cell: 0836160041 - 0827748547 & 0798382094 Email : jane.goudge@wits.ac.za - nicola.christofides@wits.ac.za & john.eyles@wits.ac.za
Protocol number	GP_2017RP0_70
Sites	Carltonville, Leratong & Sterkfontein Hospitals – GDoH Offices

Your application to conduct the abovementioned research has been reviewed by the Province and permission has been granted.

We request that you submit a report after completion of your study and present your findings to the Gauteng Health Department.

☒ Permission granted

☐ Permission denied

Dr Bridget Kalafeng
On behalf of PHRC
Date: 29/11/2017

10.5 APPENDIX E: PERMISSION TO CONDUCT RESEARCH (3)

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr Shaikh G K
Tel: 0828571925
Fax: 0866004183

GP_2017RPO_70
Tueral Rwafa

RE: PERMISSION TO CONDUCT RESEARCH IN WEST RAND DISTRICT.

Your correspondence on the above matter refers.
Thank you for your request to conduct research in West Rand District in conducting a critical analysis of health promotion, within different levels of South African Health System.

Permission is hereby granted to you to conduct research in PHC clinics in West Rand. I am anticpating that you will conduct your research with the knowledge of all relevant Managers in respective clinic and Sub-district.

You are expected to share the findings and recommendations with the district in order to improve service delivery to people of west rand.

I hope you find the above in order.

Yours faithfully,

MS PULENG MUSO
DIRECTOR
WRDCA
DATE: 14·09·2017

10.6 APPENDIX F: PARTICIPANT INFORMATION SHEET

PARTICIPANT INFORMATION LEAFLET

To be completed by health promotion practitioners, managers and external stakeholders

TITLE OF THE RESEARCH PROJECT*: Health Promotion: A critical analysis of how its policy, structure, and practice is institutionalized within different levels of the South African health system.*

HREC REFERENCE NUMBER: ___M170654_____

PRINCIPAL INVESTIGATOR: Ms. Teurai Rwafa

ADDRESS: Centre for Health Policy, School of Public Health, University of the Witwatersrand,
27 St. Andrews Road, Parktown (Education Campus), Johannesburg, South Africa

CONTACTS:
(+27) 11 717-2236 || 074 963 7019
teurai.rwafa@wits.ac.za || rwafateurai@gmail.com

Dear Colleague,

My name is **Teurai Rwafa**. I would like to invite you to participate in a research project that aims to examine how HP policy, structure, and practice are institutionalized within different levels of the South African health system.

Please take some time to read the information presented here, which will explain the details of this project. Please ask the research staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. In addition, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. If you agree to be interviewed, please note that you are free to withdraw from the interview at any stage, even if you have agreed to take part.

This study has been approved by the Health Research Ethics Committee at the University of the Witwatersrand and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- This research project aims to provide answers to the question: how are health promotion policy, infrastructure, capacity and practice institutionalized in the South African health system. The research will be submitted as scientific papers to peer-reviewed journals and will contribute to a PhD degree.
- Since the inaugural introduction of health promotion in 1986 (Ottawa Charter) in public health, there are questions regarding how health promotion policy, infrastructure and practice are organized and implemented, especially in African countries. This study aims to partly address these questions (funded by the NRF's South African Research Chair initiative (SARChi) for Health Systems and Policy at the Wits Centre for Health Policy (CHP). The research consists of **four** complementing research activities:

1. A policy implementation evaluation of the National Health Promotion Policy and Strategy (2015-2019), including identifying enablers and barriers to implementation and at national and provincial level, particularly using the school health and tobacco control programmes as tracers.

2. A cross-sectional survey to examine how health promotion infrastructure is organized and different health system levels and carrying out health promotion capacity assessments of ability to implement health promotion among HP staff.

3. A case study of two districts to obtain in-depth information on how HP is practiced, especially in the context of PHC-reengineering.

4. A policy agenda setting analysis with respect to a group of stakeholders, called the Health Promotion and Development Network (HPDNet) advocating for the establishment of a Health Promotion and Development Foundation (HPDF) in SA. Therefore, exploring perceptions of the potential role of a HPF in SA in terms of its advocacy and strategic oversight among civil society.

Why have you been invited to participate?

- You have been invited because of your employment at the Department of Health or in Health Promotion and your identified influence or your role in health promotion in South Africa.

What will the study entail?

- Health promotion practitioners, managers, decision makers and external health promotion stakeholders from civil society are invited to be interviewed. You will be interviewed by a member of the research team. The interview will take approximately 30-60 minutes.
- The interview and/or workshop will be audio-recorded with **your permission** to do so.

- Please note that the interview and/or workshop are not a performance appraisal of you as an individual.

Will you benefit from taking part in this research?

- There will be no financial gain from participating in this research.
- This research may offer benefit to the future of the health promotion role of the health system and the discipline thereof in South Africa.
- The combined findings of the project will carry a greater weight and offer more scientific and social value.

Are there in risks involved in your taking part in this research?

- There are no risks to you in this study but the interview will require some of your time.

If you do not agree to take part, what alternatives do you have?

- Participation is completely voluntary and your choice to participate or not will be respected by the research team.

Who will have access to your questionnaire results?

- The information collected will be treated as confidential and protected. When used in an aggregated report, publish articles or project report, the identity of each participant will remain anonymous. Only the research team will have access to the transcribed interviews and questionnaires, and study codes will be allocated to each participant to preserve anonymity during the data entry and analysis.

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

- No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact Teurai Rwafa on ***(Cell. 074 963 7019)*** if you have any further queries or encounter any problems.
- You can contact the Wits Human Research Ethics Committee **(011 717 2700/2656)**, if you have any concerns or complaints that have not been adequately addressed by your study doctor.
- You will receive a copy of this information and consent forms for your own records.

***Participant ID*_____**

Are you willing to participate in the study (interview and/ or workshop)?

Yes No

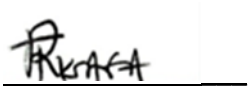
Do you agree to audio recording of the interview/workshop?

Yes No

Do you have any questions about the interview/workshop?

If you are willing to participate in this study, please sign the attached Declaration of Consent and hand it to the investigator.

Yours sincerely



Teurai Rwafa, MPH
Principal Investigator

10.7 APPENDIX G: PARTICIPANT INTERVIEW CONSENT FORM

Participant ID _____ Date _____

Designation: _____

PARTICIPANT INTERVIEW CONSENT FORM

To be completed by health promotion practitioners, managers and external stakeholders

Declaration by participant

By signing this form, I ……..……..agree to take part in this interview for the research study entitled: **Health Promotion: A critical analysis of how its policy, structure, and practice is institutionalized within different levels of the South African health system**.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this interview for the study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the interview at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the interview before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*)…… On (*date*) ……

…… **……**

Signature of participant Signature of witness

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document to ……
- 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

Signed at (*place*)…….. On (*date*) ……..

…… **……**

Signature of investigator Signature of witness

10.8 APPENDIX H: WORKSHOP PARTICIPATION CONSENT FORM

Participant ID_____

PARTICIPANT WORKSHOP CONSENT FORM
To be completed by health promotion practitioners and managers

The health promotion capacity assessment tool (HP CAT) in form of a workshop facilitated by the principal investigator. The capacity tool is divided into four domains (each with sub-domains). A group of 3-8 participants representing each level (national, province or district) will discuss each question to reach consensus. The consensus scores will be completed on the HP CAT. The workshop discussions will be audio-recorded allowing for further rich qualitative data to be collected and analysed for the study.

Declaration by participant

By signing this form, I ……..agree to take part in this workshop for the research study entitled: **Health Promotion: A critical analysis of how its policy, structure, and practice is institutionalized within different levels of the South African health system.**

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this workshop for the study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the workshop at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the workshop before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... On (*date*) ……..

…… **……**

Signature of participant Signature of witness

10.9 APPENDIX I: INTERVIEW RECORDING CONSENT FORM

Participant ID _____ Date _____

Designation: _____

INTERVIEW RECORDING CONSENT FORM

To be completed by health promotion practitioners, managers and external stakeholders

Declaration by participant

By signing this form, I ……..……..am allowing the researcher to audio record the interview proceedings as part of this research study entitled: **Health Promotion: A critical analysis of how its policy, structure, and practice is institutionalized within different levels of the South African health system.**

I declare that:

- I understand that taking part in this study involves audio recording of the interview with the researcher/her team.
- Neither my name nor any other identifying information will be associated with the audio/ audio recording or transcript.
- The audio file will be transcribed by the researcher and erased once the transcriptions are checked for completeness.
- I understand that transcripts of the interview may be reproduced in whole or part for use in PowerPoints or written products that may result from this study.
- Neither my name nor identifying information (such as voice) will be used in presentations or in written products resulting from the study.

Signed at (*place*)…… On (*date*)……

…… **……**

Signature of participant Signature of witness

10.10 APPENDIX J: WORKSHOP RECORDING CONSENT FORM

Participant ID |__|__|__| Date |__|__|__| Interviewer Case no. |__|__|__|

Designation: _____

WORKSHOP RECORDING CONSENT FORM

To be completed by health promotion practitioners, managers and external stakeholders

Declaration by participant

By signing this form, I ……..am allowing the researcher to audio record the workshop proceedings as part of this research study entitled: **Health Promotion: A critical analysis of how its policy, structure, and practice is institutionalized within different levels of the South African health system.**

I declare that:

- I understand that taking part in this study involves audio recording of the workshop with the researcher and her team.
- Neither my name nor any other identifying information will be associated with the audio/ audio recording or transcript.
- The audio file will be transcribed by the researcher and erased once the transcriptions are checked for completeness.
- I understand that transcripts of the workshop may be reproduced in whole or part for use in PowerPoints or written products that may result from this study.
- Neither my name nor identifying information (such as voice) will be used in presentations or in written products resulting from the study.

Signed at (*place*) ..... On (*date*) ……..

