HEALTH PROMOTERS' CONTRIBUTION REGARDING HEALTH PROMOTION FOR FAMILIES WITH ADOLESCENTS WITHIN THE HIV AND AIDS CONTEXT

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ABSTRACT

Health care workers are faced with increased workloads because of clients who are suffering from different types of chronic illnesses, including HIV and AIDS. This article explored and described the role of health promoters regarding health promotion programmes for families with adolescents that have been orphaned by the HIV and AIDS endemic. A descriptive, qualitative phenomenological study was employed. The population involved health promoters in the Hammanskraal region in rural South Africa. The participants were purposively selected for focus group interviews. Data were qualitatively analysed. Various health promoters' contributions were identified regarding home visits, patient care, social care and health education. The contributions of health promoters were visible and efficient in the communities. It was recommended that the community, the governmental and non-governmental organisations should train and support health promoters to assist in service delivery for local communities.

Keywords:
HIV and AIDS, contributions, health promotion, health promoters, orphaned children

INTRODUCTION

The number of patients who need health services, including health promotion, is increasing in communities as influenced by an estimated 5.6 million people in South Africa living with HIV and AIDS in 2009 (The Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010). Although the World Health Organization (WHO) managed to reduce the number of both adults and children with HIV, including the number of people dying from AIDS-related illnesses, Southern Africa, including South Africa and Central Africa, remain the regions severely affected by HIV and AIDS (Millenium Development Goals Report, 2013). In the same report, it was emphasised that health prevention efforts must be enhanced and sustained to reduce the high impact of AIDS-related infections. These efforts may include health promotion interventions aimed at changing people's health behaviours. In support of the above discussion, the World Health Organization (2015) states that various interventions should be included to assist with health promotion for individuals, families and communities. These interventions include male involvement in childbirth practices and community participation in programme planning and implementation. Therefore, these interventions stand to enhance existing strategies in health promotion for HIV-related infections in order to reduce the prevalence thereof.

Health promoters are faced with increasing workloads resulting from patients who suffer from different types of chronic diseases including HIV and AIDS. These health promoters are multi-skilled in managing diverse situations such as home visits, patient care, social work services and health education. Although UNAIDS (2010) has reported a decrease of 18% in AIDS-related deaths, another 610 000 AIDS-related illness and deaths were reported in 2009. This situation has left behind an increased number of AIDS orphans in South Africa (UNAIDS, 2010). The number of AIDS sufferers who are simultaneously stricken with other chronic conditions such as cancer, complications of hypertension and diabetes, are dependent on the health promotion services rendered by community health care providers (WHO, 2013). The majority of these services is inadequately provided or cannot be accessed at all.

The inadequate implementation of health promotion programmes is both a global and South African health concern. This inadequacy affects the health of both individuals and families. Individuals and families lack health promotion information that is necessary to promote their health and prevent communicable and non-communicable diseases. Studies by Peu (2014) and Mnisi, Peu and Meyer (2012), confirm that there are flaws in the implementation and sustainability of health promotion programmes as a result of the conflicting scope of health promoters' contributions. Mnisi et al. (2012) argue that the control of a disease such as Tuberculosis (TB) at the primary healthcare level, may pose a concern in particular for community nurses, as it may increase workload and responsibilities. On the other hand, the above concern may later cause a problem regarding the contribution of community nurses and health promoters in the prevention of TB. Both the community nurses and health promoters may have conflicting contributions related to the health promotion of clients.

Health promoters are important role players in the primary health care team. Their main function includes, among others, health promotion and disease prevention. Their promotive and preventive roles among families with adolescents orphaned by HIV and AIDS are especially significant. These health promoters face obstacles regarding their contributions

in the communities including home-based care. They travel long distances trying to cover their designated service areas as part of their responsibilities in the primary health care team. Health promoters render home-based care in order to support the well-being of families and ensure continuity of care. However, the challenge raised by Gamal (2009) is that the majority of families do not consult public health facilities for different reasons when a member of a household is ill. These families prefer their own alternative treatment to manage their ill health.

