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Factors influencing implementation of health promotion guidelines for families with adolescents orphaned by HIV and AIDS

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Abstract

South Africa was rated among the sub-Saharan countries that failed to prioritise basic focused HIV prevention programmes to combat the new HIV infections across their borders (UNAIDS, 2009). It is therefore essential to re-engineer the HIV prevention programmes through the implementation of health promotion guidelines developed in this study in order to reduce the impact of HIV and AIDS. This study was designed to explore and describe the factors influencing the implementation of health promotion guidelines in the rural Hammanskraal region of the North West Province, South Africa. This study focuses on the implementation of the guidelines that were developed as part of the main study. The study was qualitative in nature, following the explorative, descriptive and contextual design. Data were collected through two focus group discussions involving 10 purposively selected participants, which assisted the researcher to explore the research question and describe the factors as they unfolded during the interaction with participants. The transcribed data were analysed using the steps suggested in the Tesch's method of data analysis**.** The four themes identified as factors influencing implementation of health promotion guidelines were: information, door-to-door campaigns, resources and culture. The study concluded that a successful health promotion programme requires effective strategies that concentrate on strengthening existing programme implementation among the adults and youth in order to address the cultural barriers which are impediments to the successful delivery of the programme.

Keywords: Health promotion, HIV and AIDS, guidelines, families and orphans.

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Introduction

UNAIDS (2009) reported an increase in the new AIDS infection rate among older heterosexual adults but limited prevention strategies were focused on older people (UNAIDS, 2009). South Africa has, over many decades, been overwhelmed by the increase in the overall burden of diseases and AIDS-related diseases which have remained one of the leading causes of death globally (UNAIDS, 2009).

Preventing the effect of the burden of AIDS was made a strategic priority by the national Department of Health in South Africa which introduced the community-based care national guidelines in December 2001 (Department of Health, 2001), following the strategies developed by the Ottawa Charter Declaration in strengthening community actions. However, South Africa's national guidelines lacked a procedure manual that could guide community health workers on how to properly execute their roles. Therefore, the implementation of the health promotion guidelines that were developed for health promoters are discussed in this study.

The guidelines were implemented by the researcher and health promoters working in the rural Hammanskraal region in the North West Province of South Africa to give guidance to families in the community on how to render health promotion activities. This study on the implementation of the guidelines was aimed at exploring and describing the factors that influenced the implementation of guidelines among families caring for adolescents orphaned by HIV and AIDS. The outcome of this study will be helpful to describe and evaluate the implementation of health promotion guidelines

The need to strengthen community action was one of the five strategies of health promotion that were agreed upon at the Ottawa Conference in 1986 with the aim of enabling people to increase control over and improve their own health (Jackson et al., 2007). However, part of their strategies which is to achieve the state of complete physical, mental and social wellbeing was to draw up health promotion policies and a systematic assessment of the health impact on the community particularly in the areas of technology, work and energy production (Jackson et al., 2007). In assessing the effectiveness of the health promotion strategy, it was concluded that more consistent definitions should be given for: health promotion; creation of appropriate qualitative indicators to monitor or evaluate success; qualitative systematic review to hear the voice of the community; and a continuous assessment of community interventions (Jackson et al., 2007).

A study on health promotion needs for families caring for adolescents orphaned by HIV and AIDS in rural Hammanskraal, South Africa) (Peu et al., 2008) motivated the need to look into the role played by the health promoters in assisting families in rural communities. This study forms part of a wider investigation conducted on the planning, implementation and validation of health promotion guidelines for families caring for with adolescents orphaned by HIV and AIDS. The North West Province is one of the nine provinces in South Africa that was noted as having a stable but a significantly high HIV infection rate of 30 percent amongst antenatal attendees (Department of Health, 2010). However, implementation of the health promotion guidelines did not seem to be as effective as expected, as reflected by the same percentages over three

consecutive years: i.e 30.6 in 2007; 31.8 in 2008 and 30 percent in 2009 (Department of Health, 2010). Assessment of the factors influencing the implementation of health promotion guidelines would reveal the constraints of health promotion in this area. Therefore, this study was carried out the purpose to explore and describe the factors affecting the implementation of health promotion guidelines in rural Hammanskraal, North West Province of South Africa.

Methodology

Design

An explorative, descriptive and contextual design was used to explore and describe (De Vos, 2005) the factors influencing the implementation of health promotion guidelines among families caring for adolescents orphaned by HIV and AIDS.