…… **……**

Signature of participant Signature of witness

10.11 APPENDIX K: PARTICIPANT DEMOGRAPHICS FORM

Participant ID_____

PARTICIPANT SOCIO-DEMOGRAPHICS FORM

AGE GROUP

< 25	☐
25 – 34	☐
35 – 44	☐
45 – 54	☐
55 +	☐

SEX

Female	☐
Male	☐

RACE

Black	☐
White	☐
Indian	☐
Coloured	☐
Other Specify	_____

MARITAL STATUS

Single	☐
Widowed	☐
Separated/Divorced	☐
Married	☐
Other Specify	_____

HIGHEST EDUCATION		**SPECIFY QUALIFICATION**
None	☐	
Some Primary	☐	
Some Secondary	☐	
Matric	☐	
Certificate	☐	_____
Diploma	☐	_____

Bachelor Degree ☐ _____
Post Graduate ☐ _____

JOB LOCATION

National ☐
Province ☐
District ☐
Sub-district ☐
PHC/Facility ☐

JOB TITLE

Health Promoter ☐
HP Practitioner ☐
HP Coordinator ☐
HP Liaison Officer ☐
Other Specify _____

JOB/ SALARY LEVEL _____

YEARS WORKED AT CURRENT JOB LOCATION

Less than 1 year ☐
1-2 years ☐
3-4 years ☐
5-6 years ☐
More than 6 years ☐

YEARS WORKED AS CURRENT JOB TITLE

Less than 1 year ☐
1-2 years ☐
3-4 years ☐
5-6 years ☐
More than 6 years ☐

PREVIOUS JOB TITLE BEFORE CURRENT

None ☐
CHW/Care giver ☐
HIV Counsellor ☐
HP manager ☐
Other Specify _____

10.12 APPENDIX L: HEALTH PROMOTION PRACTICTIONERS' INTERVIEW GUIDE

Participant ID_____

Health Promotion Practitioners' Interview Guide

1. Pre-questions

Before we get started, I would like to understand your position at this organization **(name)**? *[Probe: What is your title? How long have you worked in this position?]*

2. Introductory questions

- Tell me about your role within HP at the DoH? [*Probe: What is your position, how long have you worked in this position?*]
- How is HP implemented within the DoH? [*Probe: How is HP organised at different levels of the DoH (NDoH, PDoH, DHO, Sub-district & facility)? How does HP sit in the DoH structure?]*
- Tell me about the positioning of HP within the DoH and how this influences its implementation?
- How has HP evolved over the time you have been in your position, if at all? *[Probe: DoH/G?]*

3. Health Promotion policy

- Can you please describe what the overall vision/goal is for HP in the DoH? *[Probe: What key strategies are in place to achieve this vision/goal?] Who do you collaborate with, in order to achieve the HP vision, if anyone at all? How is the collaboration done/achieved?]*
- What can you tell me about the National HP Policy and Strategy (2015-2019)?
- What has been your experience of the implementation of the National HP Policy and Strategy (2015-2019) so far? *[Probe: What have been key achievements/ has worked well, and why? What have been shortcomings in the implementation and why? What needs to happen, which is not happening in terms of policy implementation?*

4. Resource Allocation (CA)

- How is the budget allocated for HP, at the different levels of government (NDoH, PDoH, district, sub-district and facility)?
- What is your assessment of health promotion financing in the last decade? *[Probe: N/P/D?]*

5. **Successes**

- Can you describe to me what have been the successes in HP*? [Probe: What influenced successes?]*

6. Challenges

- What are the challenges facing HP at different levels (NDoH, PDoH, DHO, sub-district and facility)? *[Probe: What has led to these challenges?]*

7. PHC re-engineering and the role of HP

- How do health promoters work with other community health care workers, if at all? [*Probe: EHOs, school health nurse, community liaison officer, mobile clinic units etc.]*
- What is the role of HP in PHC-reengineering? *[Probe: What is the role of health promoters in PHC re-engineering?] What is the role of HP in relation to ward based outreach teams? How do health promoters work/engage with WBOTs/CHWs, if at all? What is the role of health promoters in WBOTs, if at all? How are you supposed to engage with WBOTs/CHWs if not engaging? How do you think HP as a field is contributing to PHC re-engineering in South Africa?]*
- How do you see the future of HP in the context of PHC re-engineering?
- What is the role of HP in the context of District Health Specialist Teams, if at all?
- What is the role of HP in relation to the School Health Programme? *[Probe: What is the role of health promoters in School-based Support Teams (SBST), if at all? How are health promoters supposed to engage with other members of the SBST if not engaging?]*

8. Tobacco Control and the School Health Programmes

- Tell me about the national priority HP programmes that you currently working on?
- Tell me specifically about any School Health Programme (SHP) activities happening at national level? *[Probe: Who do you work/partner with on SHP at national level, if at all?] Can you describe to be the roles of provinces and districts in the SHP?*
- Tell me specifically about any Tobacco Control Programme (TCP) activities happening at *national level? [Probe: Whom do you work/partner with on TCP, if at all?] Can you describe to be the roles of provinces and districts in the TCP?*

9. Closing questions:

- How do you think HP as a field is contributing to PHC re-engineering in South Africa?
- If you had the freedom to determine the role/structure of a HP in SA, what would it be? *[Probe: What is it about those ideas/directions that is important?*
- What do you think is the future of HP in South Africa *[Probe: Department of Health]?* ***PHILA???***

10. Comments

- Do you have any additional points that you would like to add that have not been covered?
- We have come to the end of the interview!!! ***Thank you for your time!!!***

10.13 APPENDIX M: FACILITY MANAGER INTERVIEW GUIDE

Participant ID_____

Facility Manager/Nurse in Charge Interview Guide

1. Pre-questions:

Before we get started, I would like to understand your position at this organization (name)? *[Probe: What is your title? How long have you worked in this position?]*

2. Introductory questions:

- Tell me about the role of HP at the facility level? *[Probe: What is your position, how long have you worked in this position, what did you do previously, if at all?]*
- How is HP implemented? *[Probe: What is the role of health promoters within the facility/community?]*
- Tell me about how HP is organised within the DoH)? *[Probe: How does HP sit in the DoH structure? At this facility?]*
- How has HP evolved over the time you have been in your position, if at all?

3. Resource Allocation:

- What resources are available for the functioning of health promoters in facilities? [*Probe: How are health promoters supervised, mentored and trained? What are the reporting structures?]*
- Can you describe to me, where health promoters are located in a facility *[Probe: sitting space]?*

4. PHC re-engineering and the role of HP

- What is the role of HP in PHC-reengineering? *[Probe: What is the role of health promoters?]*
- How do health promoters work with other community health care workers, if at all? *[Probe: CHWs, EHOs, school health nurse, community liaison officer, mobile clinic units etc.]*
- What is the role of HP in relation to ward based outreach teams? *[Probe: How do health promoters work/engage with WBOTs/CHWs, if at all? What the role of health promoters in WBOTs, if at all? How are health promoters supposed to engage with WBOTs/CHWs if not engaging?]*
- What is the role of HP in relation to the School Health Programme? *[Probe: How do health promoters work/engage with School-based Support Teams (SBST), if at all? What is the role of health promoters in the SBSTs, if at all? How are health promoters supposed to engage with other members of the SBST if not engaging?]*
- What is the role of HP in the context of District Health Specialist Teams, if at all?

5. Successes

- What have been the successes of HP in the facility/community? *[Probe: What has influenced these successes?]*

6. Challenges

- What are the challenges faced by health promoters facility/community? [*Probe: what has led to these challenges?]*

7. Comments

- What do you think is the future of HP in South Africa? *[Probe: with the DoH?]*
- If you had the freedom to change, what would you change about the way HP is currently structured? *[Probe: Why?]*
- Do you have any additional points that you would like to add that have not been covered?
- We have come to the end of the interview.

Thank you for your time!!!

10.14 APPENDIX N: KEY INFORMANT INTERVIEW GUIDE

Participant ID_____

Key Stakeholder Interview Guide

1. Pre-questions:

Before we get started, I would like to understand your position at this organization **(name)**? *[Probe: What is your title? How long have you worked in this position?]*

2. Introductory questions:

- Tell me about how you see the role of health promotion (HP) within the Department of Health (DoH)?
- Tell me about the positioning of HP within the DoH and how this influences its implementation? *[Probe: How does the way HP is structured help or hinder its role? From what has emerged in other interviews it seems that HP activities often are led by programmes e.g. the recent listeriosis outbreak, CDC led HP activities and it is similar for other programmes – why do you think this happens?]*
- How is HP implemented within the DoH? *[Probe: How is HP organised at different levels of the DoH (NDoH, PDoH, DHO, Sub-district & facility)?*
- If you think about the South African landscape, how has HP evolved over the past 10 years, if at all?
- What do you think the priorities for HP should be in the Department of Health?

3. Successes

- What in your opinion would you say are the successes for HP in SA? *[Probe: What has influenced these successes? Within DoH/Outside DoH]*

4. Challenges

- What are the challenges facing HP at different levels (NDoH, PDoH, DHO, sub-district and facility)? *[Probe: what has led to these challenges?]*

5. Health Promotion Foundation (HPF) policy agenda setting

There have been steps taken to establish a Health Promotion Foundation (HPF) in South Africa.

- What is your view of a Health Promotion Foundation? *[Probe: What could be the role of a Health Promotion Foundation should one be established]?*
- How could it contribute to setting the agenda for HP in SA, if at all?
- What would the role be of a HPF/National Health Commission? [*Probe: What will be its functions?]*
- How do you envision resource allocation for HP if a HPF is in place?

6. Health Promotion policy

- Can you please describe what the overall vision/goal is for HP in the DoH/GP? *[Probe: What key strategies are in place to achieve this vision/goal?] Who do you collaborate with, in order to achieve the HP vision, if anyone at all? How is the collaboration done/achieved?]*
- What has been your experience of the implementation of the National HP Policy and Strategy (2015-2019) so far? *[Probe: What have been key achievements/ has worked well, and why? What have been shortcomings in the implementation and why? What needs to happen, which is not happening in terms of policy implementation?*

7. Resource Allocation (CA)

- How is the budget allocated for health promotion, at the different levels of government (NDoH, PDoH, district, sub-district and facility)?

8. Closing questions:

The DoH has been implementing PHC-re-engineering since 2012: this includes ward-based outreach teams, district health specialist teams and the school health programme.

- How do you see the role of health promotion in line with this?
- What do you think is the future of health promotion in South Africa? [*Probe: Within NDoH/DoH specifically?]*
- What is your opinion of the national HP policy and strategy that was developed by the DoH in 2015?
- If you had the freedom to determine the role/structure of a HP in SA, what would it be? [Probe: What is it about those ideas/directions that is important?
- What do you think is the future of HP in South Africa [Probe: Department of Health]?
- What is your view about PHILA?

9. Comments

Do you have any additional points that you would like to add that have not been covered?
We have come to the end of the interview!!!

Thank you for your time!!!

10.15 APPENDIX O: CAPACITY ASSESSMENT FACILITATION GUIDE

Site ID_____

HEALTH PROMOTION CAPACITY ASSESSMENT TOOL

Capacity Assessment Tool Overview

Purpose

This Capacity Assessment Tool can be used as a measurement tool to allow for the participating institution to assess their, own and their partners, competencies and capacity in HP. The completion of this tool is the first step to jointly:

- Assess the status of four domains covered in this tool;
- Identify feasible changes that can make the HP directorate more effective;
- Monitor the results over time.