The study was conducted in Hammanskraal, a semi-rural area fifty kilometres north of Pretoria. It is occupied by communities that mostly utilise one district hospital and primary health care clinics. In Hammanskraal, the contributions of health promoters in a home setting include: the provision of HIV counselling, testing of HIV and AIDS among family members other than the patient, delivery of drugs on a monthly basis, provision of services, adherence and support (Jaffar, cited in African Press, 2009). Additionally, health promoters assist primary health care nurses to continue to initiate and manage antiretroviral drugs in the community (African Press, 2009). These nurses also conduct health screening tests to exclude high levels of glucose, cholesterol and, blood pressure. They provide health education to enhance the community members' healthy life style (Aponte and Nickitas, 2007).

LITERATURE

Health promotion is a global health issue affecting both developing and developed countries. Global governments continue to develop national health promotion plans to redirect the future of health care in order to help people stay healthy and in a safe environment (Pender, Murdaugh and Parsons, 2014). Peu, Hlahane, Madumo, Mataboge, Petlhu Prinsloo and Ricks (2012) note that health promotion is the process of improving health and assisting individuals to be healthy. The concept of "health promotion" was debated and analysed during the Alma Ata Declaration Conference held in 1978 where eight countries came together to assist with the methods of reducing health disparities in various countries (Dennill, King and Swanepoel, 2008). The authors further emphasised that the focus of discussions were based on the definition of health, existing gross inequalities in peoples' health status as well as economic and social development of people.

After the Alma Ata Declaration Conference, the Ottawa Charter Conference was conducted with the aim of achieving "health for all" by the year 2000. The key points discussed were on public policies, creation of a supportive environment, strengthening community action and personal skills development (Dennill et al., 2008). Even currently, health for all by 2000 has still not been achieved. Health for all is still a challenge as the situation in some areas is becoming worse leading to extreme poverty and HIV and AIDS. This paper, therefore, focuses on the strengthening of health promoters in health promotion in order to address existing health promotion challenges within the HIV and AIDS context and the contributions of health promoters in the community. Therefore, many families with adolescents orphaned by HIV and AIDS are left with the burden of heading households and taking care of siblings (Peu, 2014). These families need a healthcare provider who will assist them in promoting their health.

Health promotion and disease prevention are two concepts used interchangeably in preventive, promotive, curative and rehabilitative care. Health promotion is a broad term

and encompasses disease prevention and health education. It is a process that ends with outcomes. It is also approach motivated whereas prevention is avoidance motivated (Pender et al., 2014). On the other hand, disease prevention includes strategies that can be implemented to enhance health promotion.

There is an alarming increase of preventable diseases. Strategies to promote health for all populations have been addressed (Murray, Zentner and Yakimo, 2014). These preventable diseases include communicable and non-communicable diseases. Although much has been published on disparities of health care services and health promotion, diseases such as TB, HIV and AIDS and other common conditions, continue to affect vulnerable groups who lack the necessary information for promoting their own health.

More interventions and strategies, such as interventions to promote awareness of human, sexual and reproductive rights and the right to access quality skilled care (WHO, 2015), as well as a variety of roles, are needed to assist individuals, families and communities to be free from infections. Interventions and strategies have been documented on promoting the health of the society, but little has been documented on the contributions of health promoters regarding health promotion within the HIV context. Routine roles and contributions have been implemented, with little effect, on the process of health promotion. Therefore, it is necessary to explore and describe the contribution of health promoters as part of healthcare providers in the HIV context.

Health promotion is regarded as a process and an outcome. It is the process where role players, such as health care providers, families and communities, come together to enable others to take control over the determinants of their own health (Pender et al., 2014; Peu et al., 2012). This process, if conducted well, can lead to the outcomes related to good health and well-being of clients. Health care providers are expected to promote health at primary, secondary and tertiary levels of care. Therefore, a variety of role players are needed to conduct healthy campaigns, visiting homes, providing patient care and health education.