Population and sampling

The population of this study consisted of all male and female health promoters residing in the rural Hammanskraal region. To be included in the study, the participants had to be employed as health promoters by the South African government or non-governmental organisations and had to have served the rural Hammanskraal for more than three years. The sample for this study was purposively selected by two researchers and its size determined by data saturation. The typical characteristics of participants were observed during the sampling process. The selection was based on the judgement of the researcher. Knowledge of health promotion was one of the typical characteristics needed to be selected as a participant. The social worker who was working at the hospice centre selected participants from the non-governmental candidates and the health promotion coordinator from the Department of Health did the same for the governmental organisations. Eventually a sample of ten health promoters (four were male and six were females) was selected.

Data collection

Unstructured focus group discussions used to collect rich descriptive data were guided by one centralquestion: were conducted and the following question was asked, “What are the factors influencing the implementation of health promotion guidelines for families caring for adolescents orphaned by HIV and AIDS in rural Hammanskraal?” This question was followed by probing questions, which elicited more useful information (Polit & Beck, 2012). The interviews were tape recorded. Field notes were captured by an independent researcher in order to ensure credibility of data. The focus group discussions were held on separate

days with ten people in both interviews. A research assistant facilitated the discussions in English and the transcripts were later edited by Barbara English, a language editor.

Ethical issues

During the briefing meeting, participants were given an information leaflet with a consent form attached to request them to participate in the study and inform them about the value of such participation to the community. The information leaflet was explained to the participants and it elaborated on the purpose and nature of the study as well as the role of the participants in the study. Ethical principles such as beneficence, justice and respect for human dignity were observed and applied in order to protect the rights of participants (Polit & Beck, 2012). The participants were treated as autonomous agents where they were given an opportunity to decide whether or not to participate in the study. The participants were treated fairly during the research process. Impositions were avoided at all times. They were requested to take the consent form home so that they could read carefully and sign it if satisfied, before participating in the data collection process.

Data analysis

Verbatim transcription of data was done in a descriptive way soon after every interview was conducted using the Tesch's method of analysis (Cresswell, 2003). The two researchers discussed the process of data analysis soon after the focus group discussions and agreed on the preliminary themes, categories and the sub-categories based on the field notes they had both collected. Following the steps provided in the Tesch method, the researchers read through the transcribed data repeatedly to gain deeper understanding and to derive meaning of the whole while highlighting the ideas which conveyed of similar meanings and jotting them down as down some ideas as they were reflected. In formulating the main themes, the researchers grouped the highlighted ideas with similar meanings and gave them a common name that better clarified the set of ideas. The named sets of ideas were then separated, given a separate name that better explained their meaning to formulate the sub-categories. Then excerpts of statements made by participants during the discussion were further used to clrify the themes. Subsequently four themes and twelve sub-categories that better explained the factors influencing the implementation of health promotion guidelines emerged.

Measures to ensure trustworthiness

The criteria for developing trustworthiness, according to Lincoln and Guba (1985) as cited by Polit and Beck (2012), were utilised. These specifically involved credibility, confirmability and transferability. In ensuring credibility the

researchers strove to establish confidence in the truth of the findings and the context of the study (Polit & Beck, 2012). It was ensured that sufficient descriptive data were provided to allow the consumers to engage in evaluating the data for use in other contexts (Polit & Beck, 2012). Credibility also was achieved through prolonged engagement and member check.

The researcher spent a period of four months with the participants thus gaining their trust and confidence in providing truthful information. The analysed and interpreted results were shared with participants and feedback was provided to them on regular basis. Regarding confirmability, person triangulation was attained through the use of participants with different occupations such as nurses, social workers and lay counsellors in order to validate data. Transferability was achieved through the use of dense description of data (Krefting, 1991).

Results

Four themes and twelve subcategories were isolated as the factors influencing the implementation of health promotion guidelines (Table 1).

Table 1: Results: Themes, sub-themes and subcategories

THEMES	**Sub-theme**	**SUBCATEGORIES**
Information	Lack of information	Information on HIV and AIDS and health issues.
		Some have information but choose to ignore it.
	Awareness campaign	Adults feeling offended when educated amongst young people.
		Presence of important figures in campaigns.
Door-to-door campaigns	Starting time	Non-compliance to starting time affects the target.
	Follow-up on cases	Many cases identified never followed up.
	Community involvement.	The presence of young people during campaigns may yield better results.
	Referral of social problems	No feedback on cases referred to Social Department.
Resources	Transport	No transport for house visits.
	Medication	No medication issued from our centre.
	Personnel	Increased workload due to staff shortages.
	Financial sustainability	Interrupted funding affects our effectiveness.
Culture	Cultural barrier	Values and customs hindering the reception of health promotion.
	Religion	Religious beliefs resisting health education in their church.