Overview

This tool will assist the participating institution to assess their technical HP capacity, ability to effectively coordinate and implement HP activities, as well the state of institutional systems' ability to support their HP work. This tool is divided into four domains and each domain includes a set of sub-domains that drill down into various aspects of the domains. The domains covered in this tool are:

> **Institutional Systems:** This domain covers institutional systems within the DOH that are essential to lead, coordinate and harmonize HP programmes. Improved HP involves more than strengthening individual HP competencies. Institutions must be strong themselves to conduct HP programming. They must be able to lead and navigate complex and adaptive systems. In the Institutional System Domain, we will discuss systems that directly influence health promotion intervention planning: internal health promotion mechanisms; human resource systems (recruiting, supervising and supporting personnel and volunteers); management information and reporting systems, etc.)
>
> **Plan & Design:** This domain covers the HP competencies needed to effectively plan and design HP programmes. This includes conducting a situation analysis to guide/build a programme around evidence; set priorities; designing an appropriate health promotion approach to address the identified health or other social barriers to change; etc.
>
> **Implement & Monitor:** This domain covers best practices for implementing and monitoring HP programmes. This includes developing and use of programme implementation and monitoring plans; coordinating implementation with other HP programmes; supervision and mentoring; having staff, HP development plans, etc.
>
> **Evaluate, Scale, & Sustain:** This domain covers the HP competencies needed to evaluate HP programmes and to scale and sustain HP programme progress. This includes evaluating programmes; documenting and disseminating results; adapting and adjusting programming based on data for sustainability to scale up, etc.

By using this Tool, the DOH can identify the strengths and weaknesses of their current programmes and that of partners they support—where they are meeting these basic standards and where they do not—as well as define

activities that strengthen staff's capacity, refocus programmes, and improve the overall quality of their HP efforts. For each of the domains, the tool will measure the current capacity for three areas.

> **Systems Capacity:** The specific capacity of the HP directorate to manage a supportive system for HP such as health promotion mechanisms, clear mandates, and human resource systems is measured. This, domain although only measured in the Institutional systems portion of the assessments impacts on the other three domains.
> **HP Technical Capacity:** For each of the domains, specific capacity linked to the HP directorate's direct planning, designing, implementing, monitoring and evaluating HP are measured. Capacity across all four domains and within individual domains is measured.
> **Coordinating Capacity:** For each of the domains, specific capacity linked to the coordinating and leading stakeholder HP programmes is measured. Capacity across all four domains and within individual domains is measured.

Instructions for Facilitating the Assessment Tool

Step 1: Engagement and Document Collection

Engage the institution's leadership. During this step, the facilitation team should negotiate an agreement with the institution for all phases of the process, modify the tool as needed with facilitators, and identify a change leader: a staff member who will champion the changes that emerge from the workshop(s).

Collect relevant HP documents. Using the guidance provided in the document review tab collect the documents from the institution. These documents should be reviewed by an HP technical expert to assess their completeness and quality. These results will be shared and reviewed during the assessment process.

Step 2: Conduct Capacity Assessment for the Four Domains

Provide a brief introduction that stresses the purpose of the participatory assessment: Review the process with a short PowerPoint, highlighting the conceptual framework and stage of the process. Make sure to mention the purpose of this assessment is to assist the team to identify their strengths and weaknesses in the local system to design, coordinate, and lead HP programmeming. The process is not intended to criticize their current efforts and activities, but can assist the team to orient themselves to core HP components and identify their strengthening needs. The result of this assessment will be the identification of several priority areas for them to focus on in the coming year. From the assessment results and conversation, an annual CS plan will be developed. Handouts should be available for each participant for this purpose. The facilitator answers any questions before proceeding.

Ask the participants to give a general description of the current work—what is being done, which agencies are involved, where they are working, and what technical areas are being addressed. It helps to have a map of the region to orient this discussion. The facilitator will become familiar with the current situation and the team will be oriented to the assessment. Clarify roles and responsibilities of everyone involved and note any key people who may be missing, but important to the discussion.

Take the team through each of the four core domains. In each case, the facilitator defines and introduces the area to be discussed using both handouts and a projection of the tool on PowerPoint. Then the facilitator asks an open-ended question (key questions) and leads short discussions to further clarify issues and gather important background information needed for follow-up questions. For complex concepts and issues, probes are used at the end of the closed-ended questions to further clarify responses. Participatory exercises, such as ranking or voting, at the discretion of the facilitator and group. The facilitator should summarize what was found during the document review process. For each sub-domain there are:

- Key Questions: These questions should guide the discussion among the participants.
- Key Steps or Elements. This column provides some additional guidance for the facilitator on what is the ideal practice for this sub-domain.

In response to each question, the team discusses the answer, comes to a consensus, and assigns a score. The facilitator should not lead responses or suggest scores, but rather request a consensus score from the group by using questions to initiate discussion. During the discussion, the facilitator should ask for verification and/or remind participants of the results of the document review. The step is completed once all the questions in each component have been discussed and scores assigned.

Facilitators refer participants to The Stages of Development. These columns provide guidance on standards so that participants can score themselves. Participants should reach a consensus on the score. They are asked to score themselves on a continuum of stages 1-4. In general, these are grouped as followed:

- Stage 1: Function/policy/guideline/system not present
- Stage 2: Function/policy/guideline/system present; of expected quality. No/poor application.
- Stage 3: Function/policy/guideline/system present; of expected quality. Some application and some adherence.
- Stage 4: Function/policy/guideline/system present; of expected quality. Complete application and adherence.

Refer to the Means of Verification column. This column provides some guidance on the item scored in the previous column should be verified. As participants are determining the score, the facilitator should ask the participants about how they came up with these scores – either through the collection of documents during the engagement and document audit phase, or through discussion.

Enter scores for the sub-domain: These columns are where the scores are entered. We have allowed for two types of scores to be used. The Participants consensus score, where the score the participants agreed upon should be entered. The second score is the facilitator score, where the facilitator will enter their own score based upon the conversation, verification, and document review. These scores are averaged to create the overall score.

During the discussion, the facilitation team will take notes on what is being said by the participants to capture the substance of how scores are reached. **This is critical.** They will also note any proposed actions that are suggested.

Step 3: Review of Dashboard and Developing a Priorities for the Capacity Strengthening Plan

Review the scoring dashboard. The overall scores are automatically populated in the dashboard. Participants can see their results immediately. The facilitator should go over these results and discuss the results with the participants.

Work with the participants to identify priorities. During the prioritization exercise – facilitators should highlight those areas that low capacity. An additional focus should be placed on those domains and sub-domains that are considered a high priority for effective high-quality HP. The facilitators should explain how the priority areas were developed and determine if the participants agree or if they should be modified. The team should note main areas that need strengthening, develop an initial plan of action, and note any specific areas requiring technical support. This information will be used to develop a strengthening plan. The results can serve as the situational baseline for the HP directorate.

Prioritization of activities/actions. While taking notes during Step 2, several activities will have been noted. Using a priority matrix, explained in a PowerPoint as well as a handout, participants will identify priority actions within priority areas and decide which are highest impact and most achievable within their resources.

Write up the results of the assessment in a brief report that summarizes the discussions for each component and describes how the results of the assessment feed into the final capacity strengthening plan.

Using this guide

During the workshop please refer to this document to fill in answers for each competency. As the training progresses each slide that is displayed will have a coordinating matrix that is meant to facilitate careful consideration of each topic and serve as a resource for scoring the capacity assessment post workshop. You can record notes and action items in the spaces provided and refer to them after the training.

Document Collection

The institution should be requested to prepare the following documents (if they exist), which should be reviewed by the facilitator before and during the assessment, as pieces of evidence, to verify the findings from the group discussion.

Documents required before the Tool is administered:

- Guiding policy document (e.g. policy, law)
- Strategic plans
- Annual Reports
- Annual Operational Plan
- Annual Work-plans/Implementation Plans
- Organogram
- Job Descriptions
- HR policy manual
- Annual budgets
- Communication protocols
- Meeting minutes
- 2-3 Examples of a Communication Strategy linked to current interventions and/or activities
- 2-3 Examples of a Creative Brief
- Knowledge Management Strategy for organization, if applicable
- 2-3 Examples of literature reviews
- Example of a monitoring and evaluation plan linked to a current intervention and/or activity
- 2-3 Examples of program budgets linked to a current intervention and/or activity

Institutional Systems

Strong Institutional Systems are essential for your division/sector to lead, coordinate and harmonize health promotion interventions in South Africa. Improved health promotion involves more than strengthening individual health promotion competencies. Institutions must be strong themselves to conduct health promotion programing. They must be able to lead and navigate complex and adaptive systems. In the Institutional System Domain, we will discuss systems that directly influence communication intervention planning: internal communication mechanisms; human resource systems (recruiting, supervising and supporting personnel and volunteers); management information and reporting systems, etc.)

1.1 Institutional Priorities

Sub-Domain: *Ideally your division/sector will be guided by official documents that are well known externally and internally. These documents will outline your mandate and strategic objectives.*

1.1.1

Key question(s): Describe the policy or official document(s) that documents the Health Promotion Directorate's mandate? What is the mandate?

Key Steps or Elements: There is a policy or other official document that states the mandate of the division/sector

	Stage of Development	Indicate(X)	Comments
1	There are no policies or other documents in place		
2	We believe there are some policies and documents, but cannot name them specifically		
3	There is an official policy/document in place, but it does not state our mandate		
4	There is an official policy/document in place that clearly outlines the mandate of our division/sector		
Means of Verification	Guiding policy document (e.g. policy, law)		

Score: _____

1.1.2

Key question(s): Does national DoH HPD have strategic objectives? If so, how well known are they by staff at the district level? Can you state/describe the strategic objectives?

Key Steps or Elements:

1) Has documented strategic objectives 2) Staff can state/describe strategic objectives

	Stage of Development	Indicate (X)	Comments
1	We do not have strategic objectives		

2	We are in the process of developing strategic objectives		
3	We have strategic objectives, but employees do not know about them		
4	We have strategic objectives that are known by employees		
Means of Verification	Documents containing strategic objectives Participants ability to state strategic objectives		

Score: _____

Sub-Domain: *Ideally, the strategic objectives will reflect the actual work that you are preforming.*

1.1.3

Key question(s): Are your division's/unit **strategic objectives** known by your staff? Can you state/describe the strategic objectives?

Can you describe how the work you perform in province/districts links back to the strategic objectives?

Key Steps or Elements: Work that the division/sector reflects the strategic objectives

	Stage of Development	Indicate (X)	Comments
1	We do not have strategic objectives OR There is no connection between the strategic objectives that exist and the work done		
2	Staff are aware of strategic objectives, but they are not used to guide the work		
3	Staff are aware of strategic objectives, and they are partially used to guide the work		
4	Staff are aware of strategic objectives, and they fully guide the work		
Means of Verification	Participants able to directly connect work they perform to strategic objectives		

Score: _____

Institutional Mandate and Operations

Sub-Domain: *A strategic plan outlines the overall goals for your division/sector. It involves stepping back from the day to day and asking where your priorities should be. It outlines how you will achieve your strategic objectives.*

1.2.1

Key question (s): Is there a strategic plan that guides what you do on an annual or monthly basis? If so, when was the last strategic plan developed? How often is it reviewed?