THEORETICAL FRAMEWORK

A phenomenological paradigm was adopted as a method and a framework to conduct this study. Phenomenology has existed in a philosophical context for nursing research and as a research method (Lopez and Willis, 2004). The authors further specified that an assumption specific to Husserl's philosophy, was that experience as perceived by human consciousness has value and should be an object of scientific study.

Additionally, the authors noted that the Husserlian phenomenology is the belief that it is essential for the researcher to shed all prior personal knowledge, in order to grasp the essential lived experiences of those being studied. Streubert and Carpenter (2011) documented that a descriptive phenomenology follows a three step process namely, intuiting, analysing and describing. The authors noted that intuiting requires the researcher to become totally immersed in the study. In this study, during data collection, the researcher was totally immersed in the study by listening carefully to the experiences as they unfolded. Additionally, the authors identified the essence of the contributions of health promoters during data collection and analysis (Streubert and Carpenter, 2011).

THE RESEARCH SETTING

The research was conducted at a selected hospice in the Hammanskraal area which is about 50 kilometers north of Pretoria. The hospice caters for more than 78 villages with families affected and infected by HIV and AIDS. The area is served by one district hospital and various primary health care clinics. There are clinics that provide 24-hour health care services and others serve the community only during the day.

PROBLEM STATEMENT

Individuals and families lack health promotion information and guidance that is necessary to promote their health and prevent diseases. Studies suggest that there are constraints in the planning, implementation and sustainability of health promotion programmes as a result of the conflicting scope of health promoters' contributions (Peu, 2014; Mnisi et al., 2012). The authors further argue that the prevention and control of a disease, such as Tuberculosis (TB), at the primary healthcare level, may pose a concern in particular for community nurses, as it may increase their workload. Both health care providers may have conflicting roles and contributions regarding health promotion among families with HIV and AIDS and TB. Health promoters, as part of healthcare providers, involve both professionals and non-professionals who are responsible for promoting health and preventing diseases within the community. When these health promoters are allocated to serve a particular community, they experience conflicting contributions regarding health promotion programmes.

AIM OF THE STUDY

The aim of this article is to explore and describe health promoters' contributions in health promotion for families with HIV and AIDS.

RESEARCH DESIGN

This qualitative study followed a descriptive phenomenological research design to explore participants' lived experiences and health promoters' contributions in health promotion for families with adolescents in the HIV and AIDS context. The purpose of choosing descriptive phenomenology was to examine and understand health promoters' experiences on their contributions towards health promotion for families with adolescents in the HIV and AIDS context (Polit and Beck, 2012). Additionally the authors further asserted that phenomenologists insist on careful description of conscious daily life situations.

The population consisted of health promoters who were community nurses, HIV counsellors and social workers in South Africa. Purposive sampling was used to select participants who were health promoters and who provided health promotion and home-based care to families with adolescents orphaned by HIV and AIDS. The participants were recruited through a selected district hospital and a selected hospice. I visited the selected hospital and the hospice to assess the participants. The participants were provided with the information regarding the type and nature of the research. Health promoters' contributions were on families with adolescents orphaned by HIV and AIDS because the majority of the adolescents in the area were orphans in need of assistance.

Focus group discussions were used to collect rich descriptive data from the participants. Two focus groups were used during data collection. Each group consisted of eight participants. This method is a favourable method of data collection particularly in health issues (Polit and Beck, 2012). According to Polit and Beck (2012), this method is efficient for gaining the views of many people simultaneously under the direction of the researcher. The following question was posed: *What are your contributions in health promotion for families with HIV and AIDS?* This question was followed by probing questions in order to elicit in-depth information on the contributions of health promoters. The researcher became totally immersed and paid attention to the phenomenon under study (Streubert and Carpenter, 2011). Interviews were conducted for about 30-60 minutes. Data were collected until saturation was reached. After data collection, all the participants were thanked for taking part in the study.

Collaizzi (1978), as cited by Polit and Beck (2012), was utilised for data analysis. All the protocols were read, reviewed and significant statements were extracted to identify the essence of the phenomenon (Streubert and Carpenter, 2011). The meaning of each significant statement was constructed. All the meanings were organised into clusters representing the main themes. The researcher distinguished phenomenon with regard to elements and constituents and later looked at their relationships (Streubert and Carpenter, 2011). The researcher communicated and brought distinct and critical elements of the contributions of health promoters to the written and verbal descriptions. All the findings were integrated into exhaustive descriptions which were validated by the participants.