The four main themes identified were: information, door-to-door campaigns, resources and culture.

Theme 1: Information on health promotion

Information plays a vital role in promoting the health of families and communities. Any lack or abscence of information may affect the implementation of health promotion interventions. Information on health promotion was identified as the first theme with two sub-categories: lack of information and awareness campaign.

Sub-Theme 1:1 Lack of information

Lack of information was observed by the young and older people when confronted with issues involving HIV and AIDS. Health promoters seemed ignorant, not knowing the mode of spread of the disease, how it affects the people and their next of kin as confirmed by the following statement, *"...others even if they have it (information), they tend to ignore the information they have..."* The health promoters are still, themselves, immersed in behaviours that put them at risk such as having multiple partners or sex without condom.

Sub-Theme 1:2 Awareness campaign

When giving health education on HIV and AIDS especially on how to use a condom elderly people felt offended when educated amongst young people. One participant stated that: *"There are adults who still chase away children when we educate them about sexual issues."* It seemed like they preferred being taught separately from younger people. Moreover, participants felt that if they involve important figures during their health campaigns such as political and traditional leaders, music icons and teachers, the impact will be more effective, as such people are highly regarded by community members. This sub-category is epistomised in the following statement: *"If we had one of the musical icons who's HIV infected, or teachers attending the campaigns or even the political leaders, people will take the information given seriously"*.

Theme 2: Door-to-door campaigns

Door to door campaigns are activities that are conducted by the health promoters to promote the health of families in the absence of health professionals. They act as extended arms of nurses. Door-to-door campaigns emerged as a theme with the following sub-categories that influenced the implementation strategy: starting time, follow-up on cases, community involvement and referral of social problems.

Sub-Theme 2:1 Starting time

The starting time for health visits was usually delayed mainly from the participants' and the hospice's sides. Participants expressed their dissatistaction in this regard and felt that if they started earlier in the field, it would yield better

results as they would cover a wider area. Quotations such as *"we need to respected time, we all know we are supposed to start working at nine... let us not waste time on other issues"* confirmed the statement made as a reaction to an earlier comment regarding punctuality. Transport delay seemed to be the culprit as the participants sometimes had to wait for the car to run the hospice centre's errands first before it transported them to the field.

Sub-Theme 2:2 Follow-up on cases

During the door-to-door campaigns, participants covered a wide range of people and identified many health and social needs. Their shortfall was not making a follow-up visits to all the families identified for further assistance in managing their problems. Factors such as transport and shortage of staff were mentioned as setbacks as confirmed by the following excerpts *"... we usually do not do follow up because we are short staffed and have no transport to reach the areas... to check up on orphans, how they are and if they've been to the Social Department"*.

Sub-Theme 2:3 Community involvement

Participants highlighted the need to have young people during these campaigns as they believed that community involvement would yield better results concerning information dissemination as more young people would take the participants seriously. The peer pressure amongst young people made them act ignorantly and get involved in behaviour that predisposed them to contracting HIV, and indulge in risk behaviours such as alcohol and drug abuse. The statement *"I think young people should come with us during these campaign to influence other young people"* was made very often by most of the participants. The involvement of young people in educating the community would make them acknowledge the information they had previously ignored.

Sub-Theme 2:4 Referral of social problems

In this regard participants were concerned, as most of their clients were living in impoverished conditions. Excerpts of statements include: *"It is depressing to enter the family, educate about the importance of taking medication while they are hungry... at times we give them the nutritional porridge to eat"* In cases where the families or individuals were referred to the Social Welfare Department such referrals were fruitless as confirmed by the following statements: *"most of them will tell you that they've been to the Social Department and were told to bring more documentation which they didn't."* This indicates that clients did not follow up their documentation after submission and therefore they were not receiving feedback from this Department of Social Welfare.

Theme 3: Availability of resources

For effective rendering of a health promotion programme in families with adolescents orphaned by HIV and AIDS, resources should be equitably allocated and utilised. Availability of resources as a theme was described by participants in terms of four categories: transport, medication, personnel and financial sustainability. These categories were identified by participants as influencing the implementation strategy.