Key Steps or Elements:

Has a strategic plan that outlines how the strategic objectives will be achieved

Strategic plan is reviewed regularly

	Stage of Development	Indicate (X)	Comments
1	We do not have a strategic plan		
2	We have strategic plan, but we do not review it regularly		

3	We have strategic plan that is partially used to guide our work and is reviewed regularly		
4	We have a strategic plan that guides our work and is reviewed regularly		
Means of Verification	Strategic plan Review meeting reports		

Score: _____

Sub-Domain: *Based on the strategic plan, the division/sector develops an annual operational plan, and involves relevant stakeholders. The annual operational plan is implemented as scheduled.*

1.2.2

Key question (s): Do you develop operational plans? If so, how do you plan for and review the plans? Can you describe the most recent planning process you undertook?

Key Steps or Elements:

1) Have annual operational plans
2) Annual operational plan reviewed regularly, e.g. in the past two years

	Stage of Development	Indicate (X)	Comments
1	We do not develop annual operational plans		
2	We are in the process of carrying out our first annual operational plan		
3	We develop annual operational plans, but do not regularly review them		
4	We develop annual operational plans and regularly review them		
Means of Verification	Annual operational plans Review meeting reports		

Score: _____

Sub-Domain: *Based on the strategic plan, the division/sector develops an annual operational plan, and involves relevant stakeholders. The annual operational plan is implemented as scheduled.*

1.2.3

Key question(s):

Do you engage relevant stakeholders during the development of the annual operational plan development? Who do you engage and how? Can you describe the planning process you most recently undertook?

Key Steps or Elements:

1) In the past two years, stakeholders have been consulted on priorities
2) In the past two years, stakeholders have contributed to the development of the plan

	Stage of Development	Indicate (X)	Comments
1	We develop annual operational plans, but we do not engage stakeholders		

2	We develop annual operational plans, but we only engage internal stakeholders to provide inputs on the content		
3	We develop operational plans and engage a wide range of internal and external stakeholders EITHER on priority setting for the annual operational plan OR plan development		
4	We develop operational plans and engage a wide range of internal and external stakeholders to set priorities AND contribute to the development of the plan		
Means of Verification	Participants can name who and how they engage stakeholders		

Score: _____

Sub-Domain: *Based on the strategic plan, the division/sector develops an annual operational plan, and involves relevant stakeholders. The annual operational plan is implemented as scheduled.*

1.2.4

Key question(s): Is the annual operational plan implemented on schedule? Do you monitor the plan and make adjustments as needed? How often? How does this happen?

Key Steps or Elements:

1) In the past two years, the annual operational plan was implemented on schedule
2) In the past two years, regular monitoring and readjustment of the plan took place

	Stage of Development	Indicate (X)	Comments
1	We do not monitor our annual operational plan throughout the year		
2	We monitor the annual operational plan sporadically throughout the year		
3	We regularly monitor the annual operational plan		
4	We regularly monitor the annual operational plan and adjust as needed		
Means of Verification	Annual operational plan Annual reports/ implementation status		

Score: _____

Staffing Structure

Sub-Domain: *An organogram visually depicts the organizational structure and displays job titles, lines of authority, and reporting relationships both internally and externally. The organogram needs to be realistic and reflect the realities of the division/sector's needs.*

1.3.1

Key question(s): Do you have an organogram that reflects your unit at national/provincial/district levels? Can you describe the structure of your unit?

Key Steps or Elements:

Organogram correctly displays the organization's structure needed to complete the work. It has realistic job titles, lines of authority, reporting relationships within the division/sector and outside (e.g. MOH), and the organogram captures technical and operational expertise needed to achieve strategic objectives

	Stage of Development	Indicate(X)	Comments
1	There is no organogram for the division/sector		
2	We are in the process of developing an organogram OR An organogram exists, but it does not have all the necessary elements, e.g. less than three of the elements listed		
3	An organogram exists that has all the elements, BUT: the structure is not fully implemented AND/OR reporting lines are not fully adhered AND/OR it does not reflect what is needed for our work		
4	An organogram exists that has all the elements, it is fully adhered to, and it reflects the positions and reporting requirements needed for our work		
Means of Verification	Approved organization chart		

Score: _____

Sub-Domain: *The job descriptions are reflective of the staff's jobs; they are comprehensive, addressing position titles, roles and responsibilities, required qualifications and skills, reporting, delegation of authority, and re-assignments.*

1.3.2

Key question(s):

Do you have comprehensive and updated job descriptions? Are these job descriptions reflective of what the staff actually does?

Key Steps or Elements:

Job descriptions address:

1. Position title
2. Roles and responsibilities
3. Required qualifications and skills
4. Reporting, delegation of authority
5. Reassignments

	Stage of Development	Indicate (X)	Comments
1	We have not developed job descriptions for all our staff		
2	We are in the process of developing them for each of the positions within our division/sector We have job descriptions for some of our positions within our division/sector.		
3	We have job descriptions that address all the five elements for all our position However, they are not followed. What staff do is different from what the job titles state/dictate		
4	We have job descriptions that address all the five elements for all our positions.		

	The organization fully adheres to these job descriptions		
Means of Verification	Job descriptions		

Score: _____

Sub-Domain: *The organization has sufficient technical staff with the relevant skills and clear roles and responsibilities.*

1.3.3

Key question(s): Are the staff's skills aligned with what is in their job description?

Key Steps or Elements: CVs and Job descriptions match (e.g. skills, knowledge, and qualities)

	Stage of Development	Indicate (X)	Comments
1	Staff have technical responsibilities, but lack the relevant competencies/ required qualifications		
2	Staff have technical responsibilities and relevant competencies, but lack clearly assigned responsibilities		
3	Staff has technical responsibilities, relevant competencies, and clearly assigned responsibilities. However, they do not always perform their technical functions as stated in their roles		
4	Staff has technical responsibilities, relevant competencies, and clearly assigned responsibilities. They perform their technical functions as stated in their roles		
Means of Verification	Organogram, Staff CVs, Staff contracts/ job descriptions		

Score: _____

Sub-Domain: *Staff in senior management and technical positions equipped with enough skills to manage and implement health promotion programs.*

1.3.4

Key question(s): Does your management and technical staff have the capacity to manage and implement health promotion programs?

Key Steps or Elements: See above, with focus on health promotion-specific skills and qualifications

	Stage of Development	Indicate(X)	Comments
1	We do not make sure that staff are trained in health promotion		
2	We make sure that some managers are trained in health promotion		
3	We make sure that managers and technical staff are trained in health promotion, but have limited experience with health promotion implementation		
4	We make sure that managers and technical staff are trained and have		

	extensive experience with health promotion implementation		
Means of Verification	Organogram Staff CVs Staff contracts/ job descriptions		

Score: _____

Staffing Retention and Management

Sub-Domain: *Identifying and keeping staff is essential for successful operations. The division/sector needs to have documented staff requisition and retention policies and procedures that are regularly updated as needed. Staff is hired in an open and transparent manner with references and salary history consistently being verified. The division/sector should aim for low staff turnover and ensuring staff have opportunities for career advancement, salary reviews, and development.*

1.4.1

Key question(s): Are there staff recruitment and policy procedures in place? Can you please describe the process for the last two people that were hired?

Key Steps or Elements: Staff are recruited/hired in an open and transparent manner, with references and salary history consistently being verified OR If government, there is a clear procedure for staff requisition (if hiring is done centrally)

	Stage of Development	Indicate (X)	Comments
1	We do not have a staff recruitment policy or procedures OR We do not have a documented process for bringing new staff into the division/sector		
2	We are in the process of developing staff recruitment procedures and policies We have documented staff requisition procedures/policies; however, they are not followed		
3	We have a staff recruitment policy and procedures that are regularly updated as needed However, they are not consistently followed, e.g., sometimes jobs are not advertised or reference checks are not made		
4	We have recruitment and retention policies and procedures that are regularly updated as needed and consistently followed. New staff is recruited/hired/brought on board in an open and transparent manner with references and salary history verification.		
Means of Verification	Human resources policy manual Audit statements		

Score: _____

1.4.2

Key question(s): Would you categorize your division/sector as having low or high turnover? Why do you think this is?

Key Steps or Elements: There is low turnover of staff

	Stage of Development	Indicate (X)	Comments
1	Staff do not stay long in this division/sector It is difficult to fill key positions		
2	There is a relatively high turnover rate for some positions		
3	While most positions are filled and stable, there is some turnover		
4	Staff retention is very high across all positions		
Means of Verification	Organogram (of positions filled)		

Score: _____

1.4.3

Key question(s): Does your staff have a training and development plan (PROGRESS)?

Key Steps or Elements:

1) Performance reviews are conducted
2) Salary reviews are conducted
3) Annual performance plans are used to develop and strengthen staff
4) There are career advancement opportunities

	Stage of Development	Indicate (X)	Comments
1	We do not have staff training and development plan OR We are in the process of developing a staff training and development plan		
2	We have an annual performance or salary review processes, but are not used for anything We have a staff training and development plan, but it is not implemented		
3	We have an annual performance and salary review process that is consistently implemented. The outcomes of the process are used to develop plans and goals for that staff member We have a staff training and development plan, but do not adhere to it consistently		
4	We have an annual performance and salary review processes that are consistently implemented. The outcomes of the processes are used to develop plans and goals for that staff member along with identification of career/skill development opportunities available to them We have a staff training and development plan. Staff and volunteer competencies are routinely		

	strengthened to enhance their ability to meet performance targets and organizational objectives. Staff training and development plans are adhered to		
Means of Verification	Human resources policy Staff training and development plans		

Score: _____

Resource Allocation

Sub-Domain: *Having sufficient resources to carry out planned activities is essential. It is important to ensure sufficient resources to implement your activities, but also to monitor the budget.*

1.5.1

Key question(s): Do you lead the annual budgeting process for health promotion and engage others? Can you describe the annual budget process you recently completed?

Key Steps or Elements:

1) Develop annual budgets linked to the annual operational plan
2) Engage others outside of the division/sector to provide input

	Stage of Development	Indicate(X)	Comments
1	The sector/division does not develop annual budget(s) The budget is not linked to the annual operational plan		
2	There is an annual budget(s), but it is not linked to the operational plan		
3	There is an annual budget for our operational plan, but we do not engage others when developing it		
4	There is an annual operational budget linked to our operational plan that is developed with the inputs of other stakeholders		
Means of Verification	Annual budget Costed work plan Participants can clearly link budget line items to annual operational plans		

Score: _____

1.5.2

Key question(s): Do you have systems in place to oversee/monitor your budgets?

Key Steps or Elements:

1) Review expenditures periodically and monitor remaining funds
2) Adjust budget as needed when activities change and/or there is a shortfall

	Stage of Development	Indicate(X)	Comments
1	We do not monitor or adjust our annual budget(s)		
2	We monitor our budget sporadically		

3	We monitor our budget regularly using an agreed upon process, but we do not adjust		
4	We monitor our budget regularly using an agreed upon process and we discuss and agree upon any adjustments that need to be made based on the monitoring reports		
Means of Verification	Annual budget; financial report/template, evidence budget adjustments were discussed and made		

Score: _____

Communication and Coordination

Sub-Domain: *Communication and coordination within your division, externally with other government programs in the MOH and other relevant partners is important to harmonizing and leveraging potential benefits for the work you do. As there is much overlap and technical expertise both within your group and outside it is important to communicate and coordinate efforts with other government entities and external stakeholders.*

1.6.1

Key question(s): Do you communicate or coordinate other programmes/departments within the DoH?