Measures to ensure trustworthiness

Trustworthiness was confirmed through credibility, dependability, transferability and confirmability. In ensuring credibility the researcher used prolonged engagement and member checking. The researcher spent sufficient time with the participants during interview discussions. The reason for spending such time was to build trust and rapport which assisted during the research process in achieving saturation. During member checking, the researcher shared the results with participants as well as the interpretation thereof. Consensus was reached with the participants to elicit the understanding of results. Both the researcher and the co-coder met and reached a consensus on the findings. The researcher kept data safe and secured for future reference. The use of field notes, the interview report and recorded data ensured confirmability. Confirmability was also established through the involvement of the co-coder and the objectivity in the study (Polit and Beck, 2012). The objectivity of the study was ensured through bracketing of researchers' pre-conceived ideas. Transferability was ensured through the use of dense description of data. The use of various interviews and the use of the context assured the extent of the study's transferability.

Ethical considerations

Permission was requested from the sub-district in the North West Department of Health. The researcher observed principles of ethics such as beneficence, respect for human dignity and justice (Polit and Beck, 2012). The participants were protected from all forms of ethical misconduct. The researcher tried to reduce any harm during the research process. Participants were assured that they could withdraw from the study at any stage during data collection. Qualified researchers were used to conduct data collection and analysis then

report every research process or step to the participants and supervisor. Fairness and respect were applied during data collection at all the times (Polit and Beck, 2012). The researcher ensured fairness and equity during the selection of participants. The researcher ensured equal and fair treatment for each individual participant in expressing their contributions. Care was taken not to discriminate the participants against a particular group on the basis of their age, gender, disability and sexual orientation (Holloway and Wheeler, 2010). All participants were treated equally during the research process.

FINDINGS

Four themes, as the essence of phenomenon, emerged from the focus group data. These included conducting health promoting home visits, ensuring patient care and general well-being, social care and facilitating health education as health promoters' contributions.

Conducting health promoting home visits

Conducting health promoting home visits emerged as the first theme. The participants reported that they conducted home visits by assessing their clients upon entering the homes to see whether they were bedridden or not. During home visits the health promoters assessed the type of treatment their clients were on, and whether their clients were in general health and wellbeing or not. The majority of participants indicated that their clients received chronic patient care. Additionally, participants reported that they conducted home visits to their clients two or three times a week. This was expressed as:

"*We do door-to-door campaigns to the community to teach about HIV and AIDS.*

We visit homes three times a week i.e Monday, Wednesday and Friday to different clients with HIV and AIDS, cancer, TB and infected and affected persons. We do house visits on specific days to see if our patients are taking their medication correctly and we check if the environment is clean. We observe if the client is going for their check-up regularly and checking if the family is supporting our client".

The duties performed included: mainly nursing care as they assessed the nutritional status of the client and the family at large; keeping the clients and their home environment clean; and assessing the general health status of the family.

Ensuring patient care and general well-being

Patient care is a priority to all health care providers. Patient care emerged as the second theme. During access of entry to the homes of their clients, participants reported that they provided treatment and conducted bed bathing to clients while encouraging the family members to clean the surroundings. They also monitored vital signs which included blood pressure, temperature and breathing as confirmed by the following quote: "*I take care of ill patients; and I do vital signs"*. Participants also mentioned that they checked the general condition of the other family members and referred those that needed medical attention. The participants further mentioned that:

"Majority of us perform observations and monitor clients if they take their treatment on time. Yes we assess the general status of the client, regarding wounds and pressure sores that need dressing or treatment. We assess the physical and mental well-being of the new clients and take care of our client. Yes we give love and support and also to check if

monitor if clients are taking treatment well. Whether client eating well and well cared for. The vital signs are taken to see if client's condition is normal. Food supplements are given to boost their immune system. We do bed bath for the patients who are unable to bath themselves".