Sub-Theme 3:1 Transport

Transport was reported as the main contributor to the challenges faced by participants. Factors such as starting time, follow up not done and lack of working material were central to this sub-category, as confirmed by the following excerpt: *" At times we have to wait for the car to collect the orders and transport those going to meetings first before it takes us to the field."* At times they would fail to do home visits to areas farther from their homes and visit schools instead because of transport difficulty.

Sub-Theme 3:2 Medication

The fact that the hospice centre does not supply medication to clients discourages them. Many of their clients expect medication from them as they are weak and cannot withstand the long queues at the local clinic. Statements such as, *"You find that they are weak and cannot go to the clinic on their own; it becomes a problem... some of them would come to the hospice centre expecting to get their medication refilled"*. This becomes a challenge as they end up defaulting on treatment as a result of many factors preventing them from getting to the clinic or health centres.

Sub-Theme 3:3 Personnel

Staff shortages contributed to increased workload, as they strive to cover a wider range of clients in one day, which leaves them exhausted. Examples of such statements are: *"we get so tired and the workload is too much for us; we need more health workers in the field with us."* Participants wished that if more personnel were added to their team, it would aid in relieving the burden of workload that they carry.

Sub-Theme 3:4 Financial sustainability

The interruption in funding from the donors affects the participants directly, as every time it happens they go without pay. This was confirmed by the following excerpts: *"At times I have to borrow money from others, just to maintain my*

children because to them they do not understand these things...” Participants were solely dependent on the stipend as their source of income. They felt negatively affected by this factor, as it dampened their morale: *“it is very discouraging to work for the whole month and go without pay”*.

Theme 4: Culture

Culture is a way of living; it is inherent in all ethnic groups and determines an individual’s traditional affiliation. Health promoters are expected to observe the principles of transcultural nursing while working with different families. Culture emerged as a theme with the following sub-themes: cultural barrier and religion.

Sub-Theme 4:1 Cultural barrier

Participants in this sub-category felt that the cultural factor was restricting them from educating the community about HIV and AIDS and other health promotion activities. The fact that a young health promoter would stand in the midst of adults, and teach them about safe sexual practice was regarded as disrespectful in their culture as confirmed by the following statements: *“...our parents need to know that in order to prevent teenage pregnancy; we must adapt and educate them together... “...there are parents who still chase away young children especially when we talk about sexual issues”*. Also, for a young female health promoter to teach male adults was regarded as taboo in their clients’ culture, as supported by the following expressions: *“It was better if we had male health promoters in the field to educate male adults... it feels unpleasant for them to listen together... especially when condom illustration is done”* This factor came as a challenge to them and they had no way of resolving it “*... certain people still believe that when HIV positive you are bewitched; there is still a lot of myth going around this topic”*. Instead, the health promoters were stigmatised by the same community members as being associated with people living with HIV and AIDS *“... they already know what we are to say to them... they tend to undermine us... we become stigmatised and it de-motivates us”*.

Sub-Theme 4:2 Religion

The religious factor was regarded as a major impediment, as it contradicted their health promotion activities, as confirmed by the following statement: *“It becomes difficult to centre those places and teach about HIV and AIDS since they believe HIV can be cured.”* Their duties were to educate the community on safe sex practice whereas the religious group resisted it as they believed in abstinence before marriage. For an example, some participants said: *“Most churches do not allow young people being taught about sexual issues.”* Their concerns were that the young people from the same religious groups were falling

pregnant, which showed that they ignored both their religious principles and the health promotion information.

Discussion

Information on health promotion was inadequately disseminated in the study setting as many young and old people demonstrated lack of knowledge on issues involving HIV and AIDS. Those who had information on HIV and AIDS still indulge in high-risk behaviours such as alcohol and drug abuse. Though evidence has hardly been provided on drug user infection rate in Africa, the UNAIDS report notes an elevated level of infections across all regions (UNAIDS, 2009). A study by Pirincci et al., (2008) found a significant difference in health promoting lifestyle behaviour between married people who showed in good lifestyle behavior increases and unmarried people whose lifestyle behavior deteriorated. It has been observed that health responsibility increases among individuals with higher educational level than those with lower levels (Pirincci et al., 2008). This indicates that when a person is educated, the person has more understanding of good health than a person who is not educated. These authors' findings are similar to those of a study conducted by Bourne (2009), where married men reported illnesses than those who were never married. It was further emphasised in the same study that marriage is beneficial for men but once they separate or divorce deterious health conditions are observed.