Key Steps or Elements:

1) Communicates and coordinates with other governmental departments/programs within the DoH.
2) Has a formal mechanism/ operational structure for facilitating interdepartmental communications, e.g. bulletin boards, internet, and feedback mechanisms.

	Stage of Development	Indicate (X)	Comments
1	We do not regularly communicate with other departments/ programs in the ministry		
2	We communicate and coordinate with other departments/ programs, but it is sporadic and not through a formal mechanism		
3	We regularly communicate with other departments/ programs. The communication is frequent, regular and done through specifically channels known by all staff. However we do not coordinate efforts		
4	We regularly communicate and coordinate with other departments/ programs. The communication is frequent, regular and done through specifically channels which are known by all staff. Interdepartmental activities/efforts are coordinated this way		
Means of Verification	Communication protocols, examples of past efforts, emails and other documentation		

Score: _____

1.6.2

Key question(s): Do you communicate or coordinate other departments outside of the DoH?

Key Steps or Elements:

1) Communicates and coordinates with other departments
2) Has a formal mechanism/ operational structure for facilitating inter-ministerial communications.
3) It is known by all relevant staff and used. It includes things such as bulletin boards, internet, and feedback mechanisms.

	Stage of Development	Indicate(X)	Comments
1	We do not regularly communicate with other departments/ programs in the ministry		
2	We communicate and coordinate with other departments/ programs, but it is sporadic and not through a formal mechanism		
3	We regularly communicate with other departments/ programs. The communication is frequent, regular and done through specifically channels known by all staff. However we do not coordinate efforts		
4	We regularly communicate and coordinate with other departments/ programs. The communication is frequent, regular and done through specifically channels which are known by all staff. Interdepartmental activities/efforts are coordinated this way		
Means of Verification	Communication protocols, examples of past efforts, emails and other documentation		

Score: _____

1.6.3

Key question(s): How do other departments within the DoH and other ministries communicate and coordinate with your staff?

Key Steps or Elements:

1) Others reach out to the division/sector
2) Others coordinate their priorities/activities with the division/sector
3) Others seek out the division/sector for technical input and consultation, when appropriate

	Stage of Development	Indicate(X)	Comments
1	We do not receive requests from other departments or ministries		
2	We do not receive requests from other departments or ministries, but we initiate and maintain communication/ coordination efforts		
3	Others inform us of what they are planning and coordinate activities sporadically. They do not seek us out for technical input and consultation		
4	We are regularly informed and consulted by other departments and ministries. We provide		

	technical input and consultation on areas concerning our mandate		
Means of Verification	Examples of past times, emails and other documentation; staff can clearly articulate examples		

Score: _____

Sub-Domain: *Documenting and disseminating results and lessons learned is as important contribution to the sector. Seeking out and sharing best practices while also using new knowledge enables you to ensure your programs are up to date and lets others see you are a leader in the field.*

1.6.4

Key question(s): Do you document and disseminate results, lessons learned, and best practices within the DoH and with other stakeholders

Key Steps or Elements: 1) Document results 2) Disseminate results

	Stage of Development	Indicate(X)	Comments
1	We do not document or disseminate results		
2	We document results, but we do not share them		
3	We document and disseminate results sporadically		
4	We frequently document results and disseminate them through established channels		
Means of Verification	Documented results, dissemination products, proof of dissemination		

Score: _____

1.6.5

Key question(s): Do you actively seek information about best practices in sector focus area(s)

Key Steps or Elements:

1) Actively search for best practices in the sector
2) Share and incorporate best practices in own programming

	Stage of Development	Indicate(X)	Comments
1	We do not seek out the latest information on best practices or document our own best practices.		
2	Our staff sporadically and informally seeks out information on best practices and share our own		
3	We actively search out and share best practices		

4	We search, identify, and share best practices that are incorporated in our programming		
Means of Verification	Staff can articulate examples of when they have found a best practice, shared, and incorporated it into the program AND/OR have documents of their own best practices		

Score: _____

1.6.6

Key question: Do you have systems for organizing and storing new information?

Key Steps or Elements:

1) Develop a protocol for organizing and storing new knowledge
2) Define a system in which new knowledge can replace outdated information

	Stage of Development	Indicate(X)	Comments
1	We do not have a system of organizing and storing new information or for removing redundant information in our information backlogs		
2	Our staff have their own systems for organizing new knowledge and information but there is no defined protocol for cross-organizational knowledge management		
3	We have a system in place for storing new information that all staff have access to		
4	We have a clear protocol and system in place for storing, organizing, and prioritizing new information and knowledge that allows for easy access for future use		
Means of Verification	Staff can access new knowledge to meet their needs and are well versed in how to contribute to the knowledge management system		

Score: _____

Plan & Design

Conducting a situation analysis to guide/build a program around evidence; set priorities; designing an appropriate communication approach to address the identified health or other social barriers to change; etc.

2.1 Situation Analysis

Sub-Domain: *Before we develop or design any health promotion program, it is important to undertake a situation analysis where we look at what is happening, understand why it is happening, consider theories that may help explain this and how to address it. From a situation analysis, you will clearly develop a problem statement and theory of change that will guide your interventions.*

2.1.1

Key question(s): Describe your process for conducting a situation analysis? Which key steps does your organization use?

Key Steps or Elements:

1) Conduct a baseline and/or formative research to establish the aspirations, practices and their determinants (psychological, environmental, and social) of target audience(s)
2) Conduct a review of relevant studies.
3) Assess existing policies and programs.
4) Learn about active and available communication channels.
5) Identify key stakeholders (partners, allies, and opposition).
6) Assess organizational capacities.
7) Be sensitive to possible gender differences and make sure all viewpoints are represented.
8) Summarize the understanding of the problem into a problem statement.

	Stage of Development	Indicate(X)	Comments
1	We do not contribute to any of the key steps		
2	We contribute to 1-3 of the key steps		
3	We contribute to 3-5 of the key steps		
4	We contribute to 6-8 of the key steps		
Means of Verification	List key steps named and ask for verification based on it. Some may be: Baseline Evaluation Report; Secondary analysis report; Situational Analysis report; Formative Research report(s); Stakeholder meeting minutes; visuals, e.g. maps (stakeholder, assets, etc.)		

Score: _____

2.1.2

Key question(s): Do you routinely conduct audience analysis to set priorities?

Key Steps or Elements:

1) Conducts an audience analysis for each program to identify potential audiences and to understand their characteristics, needs, and behaviours
2) Audience characteristics (as part of larger situational analysis) inform priority setting

	Stage of Development	Indicate(X)	Comments
1	We do not routinely conduct audience analysis to set priorities		
2	We occasionally conduct an audience analysis to set our priorities		
3	We conduct an audience analysis, but we do not use the information to set our priorities		
4	We always conduct an audience analysis to inform our priority setting. We can explain how information from the analysis influence the priority setting		
Means of Verification	Audience analysis report Communication strategy		

Score: _____

2.2 Using Data and Evidence in Priority Setting

Sub-Domain: *Setting priorities for you to focus your health promotion efforts on is important. These priorities should be developed and documented in consultation with a wide range of stakeholders. In addition, they should be based on theory and integrate gender.*

2.2.1

Key question(s): How are national/provincial/ district priorities set during the planning and design process of your health promotion strategies? Who is involved?

Key Steps or Elements: District-level priorities are determined with stakeholders, including decision-makers, implementing partners, and intended audience members

	Stage of Development	Indicate(X)	Comments
1	All priority setting at the district level is done by one or a few individuals or consultants		
2	We base our strategy on internal (HES) and institutional (MOH) understandings of district-level priorities		
3	Beyond internal and institutional players, some key external stakeholders are involved in informal conversations and meetings to determine district-level priorities		
4	The strategy is designed together with a group of program partners, decision-makers, audience members, and technical experts. The entire team comes together at crucial points in the planning and implementation process to agree on district-level priorities.		
Means of Verification	Meeting reports (for stages 2-4)		

Score: _____

2.2.2

Key question(s): Do you conduct an audience analysis for each program/campaign? If so, how are those findings used in setting priorities?

Key Steps or Elements:

1) Conducts an audience analysis for each program to identify potential audiences and to understand their characteristics, needs, and behaviours
2) Audience characteristics (as part of larger situational analysis) inform priority setting

	Stage of Development	Indicate(X)	Comments
1	We do not routinely conduct audience analysis to set priorities		
2	We occasionally conduct an audience analysis to set our priorities		
3	We conduct an audience analysis, but we do not use the information to set our priorities		
4	We always conduct an audience analysis to inform our priority setting. We can explain how information from the analysis influence the priority setting		
Means of Verification	Audience analysis report Communication strategy		

Score: _____

2.2.3

Key question(s): Can you describe the process of how priorities are set at the district level? Who is involved?

Key Steps or Elements: District-level priorities are determined with stakeholders, including decision-makers, implementing partners, and intended audience members

	Stage of Development	Indicate(X)	Comments
1	All priority setting at the district level is done by one or a few individuals or consultants		
2	We base our strategy on internal (HES) and institutional (MOH) understandings of district-level priorities		
3	Beyond internal and institutional players, some key external stakeholders are involved in informal conversations and meetings to determine district-level priorities		
4	The strategy is designed together with a group of program partners, decision-makers, audience members, and technical experts. The entire team comes together at crucial points in the planning and implementation process to agree on district-level priorities.		
Means of Verification	Meeting reports (for stages 2-4)		

Score: _____

2.2.4

Key question(s): When developing priorities, how do you consider and incorporate gender? Can you describe how you have done this in the past?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	We do not include gender when we are developing district-level priorities		
2	We agree that gender should be included in setting district-level priorities, but most people are not clear what that means		
3	We include gender in setting district-level priorities, but gender does not, in reality, direct priority setting		
4	We include gender during the priority setting. Gender equity is reflected throughout the priority setting process		
Means of Verification	Communication Strategy		

Score: _____

Sub-Domain: *It important to consult with implementing partners to align priorities based on local evidence. Ideally, you want to be following the same best practices, in a coordinated way.*

2.2.5

Key question(s): When you are reviewing health promotion priorities set by implementing partners in their strategies, how do you ensure the priorities are based on evidence?

Key Steps or Elements:

1) We discuss priorities with partners, to seek alignment
2) We review data used by partners to make decisions, to check evidence base

	Stage of Development	Indicate(X)	Comments
1	We do not review implementing partner's priorities for their programs or review their use data		
2	We review partners' program priorities, and assume they use data in their priority setting, but cannot verify it.		
3	We discuss partner's priorities and data, but do not always coordinate this with our own priority setting		
4	Our discussions with partners about their priorities and data are aligned and coordinated with our priority setting process		
Means of Verification	Minutes or notes from meeting when review happened Participants able to articulate a specific example		

Score: _____

2.3 **Budgeting for health promotion Interventions/Activities**

Sub-Domain: *Budgeting for health promotion programs/interventions is important to ensure activities can be implemented with the funds available. Budgeting happens throughout the planning and design process, not just during implementation*

2.3.1

Key question(s): Do you develop budgets for health promotion programs?