The participants mentioned that they took care of their clients and gave them support where necessary. It showed that they were keen to provide quality of care.

Social care

Social care is regarded as the cornerstone of social services. Social care was identified as one of the themes. Participants indicated that they assessed whether the adult clients had children or not and whether the children were attending school. This is confirmed by the quote from one of the participants: "*...if he/she has children and whether they are going to school and whether the family needs to be referred to the social worker"*. Participants also noted that they established if the family received social relief in the form of food packages and, if not, they referred the family to the social workers. This was asserted as: *"...if they are receiving any disability grant and if not I refer them to the social worker..."* They also indicated that they supplied the nutritional supplements received from the Hospice to impoverished families while waiting for the social grant to be processed. However, the participants emphasised that the nutritional supplements only met the nutritional needs to a certain point and the conditions of living were still noted as under distress.

The participants further reported that they offered social work duties such as application for school based care, investigating adoption and foster care placement of abandoned and orphaned children. These were mentioned as: "*I process adoption, foster care placement, school and home visit"*. The participants confirmed that they offered counselling to the families and individuals in need of care ("*basically giving care and support*"), supported sufferers and survivors of gender based violence:

"Majority of us conduct awareness in schools, churches and the community. I facilitate training on HIV and AIDS and Gender related issues and Peer education. We render counselling to individuals and families and give care and support to various clients. Adoption and foster care placement are done. We conduct school and home visits; check on home circumstances and conditions".

The quotations above summarise the contributions of health promoters regarding health promotion. They were not only focusing on the sick but also promoted health and prevent diseases.

Facilitating health education

Health education was noted by the participants as a continuous process which was offered on a daily basis in the community. Participants reported that they gave health education regarding infection control. This was expressed as: "*On arrival, I first check if windows are opened*". The participants indicated that they advised families to open windows to allow in fresh air for the sick. They further noted that they educated the family on the condition of the clients, on how to administer treatment, as well as taking care of their hygiene, nutrition and healthy living. *"...Regarding the client's condition and educate them if they lack any.*

I educate on treatment and on nutrition and on hygiene and the importance of staying clean to keep out of infection".

The participants also emphasised that they educated the clients on the importance of adhering to treatment: *"...reinforce education on the importance of taking treatment to the family". We teach family members on how to take care of the clients. We teach them about nutrition and monitor if clients take their treatment on time".*

It shows that health education seemed to be their major contribution in the community and the participants demonstrated enthusiasm and passion when they spoke about health education.

Health education was emphasised by the participants as a strategy to promote a positive and healthy lifestyle by rendering health education to the clients, for example, the encouragement of developing vegetable gardens in their homes to emphasise healthy lifestyles. This was attested by the following: "*...I facilitate gardening services. To all the clients, I teach them on how to grow different vegetables*". The vegetables in the garden were used to serve the clients admitted to the hospice while some were sold in the community to generate funds to maintain the centre.

The participants provided teaching to family members about nutrition and on how to take treatment. No literature has been included for verification of each finding to locate the findings in the general literature both globally and locally.

DISCUSSION

Conducting health promoting home visits

The objective of this study was to explore and describe the contributions of health promoters regarding health promotion for families with adolescents within the HIV and AIDS context. It was evident that health promoters contribute immensely in health promotion programmes. They are taking charge in conducting health promoting home visits, ensuring patient care and general well-being, social care and facilitating health education as their contribution. During the discussions, the participants realised that their contributions were interlinked and overlapping with other nursing categories. They further emphasised that they worked with social workers during health promoting home visits and door to door campaigns (Peu, 2014). Similarly Kemppainen, Tossavainen and Turunen (2012) confirm that the role of nurses involves clinical nursing practice, follow up treatment, patient education and illness prevention. The authors additionally mentioned that these contributions had improved availability of health care services and increased cost effectiveness thereof.