In Bourne's (2009) study the platform was provided to investigate the health of men in Jamaica. This Jamaican study highlights the lack of health promotion among various groups, including men. However, lack of information was associated with long distance to facilities, ignorance and lack of adequate educators in the communities (Mboera, 2007). Regarding the awareness campaigns, participants expressed the need for important persons in the community to form part of these campaigns in order to encourage the community to accept the health promotion messages. Prominent people such as religious leaders, school teachers and influential people were regarded as the reliable providers of health information in the study conducted by Mboera et a.l (2007). Therefore, the inclusion of these prominent people in the community should enhance the implementation of health promotion guidelines for families caring for adolescents orphaned by HIV and AIDS in rural Hammanskraal.

During door-to-door campaigns, factors such as starting time affected the effective rendering of health promotion in the community. Health promoters seemed to be delayed at the centre and started late to visit families. Participants acknowledged the fact that they could not go back to all cases identified for follow-up visits. Prasad and Muraleedharan (2007) reported that service coverage varies according to communities and populations. In Sri Lanka for example, health care workers

cover 10 households but while in India they cover up to 1000 households (Prasad & Muraleedharan, 2007).

Through community involvement, the presence of young people could help in convincing the youth to accept the health promotion messages. This notion was supported in China where a comprehensive sex education programme significantly increased their sex-related knowledge and attitude towards premarital sexual activity, thereby encouraging them to abstain from sex (Wang et al., 2007). The National Departments of Health and Social Development in South Africa reported that there are several people that are still living in impoverished conditions with no social grants. According to the 2009 statistics, there were an estimated 1.95 million orphans in South Africa (Department of Health, 2010), while poverty, unemployment and lately HIV and AIDS were noted as the most prevalent problems affecting families in the rural areas of the country (Maqoko & Dreyer, 2007).

There were many factors involved in the theme on availability of resources that were seen as influencing the implementation of health promotion guidelines. These resource factors involved transport, medication, personnel and financial sustainability. Transport was seen as the major factor that prevented the health promoters from working efficiently. Because transport serves as a necessary factor in transporting these health workers to the community to provide health promotion, it should be available, efficient and accessible as an asset to health promoters.

Studies have shown that recruiting health workers from the same community has an impact on utilisation of the services and creating health awareness and outcomes within the community (Prasad & Muraleedharan, 2007). The fact that the health promoters are not issuing repeat medication to clients makes their work incomplete, as clients expect them to regularly supply them with medication. Their job description does not include dispensing but they support clients to promote adherence to medication. The assessment made by Prasad and Muraleedharan (2007) was that most community health workers offer preventive care rather than curative care, which reduces the community's confidence on the effectiveness of their services. Staff shortage negatively affects the morale of health workers and leaves them overworked, exhausted and discouraged. Resources such as inadequate personnel and transport were seen as challenges to successful implementation of antiretroviral therapy in the study conducted by Chung et al. (2008). Lack of financial sustainability was also seen as affecting the ability of health promoters to function productively. Fixed salaries or voluntarism could not be singled out as influencing community health workers' performance but other factors including resources; population and service coverage also influence effective delivery of health promotion programmes (Prasad & Muraleedharan, 2007).

In this study, culture was seen as a factor that influenced successful implementation of health promotion activities. Culture also has become a barrier in the efforts to educate people in some communities. The subcategory of cultural barrier affected both parties, since the health promoters were part of the same culture that requires that young people do not talk about sex to adults. Similar studies have confirmed cultural barrier; especially gender barrier that restricts female health promoters from meeting the needs of male clients (Jackson et al., 2007; Mboera, 2007). In addressing the cultural barrier, Jackson et al. (2007) employed multiple strategies, which included using male health care workers to provide training and supervision to reduce gender stereotyping. The religious group which claimed in the current study that it could cure HIV made it difficult for the health promoters to penetrate their territory of believers. In contrast, religious leaders were regarded second as a source of information in a 94.3% Christian-dominated community in Tanzania (Mboera et al., 2007).

Conclusion

The findings of this study showed that many factors affected the successful implementation of health promotion guidelines in rural Hammanskraal. These factors prevented health promoters from working effectively and efficiently. As Huff and Kline (2008) affirm that failure to understand cultural differences can present major barriers to effective rendering of health promotion. The results of this study thus provide insight to researchers to be cognizant, considerate and sensitive to the cultural differences associated with health promotion. Since the study was limited to the health promoters at Hammanskraal community their views may be different from those of other communities as different research settings have unique challenges. However, it is recommended that implementation strategies be developed that concentrate on health promotion for adults and young people separately, so that the learning environment becomes more comfortable and culturally appropriate.

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