Key Steps or Elements:

1) Develop budgets before interventions
2) Track costs along the way
3) Periodically readjust costs as needed
4) Intervention budgets are part of the larger HP unit's annual operating budget

	Stage of Development	Indicate(X)	Comments
1	We do not develop a budget		
2	We develop a budget based on assumed costs, but do not always keep track of costs along the way		
3	We develop a realistic budget based on previous experience and periodically adjust it based on actual costs		
4	We develop a realistic budget based on previous experience and periodically adjust it based on actual costs. These budgets are part of or included in the annual operating budget		
Means of Verification	Work plans, Program Budget		

Score: _____

2.4 Developing a Communication Strategy

Sub-Domain: *There are certain elements of a health promotion strategy that are important. Each piece of the health promotion strategy builds off each other. This section explores whether the HES strategy meets the strategic needs of those working at zonal/district levels in terms of audiences, communication objectives, channels, and materials based on analysis and integrated by a strategic approach.*

2.4.1

Key question(s): Does the strategy provide a succinct situational analysis, based on sound and current evidence?

Key Steps or Elements: [See 2.1 as to what constitutes a sound situational analysis]

	Stage of Development	Indicate(X)	Comments
1	We do not have a health promotion strategy The strategy does not include a background		
2	The strategy includes a brief background, based on general knowledge, with a few references		
3	The health promotion strategy includes a situational analysis, which includes some evidence. However, it is not reflected in the content of the strategy		
4	A situational analysis, based on evidence that is well-referenced, is presented as the basis for		

	the health promotion strategy. These issues are reflected in priorities.		
Means of Verification	health promotion Strategy		

Score: _____

2.4.2

Key question(s): Does the strategy identify audiences and segment them into specific groups to tailor programs effectively for your unit (national/province/ district)?

Key Steps or Elements:

1) Audiences are be identified as primary, secondary or tertiary
2) Their role in influencing change identified

	Stage of Development	Indicate(X)	Comments
1	We do not have a health promotion Strategy Communication programs/activities are addressed to the general population		
2	Programs select audiences, e.g. women, but do not segment them into specific groups		
3	Programs select specific audience segments, but programs are often not tailored enough to our specific contexts at district level		
4	Programs select specific audience segments and create tailored programs for them, based on deep insight into our specific contexts at district level		
Means of Verification	health promotion Strategy		

Score: _____

2.4.3

Key question(s): Do you set SMART communication objectives that address barriers to change? (SMART = Specific, Measureable, Attainable, Reliable and Time-bound)

Key Steps or Elements:

1) Communication objectives set based on highest priority programmatic issues
2) Target audiences selected based on highest priorities
3) Communication objective targets and measures set based on evidence of priorities and attainability

	Stage of Development	Indicate(X)	Comments
1	Programs only have program objectives (No health promotion strategy)		
2	Programs set communication objectives		
3	Programs set SMART communication objectives, but they may not be 100% linked to situational analysis		

4	Programs set SMART communication objectives that address barriers to change for each audience segment. Communication objectives are set based on priorities highlighted in situational analysis as well as what is attainable		
Means of Verification	health promotion Strategy		

Score: _____

2.4.4

Key question(s): Do you have a communication strategy that is driven by a strategic approach that links all strategies and channels into a coordinated effort or campaign or intervention?

Key Steps or Elements:

1) Approaches are selected based on the target set out by each objective.
2) Coordination between objectives and approaches for streamlining

	Stage of Development	Indicate(X)	Comments
1	Programs' communication strategy does not include an overall strategic approach		
2	Programs' communication strategy includes an overall key strategy. However, the approaches may lack a clear theoretical or empirical basis linked to the communication objectives or priorities		
3	Programs' communication strategy has a strategic approach. The individual approaches may have a strong theoretical or empirical basis, but they may not be well coordinated		
4	Programs' communication strategy has a strategic approach that links all approaches and channels packaged into a recognizable campaign or intervention. This is all based on a prioritization process, grounded in evidence		
Means of Verification	health promotion Strategy		

Score: _____

2.4.5

Key question(s): When designing an intervention, how do you identify communication channels appropriate for your nation/province/ district? How are communication channels coordinated?

Key Steps or Elements:

1) Channels selected based on the approach, e.g. IPC or mass media, and audience
2) Channel selection based on evidence

3) If multiple channels, coordinated

	Stage of Development	Indicate(X)	Comments
1	Channels are identified independently from other processes Usually use only one channel for communication		
2	We identify channels for an audience based on what we think the audience would utilize. We may use multiple channels, but they are not coordinated		
3	We identify channels per target audience based on what we think the audiences would utilize We use multiple channels to support the intervention. They are not always coordinated		
4	We identify appropriate channels per target audience based on media habits, validated by data. We use multiple channels in a coordinated way, e.g. we achieve scale through coordination of channels by using mass media tied to community mobilization, ICT and interpersonal communication among multiple audiences		
Means of Verification	Communication Strategy Creative Brief Media Plans Communication Strategy		

Score: _____

2.4.6

Key question(s): Costed implementation plan and timeline?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	There is no costed plan or timeline in the strategy		
2	There is a timeline set out, but it has not been linked to costs This may be difficult or too generic to translate into district planning in current format		
3	There is a timeline and separate budget, but they are not completely aligned This can be used for district planning		
4	All activities and related costs of the strategy have been fully accounted for and mapped onto a project timeline This can be used for district planning		
Means of Verification	Strategy		

Score: _____

2.4.7

Key question(s): Monitoring and evaluation plan

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	There is no monitoring and implementation plan linked to the strategy.		
2	There are a few key indicators linked to the plan		
3	There is a monitoring plan, which is aligned with the planned activities and largely focused on outputs and processes		
4	There is both a monitoring and evaluation plan, including [impact], outcome, output, process and input indicators and tools		
Means of Verification	Communication Strategy		

Score: _____

2.4.8

Key question(s): Dissemination plan

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	There is no articulated plan for how the results of the strategy will be shared		
2	There is reference to internal reporting processes, but not much more		
3	The strategy discusses the value of dissemination findings beyond reporting , although there are no resources set aside for this		
4	There is a clear dissemination plan costed into the strategy that includes both internal as well as external stakeholders		
Means of Verification	List the number associated with the key elements: Example Documents: Communication Strategy; M&E plan; Dissemination Plan; Work plan		

Score: _____

2.4.9

Key question(s): Do you ensure gender equity is the underlying approach and is reflected throughout the strategy design

Key Steps or Elements: Ensure to include gender in the health promotion strategy design.

	Stage of Development	Indicate(X)	Comments
1	We do not include gender in the health promotion strategy		

2	We agree that gender should be included but most people are not clear what that means		
3	We include gender in the health promotion strategy but it does not, in reality, guide activities		
4	We include gender in the health promotion strategy design. Gender equity is reflected throughout the communication plan		
Means of Verification	Communication Strategy		

Score: _____

Sub-Domain: *As implementing partners developing their own strategies, it is important that they are also incorporating best practices into their plans.*

2.4.10

Key question(s): Do you review implementing partners' health promotion strategies?

Key Steps or Elements:

1) Situational analysis that demonstrates theoretical and multi-level consideration.
2) Audience segmentation
3) Evidence-based and SMART communication objectives
4) Evidence-based program approaches, with validated channels
5) Costed implementation plan and timeline
6) Monitoring and evaluation plan
7) Gender mainstreaming

	Stage of Development	Indicate(X)	Comments
1	We do not review or discuss partners health promotion strategies		
2	We review our partners health promotion strategies as part of coordination Our partners have 2-3 of the key elements		
3	We review our partners health promotion strategies as part of coordination Our partners have 4-5 of the key elements		
4	We review our partners health promotion strategies as part of coordination Our partners have 6-7 of the key elements		
Means of Verification	Minutes or notes from meeting when review happened; participants able to articulate a specific example Partner strategies		

Score: _____

2.5 **Designing Campaigns and Materials Development**

Sub-Domain: *Use of health promotion strategy*

2.5.1

Key question(s): Do you ensure health promotion interventions (campaign, materials/products/activities) are aligned with the health promotion strategy?

Key Steps or Elements:

1) Health promotion strategy consulted during the design of campaign materials and development
2) Campaign materials and materials, products, and activities support health promotion strategy goals and flow from decisions made about channels and messages

	Stage of Development	Indicate(X)	Comments
1	Interventions and/or materials at the district level are designed independently of any strategy There is no health promotion strategy		
2	Interventions/material at the district level support the objectives in the health promotion strategy most of the time		
3	Interventions fully reflect health promotion strategy and its objectives at the national level, but there is little space to adapt them for differences at district level		
4	Communication interventions are produced and tailored to meet specific objectives in the health promotion strategy, and change as the strategy changes		
Means of Verification	health promotion strategy Creative briefs Communication intervention/ products		

Score: _____

Sub-Domain: *Pretesting and designing products and materials*

2.5.2

Key question(s): When designing or adapting communication products/materials, which key steps do you use?

Key Steps or Elements:

1) Conduct inventory of existing materials.
2) Host a participatory process, including technical staff and creatives, that facilitates agreement on both design or revisions required
3) Develop creative briefs.
4) Create draft concepts and materials for audience pretesting.
5) Test concepts and materials with intended audience and key decision-makers.
6) Share results of pre-test with the creative team and stakeholders.
7) Revise materials based on feedback.
8) Re-test materials to make sure revisions resolve key issues.

	Stage of Development	Indicate(X)	Comments
1	We do not design or adapt materials OR We do not use any of the key steps		
2	We use 2-4 of the key steps but cannot clearly articulate them		
3	We use 5-6 of the key steps and can clearly articulate them		
4	We use 7-8 of the key steps and can clearly articulate them		
Means of Verification	List the number associated with the key steps: Other: Communication strategy; Pre-test reports; Example of communication products		

Score: _____

Sub-Domain: *Gender mainstreaming*

2.5.3

Key question(s): Do you ensure that the different needs of men and women are considered/consulted when developing interventions and products/materials in order to change harmful gender norms specific to country context?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	We do not include or consider the impact the interventions and products/materials may have on gender issues		
2	We include or consider gender when developing interventions and products/materials so not to reinforce gender stereotypes		
3	We include or consider the different needs of men and women when developing interventions and products/materials and design them accordingly		
4	We include or consider the different needs of men and women when developing interventions and products/materials in order to change harmful gender norms specific to our local context		
Means of Verification	Creative brief Communication strategy		

Score: _____

Sub-Domain: *Youth Integration*

2.5.4

Key question(s): Do you consider age-specific issues in the health promotion strategy?