Patient care came up very strongly as part of quality care. During the participants' visits, they assisted families with patient care, while assessing the environment, educating the family and the clients on HIV and AIDS care and support, disease prevention and the treatment they were taking (Peu, 2014). The author further confirmed that health promoters assessed and assisted clients in establishing their own vegetable gardens. Kemppainen et al. (2012) concur with Peu (2014) that nurses are general health promoters as well as patient focused health promoters. The authors further noted that nurses are associated with

common universal principles of nursing. These nurses provide health promotion intervention such as health education. In the current study, participants emphasised that they gave health education to individuals and families.

The health and social welfare professionals play vital roles in the communities. Their skills and expertise are greatly needed and may be effective and efficient if they were rendered through a home-based care programme. There was a plea for the skills by the participants. The plea was about empowering health promoters with relevant and diverse skills such as caring for clients and conducting health promoting interventions to various clients. The challenge of the shortage of nurses and social workers has made the South African government to declare the two professions as scarce skills (Wildschut and Mqolozana, 2008). South Africa is sitting with 41.2% of professional nurses, 19.5% of enrolled nurses, followed by nursing auxiliaries at 30,3% at governmental and non-governmental institutions, of which 32.8% of these nurses are between 40-49 years of age (Wildschut and Mqolozana, 2008). What is of concern with this report is the fact that nurses below the age of 25 only account for 1.3%; giving an impression that the nursing profession is comprised of an ageing generation with no significant new enrolments to the profession (Wildschut and Mqolozana, 2008). In a similar study conducted by Laperrier (2008) participants had perceived themselves as liaison officers between the community and the public health agencies to give account of their activities to their supervisors or facilitators, including reporting and referring clients on behalf of the community.

Facilitating health education

Health education was noted by the participants as a continuous process which is offered on a daily basis in the community. Participants reported that they give health education regarding infection control and disease prevention. Obasi, Cleophas, Ross, Chima, Mmassy, Gavyole, Plummer, Makokha, Mujaya, Todd, Wight, Grosskurth, Mabey and Hayes (2006) report that in order to address certain aspects of sexual reproductive health in the community, the key intervention components should include reproductive health education in primary schools, training of health care workers, community health care promotion by the youth, and community activities to address socio-cultural barriers as well as to promote support structure within the concerned groups. Jaffar as cited in African Press International (2009) is of the opinion that a successful rolling out of home-based care programmes would mean providing training and support mechanisms to health care workers in order to promote proficiency in their skills. Peer education had been successfully used as a strategy to prevent and educate young people on HIV and AIDS in the sub-communities of India (Bowles, 2005). This programme can be translated into the South African context, particularly during follow-up visits and in promoting and enhancing adherence of treatment on patients who fail to take their treatment. Health care workers and pharmacists monitored these clients using the med-boxes where patients met once a week and filled their own med-boxes in the community (Pahlevan-Sabbagh and Feleke, 2007). This programme necessitated the involvement of pharmacists and professional nurses regarding monitoring clients in the community which assisted the clients in attaining an improved adherence to treatment. Therefore, it shows that involving other health care providers such as health promoters can influence good health behaviours in the community.

IMPLICATIONS OF THE STUDY

Based on the results of this study, health promoters provide health promoting home visits; provide health education, patient care and social services to many families. These results have implications on future practice and policy.

Policy makers

Policy makers should be alerted that health promoters have potential, interests and skills to develop and implement policies regarding health promotion among families. It is expected that policy makers should support the endeavour and integrate them within the existing health care system.

Community nursing practice

Health promoters should be fully utilised in ward based primary health care services to address the impact of HIV and AIDS in the community.

CONCLUSION

The contributions of health promoters are visible and efficient in the community under discussion. The participants have shown commitment to the community and clients despite the challenges they have come across. Their availability has assisted the community and the affected families in understanding the HIV and AIDS epidemic. Education and support will prevent further complications caused by the disease. Health promoters may assist in creating HIV and AIDS awareness in the community and educating youngsters about the prevention of the disease. Successful collaborative efforts among the Departments of Health and Social Development, non-governmental organisations, the community and the private sector are needed to fight against HIV and AIDS's new infections guided by the national strategic objectives by 2016.

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