Key Steps or Elements: Ensure that strategy design is appropriate for all ages

	Stage of Development	Indicate(X)	Comments
1	We do not consider age-specific issues in the health promotion strategy		
2	We agree that youth should be included but most people are not clear on what that means		
3	We include youth in the health promotion strategy but it does not guide activities		
4	We include youth in the health promotion strategy. Youth considerations and the issues associated with various age segments within the youth population are reflected throughout the communication plan		
Means of Verification	Creative brief Communication strategy		

Score: _____

Sub-Domain: *Branding and Marketing*

2.5.5

Key question(s): Do you have an up-to-date branding and marking plan? All staff and partners adhere to the plan? Are endorsed communication campaigns/products easily recognized by the branding? Is there a particular logo or tagline you use?

Key Steps or Elements: Ensure that strategy design is appropriate for all ages

	Stage of Development	Indicate(X)	Comments
1	We do not have a branding and marking plan OR Our plan is unstructured (informal) or draft and not yet implemented		
2	We have a branding and marking plan, but it is not being used		
3	We have a branding and marking plan that is up-to-date. However, we do not consistently adhere to the plan (some products/assets are not branded)		
4	We have a branding and marking plan that is up-to-date. Staff members consistently adhere to the plan, with communication products, assets, and vehicles easily recognized by the branding		
Means of Verification	Branding and marking plan; branded communications products (such as website and intranet, printed pieces, collateral materials)		

Score: _____

Sub-Domain: *Do you review implementing partners are campaign materials and messages for quality of materials and consistency of messages?*

2.5.5

Key question(s): Do you review implementing partner's campaigns and materials? Do you do this all the time?

Key Steps or Elements:

1) Conduct inventory of existing materials.
2) Host a participatory process, including technical staff and creatives, to share campaign materials
3) Review their process for development (see 2.5.2) to check for quality
4) Review messages against strategic objectives and target audiences for consistency
5) Agree on adaptation or realignment if necessary

	Stage of Development	Indicate(X)	Comments
1	We do not review partners' campaign plans or materials OR they do not share it with us even though its encouraged		
2	We coordinate or share materials with partners in some cases, but this is not systematic		
3	We regularly review health promotion campaign plans with key implementing partners to coordinate activities/materials and reduce duplication. The checking of quality and/or the adaptation or realignment of plans does not happen.		
4	We regularly review health promotion campaign plans with key implementing partners to coordinate activities/materials and reduce duplication. We are committed to ensuring high quality and coordinated campaigns at the district level.		
Means of Verification	Minutes or notes from meeting when review happened; participants able to articulate a specific example		

Score: _____

Implement & Monitor

This domain covers best practices for implementing and monitoring health promotion programmes. This includes developing and use of programme implementation and monitoring plans; coordinating implementation with other health promotion programmes; supervision and mentoring; having staff, health promotion development plans, etc.

3.1 Coordination of Implementation

Sub-Domain: *Implementing*

3.1.1

Key question(s): How are health promotion interventions planned and implemented within your organization? At the provincial/ district level?

Key Steps or Elements:

1) Mapping activities linked to communication objective
2) Scheduling of activities onto Gantt charts
3) Costing of entire plan (activities/staff/M&E...)
4) Personalized planning for staff (clear responsibilities - micro-planning

	Stage of Development	Indicate(X)	Comments
1	We do not have an implementation plan. Most organizational activities are decided on short notice or reactive to external demands		
2	We develop a rough implementation plan for some intervention areas The plans are developed to meet funders' requirements		
3	The health promotion strategy includes a situational analysis, which includes some evidence. However, it is not reflected in the content of the strategy		
4	A situational analysis, based on evidence that is well-referenced, is presented as the basis for the health promotion strategy. These issues are reflected in priorities.		
Means of Verification	health promotion Strategy		

Score: _____

3.1.2

Key question(s): How do you communicate and coordinate with partners to implement programmes?

Key Steps or Elements: Have identified staff who serve as point of contact for partners, partners understand their roles, ensures partners are updated, shares credit for good work

	Stage of Development	Indicate(X)	Comments

1	We do not coordinate implementation with other programs		
2	Coordination with other programs happens on activity at a time		
3	Coordination with programs is considered for multiple activities, based on the work plan		
4	We coordinate implementation of the work plan with multiple programs, guided by the communication strategy		
Means of Verification	Meeting minutes; evidence in work plan coordination among partners		

Score: _____

3.1.3

Key question(s): Do you review stakeholders' activities, share program plans, and collaborate to reduce replication of services and overlap of activities?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	We do not review others' activities		
2	We review others' activities or share program plans and ideas		
3	We review others' activities and share program plans and ideas		
4	We review others' activities, share program plans, and collaborate to reduce replication of services and overlap of activities		
Means of Verification	Meeting minutes; evidence in work plan coordination among partners		

Score: _____

3.2 **Monitoring of Implementation**

Sub-Domain: *Monitoring the implementation of a program is essential for ensuring that the program is on track, key processes are being followed and that quality is being maintained. It also enables readjustment, if problems emerge, contexts shift, or assumptions do not bear out.*

3.2.1

Key question(s): Do you develop M&E plans for your health promotion programmes?

Key Steps or Elements:

1) Refine intervention objectives
2) Identify key performance indicators
3) Identify where, when and by whom data will be collected

	Stage of Development	Indicate(X)	Comments
1	We do not have a monitoring and evaluation plan		

2	We have some indicators, but no clear monitoring and evaluation plan to determine the success of interventions.		
3	We have a monitoring and evaluation plan for each intervention during strategy design Indicators are largely developed based on what the funder wants to know. Once developed, the organization does not review or adjust the plan		
4	We develop an M&E plan for all interventions during strategy design. The plan specifies who collects data, when they collect data and where data comes from. Indicators are developed and clear. The plan is reviewed and adjusted on a routine basis.		
Means of Verification	M&E plan; M&E reports; Project reports; Log frame; Indicator tracking table or dashboard		

Score: _____

3.2.2

Key question(s): Do you develop indicators for health promotion programs that are linked to your communication objectives?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	Programs do not have health promotion indicators OR Only a few programs have health promotion indicators		
2	All programs have some indicators, but they are not clearly linked to the communication objectives		
3	All programs have process and output indicators linked to the communication objectives		
4	Programs have process, output, and outcome indicators linked to the communication objectives		
Means of Verification	M&E plan		

Score: _____

3.2.3

Key question(s): Do you have tools to monitor implementation of health promotion programs?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	We do not have tools to monitor health promotion program implementation		

2	We have tools to monitor health promotion programs, but only as needed		
3	We use standardized tools to monitor health promotion indicators		
4	Programs always use standardized tools to monitor indicators		
Means of Verification	M&E plan, tools		

Score: _____

3.2.4

Key question(s): Do you have a program monitoring mechanisms in place for both internal and external review? Can you describe them?

Key Steps or Elements:

1) Monitoring reports are consolidated as per plans
2) Monitoring reports are analysed
3) Results of monitoring are reviewed with key stakeholders
4) Findings from monitoring are used to inform program and adjust as necessary

	Stage of Development	Indicate(X)	Comments
1	We do not have a program monitoring mechanism in place. The organization does not perform internal and or external program reviews		
2	We do not have formal program monitoring mechanisms in place; however, the organization does perform internal and/or external reviews (unstructured)		
3	The organization has internal and external program monitoring mechanisms in place; however, the review findings are not used to inform program development and implementation		
4	The organization has program monitoring mechanisms in place for both internal and external reviews, with evidence that review findings are used to inform program development or implementation		
Means of Verification	Monthly, quarterly and annual reports. PMP and M&E plans.		

Score: _____

3.2.5

Key question(s): When implementing interventions, how does the directorate maintain program quality?

Key Steps or Elements:

1) Indicators of quality are developed
2) Tools to monitor quality are implemented
3) Quality is monitored as per indicated time

4) Adjustments are made as per findings

	Stage of Development	Indicate(X)	Comments
1	We count the numbers but have no system to monitor the quality of activities		
2	We acknowledge the importance of high quality programing. We are considering activities that will help staff regularly assess and improve quality		
3	We have undertaken activities to assess and improve the quality of programs. A few interested staff members are responsible for these activities		
4	We have an established system for assessing and improving the quality of activities. All staff are trained to regularly use the system		
Means of Verification	Routine data analysis report (RDAR) Protocol/ Guidelines		

Score: _____

Sub-Domain: *Coordination of Monitoring*

3.2.6

Key question(s): Do you coordinate the monitoring of activities with partners?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	We do not engage with partners about how they monitor their activities.		
2	We encourage partners to share monitoring information, but do not actively facilitate forums to coordinate		
3	We expect partners to share monitoring information during implementation. However, there is no expectation they must change programs		
4	We expect partners' to sharing monitoring information and to adjust health promotion programs if there are problems, to coordinate efficient distinct health promotion campaigns		
Means of Verification	Partner monitoring reports		

Score: _____

Evaluate, Scale, & Sustain

This domain covers the health promotion competencies needed to evaluate health promotion programmes and to scale and sustain health promotion programme progress. This includes evaluating programmes; documenting and disseminating results; adapting and adjusting programming based on data for sustainability to scale up, etc.

By using this Tool, the DOH can identify the strengths and weaknesses of their current programmes and that of partners they support—where they are meeting these basic standards and where they do not—as well as define activities that strengthen staff's capacity, refocus programmes, and improve the overall quality of their health promotion efforts. For each of the domains, the tool will measure the current capacity for three areas.

4.1 Commissioning and Conducting Outcome Evaluations

Sub-Domain: *Evaluation and Planning*

4.1.2

Key question(s): How does your directorate/province/ district contribute to impact and outcome evaluation planning?

Key Steps or Elements:

1) Refine intervention objectives
2) Allocate resources to ensure evaluation data are collected as planned

	Stage of Development	Indicate(X)	Comments
1	We are not involved in evaluation planning.		
2	We assist in data collection (e.g. baseline or end line) but not enough to assess the implementation or impact of our interventions		
3	We support baseline data collection and then periodically compare results to this baseline to determine process towards the desired result, but are not conceptually involved		
4	We collect comprehensive baseline data to and then periodically compare results to this baseline to determine progress towards the desired result. End line data is compared to the baseline.		
Means of Verification	Evaluation reports		

Score: _____

4.1.3

Key question(s): Do you support write up of results of evaluations and submit for publication, conference presentations, or other forms of sharing?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	We do not write up results for publication or presentation		
2	We have staff that would like to publish and participate in conferences, but do not have capacity or resources		
3	We have some capacity to publish and participate in conferences, but rarely do so		
4	We frequently publish evaluation data and attend conferences to present results. Information and lessons learned are disseminated and used to influence future programs, both internally and with other stakeholders		
Means of Verification	Fact sheets Lessons learned documents Submitted evaluation reports or papers Confirmation of submission from journal Published articles		

Score: _____

4.1.4

Key question(s): Do you support partners to write up results of evaluations and submit for publication, conference presentations, or other avenues?

Key Steps or Elements: Synthesize data for intended audiences and circulate findings

	Stage of Development	Indicate(X)	Comments
1	Partners do not share the results of their research		
2	We encourage our partners to share their research, but it is not a requirement and we do not ask for proof		
3	We require our partners to disseminate the findings of their research, at least to key stakeholders in the program		
4	We require our partners to disseminate the findings of their research, with a strong emphasis on wide dissemination through reputable channels (journals, conferences, etc.)		
Means of Verification	Submitted evaluation reports or papers; confirmation of submission from journal; published article		

Score: _____

4.2 Re-planning Based on Data

Sub-Domain: *Evaluation and Planning*

4.2.1

Key question(s): How does your directorate/province/district use program data to make decisions about ongoing interventions?

Key Steps or Elements:

1) Reviews intervention data regularly
2) Adjusts program based on program quality reports

	Stage of Development	Indicate(X)	Comments
1	We do not review intervention data while we are implementing		
2	We review intervention data when asked or if something goes wrong		
3	We have a system in place to review intervention data regularly at set times but do not use it to adjust the interventions		
4	We review intervention data regularly at set times for monitoring purposes and make mid-course adjustments to the intervention in response We use the lessons learned from the evaluation activities to improve the design of future programs		
Means of Verification	M&E strategic documents and frameworks; M&E progress; reports on key results areas, PMP status reports, updated work plans		

Score: _____

Sub-Domain: *Data Literacy*

4.2.2

Key question(s): To what degree can national/provincial/district staff interpret and act upon the indicators being monitored?

Key Steps or Elements:

1) Staff are involved in the analysis of project data
2) The analysis is discussed and fed back into the program
3) There is scope to revise or adapt the project based on a clear understanding of what the data mean

	Stage of Development	Indicate(X)	Comments
1	The indicators being monitored are beyond our current staff's scope to interpret and/or act upon		
2	Our staff understands the indicators we monitor, but do not necessarily understand how they are related to activities or each other. They are dealt with in isolation		

3	Our staff can interpret most if not all indicators being monitored, but are not always clear how this can be used to adjust current programming		
4	Our staff understand our indicators and use them as a way to adjust programming throughout the course of implementation		
Means of Verification	N/A		

Score: _____

Sub-Domain: *Coordination of re-planning*

4.2.3

Key question(s): Do you work with partners to use M&E data to improve current health promotion programs?

Key Steps or Elements: N/A

	Stage of Development	Indicate(X)	Comments
1	Partners are not assisted to use M&E data to improve programs		
2	Partners are encouraged to use M&E data to assess program progress, but no support is given		
3	We support partners to use M&E data to assess program progress and improve programs, but this is ad hoc		
4	We coordinate forums for partners to use M&E data to assess program progress, to improve programs in a systematic manner		
Means of Verification	N/A		

Score: _____

Sub-Domain: *The key dimensions of data quality are said to be accuracy, reliability, completeness, precision, timeliness and integrity. These six dimensions are all important for delivering the highest quality health promotion programming.*

4.3.1Key question(s): How does your organization check the accuracy and validity of data that are collected and/or used for decision making?

Key Steps or Elements:

1) There are clear data management practices, such as:
2) Designated and trained staff assigned for data collection/capture, monitoring, analysis and verification/ reporting
3) Storage and disposal standards, such that raw data can be found easily
4) Data collection tools with clear instructions
5) Remedial action plan

	Stage of Development	Indicate(X)	Comments
1	Our organization does not collect data OR We do not assess the quality of our data internally		
2	We only check data when questioned or if it seems wrong. We do not do it systematically		

3	We have staff responsible for monitoring data who are also responsible for maintaining data quality. Some, but not all of these processes are documented		
4	We have a Routine Data Management Plan that the organization applies. Staff are trained on this and it is part of our organizational culture to take remedial action if quality issues are detected		
Means of Verification	Data collection tools Standard operating procedures for data storage/disposal. Job descriptions Raw data Data Management (or Quality Assurance) Plan		

Score: _____

Sub-Domain: *When coordinating implementing partners, it is important to ensure that the data they are generating is of high quality.*

4.3.2

Key question(s): How does your directorate/province/district ensure that implementing partners have quality assurance practices in place?

Key Steps or Elements:

There are clear data management practices, such as:

1) Designated and trained staff assigned for data collection/capture, monitoring, analysis and verification/ reporting
2) Storage and disposal standards, such that raw data can be found easily

	Stage of Development	**Indicate(X)**	**Comments**
1	We do not have quality assurance measures in place with partners		
2	Partners provide us with reports and must make raw data available, on request. This is usually only done if a problem is suspected		
3	Implementing partner data quality is audited periodically. Remedial action is recommended in severe cases		
4	Implementing partner data quality is audited regularly, with remedial action reports if necessary		
Means of Verification	Data Quality Audit reports		

Score: _____

10.16 APPENDIX P: CO-AUTHORS' AGREEMENT CHAPTER FOUR (PAPER I)

CO-AUTHORS' AGREEMENT

AND DECLARATION OF STUDENT'S CONTRIBUTION TO ARTICLES

The following people and institutions listed below contributed to the publication of work undertaken as part of this thesis. By signing this declaration, co-authors listed agree to the use of the article by the student as part of her thesis.

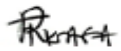
Author 1: Teurai Rwafa (Candidate)	**Centre for Health Policy, Wits School of Public Health**
Author 2: Nicola Christofides	Wits School of Public Health
Author 3: John Eyles	School of Geography and Earth Science, McMaster University
Author 4: Jane Goudge	Centre for Health Policy, Wits School of Public Health

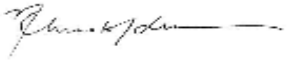
Paper I: Rwafa-Ponela, T., Christofides, N., Eyles, J., and Goudge, J. (2020) Health promotion capacity and institutional systems: An assessment of the South African Department of Health. *Manuscript in-press at Health Promotion International Journal.*

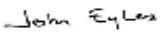
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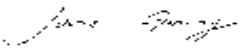
- **Candidate contribution**: TR was the primary author. She conceptualised the study, conducted the data collection and analysis and wrote the paper.
- Author 2: NC provided conceptual input to the design of the study, assisted with data collection, contributed conceptually to the analysis and writing of the paper.
- Author 3: JE commented on paper drafts.
- Author 4: JG reviewed, commented on drafts and writing of the paper.

Signed:

Author 1:  Date: 24/07/2020

Author 2:  Date: 5 Aug 2020

Author 3:  Date: 13 Aug 2020

Author 4:  Date: 5 Aug 2020

10.17 APPENDIX Q: CO-AUTHORS' AGREEMENT CHAPTER FIVE (PAPER II)

CO-AUTHORS' AGREEMENT

AND DECLARATION OF STUDENT'S CONTRIBUTION TO ARTICLES

The following people and institutions listed below contributed to the publication of work undertaken as part of this thesis. By signing this declaration, co-authors listed agree to the use of the article as part by the student as part of her thesis.

Author 1: Teurai Rwafa (Candidate)	**Centre for Health Policy, Wits School of Public Health**
Author 2: Jane Goudge	Centre for Health Policy, Wits School of Public Health
Author 3: Nicola Christofides	Wits School of Public Health

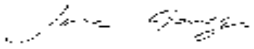
Paper II: Rwafa-Ponela, T., Goudge, J. and Christofides, N. Institutionalization of health promotion in the South African health system: A qualitative case study - *"The one who pays you has no name for you". Manuscript under-review at BMJ Open Journal.*

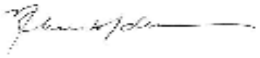
Located in Chapter 5

- **Candidate contribution**: TR was the first author. She conceptualised the study with the assistance of JG, collected the data, conducted data analysis and wrote the manuscript.
- Author 2: JG contributed conceptually to the analysis of the manuscript, commented and edited progressive drafts of the manuscript.
- Author 3: NC contributed to the data collection, data analysis and commented on manuscript drafts.

Signed:

Author 1:  Date: 24/07/2010

Author 2:  Date: 5 Aug 2020

Author 3:  Date: 5 August 2020

10.18 APPENDIX R: CO-AUTHORS' AGREEMENT CHAPTER SIX (PAPER III)

CO-AUTHORS' AGREEMENT

AND DECLARATION OF STUDENT'S CONTRIBUTION TO ARTICLES

The following people and institutions listed below contributed to the publication of work undertaken as part of this thesis. By signing this declaration, co-authors listed agree to the use of the article by the student as part of her thesis.

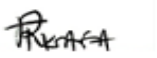
Author 1: Teurai Rwafa (Candidate)	**Centre for Health Policy, Wits School of Public Health**
Author 2: John Eyles	School of Geography and Earth Science, McMaster University
Author 3: Nicola Christofides	Wits School of Public Health
Author 4: Jane Goudge	Centre for Health Policy, Wits School of Public Health

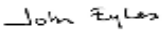
Paper III: Rwafa-Ponela, T., Eyles, J., Christofides, N., and Goudge, J. (2020) Implementing without guidelines, learning at the coalface: a case study of health promoters in an era of community health workers in South Africa. BMC Health Research Policy and Systems. 18, 46. https://doi.org/10.1186/s12961-020-00561-5

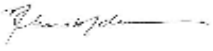
Located in Chapter 6

- **Candidate contribution**: TR was the first author. She conceptualised the study, conducted the data collection, data analysis and wrote the paper.
- Author 2: JE contributed conceptually to the analysis, and commented on paper drafts.
- Author 3: NC contributed to the analysis, commented on drafts of the paper.
- Author 4: JG reviewed, edited and commented on drafts of the paper.

Signed:

Author 1:  Date: 24/07/2020

Author 2:  Date: 13 Aug 2020

Author 3:  Date: 5 August 2020

Author 4:  Date: 5 Aug 2020

10.19 APPENDIX S: PLAGARISM DECLARATION

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I _____Teurai Rwafa_____ (Student number: ____740701_____) am a student registered for the degree of ____Doctor of Philosophy_____ in the academic year ___2020_.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature: _____ Date: _____31/07/2020_____

1

10.20 APPENDIX T: TURN-IT-IN REPORT

740701:Teurai_PhD_Thesis_v26.docx

ORIGINALITY REPORT

7%	4%	4%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Teurai Rwafa-Ponela, John Eyles, Nicola Christofides, Jane Goudge. "Implementing without guidelines, learning at the coalface: a case study of health promoters in an era of community health workers in South Africa", Health Research Policy and Systems, 2020 Publication	1%
2	www.cse.dmu.ac.uk Internet Source	1%
3	www.tech.dmu.ac.uk Internet Source	<1%
4	203.157.71.227 Internet Source	<1%
5	Wills, J., and M. Rudolph. "Health promotion capacity building in South Africa", Global Health Promotion, 2010. Publication	<1%
6	"Encyclopedia of Public Health", Springer Science and Business Media LLC, 2008 Publication	<1%