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Supplement Article

Organizational structure and human agency within the South African health system: a qualitative case study of health promotion

Teurai Rwafa-Ponela[1,2,*], Jane Goudge[1] and Nicola Christofides[3]

[1]Centre for Health Policy, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa
[2]SAMRC/Wits Centre for Health Economics and Decision Science—PRICELESS SA, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa
[3]School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

*Corresponding author. SAMRC/Wits Centre for Health Economics and Decision Science—PRICELESS SA, School of Public Health Building, University of the Witwatersrand (Education Campus), 27 St. Andrews Road, Parktown, Johannesburg 2193, South Africa. E-mail: rwafateurai@gmail.com

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Abstract

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. This diminishes its ability to deliver on its public health promises. This paper examined the role of organizational structure and human agency within the South African health system (drawing on Giddens's structuration theory) in determining the extent of, and barriers to, the institutionalization of HP. We conducted a qualitative case study using a combination of in-depth interviews ($n = 37$), key informant interviews ($n = 8$) and one-day workshops ($n = 5$) with Department of Health (DoH) staff (HP and non-HP personnel) from national, provincial and district levels as well as external HP stakeholders. Within the South African health system, there are dedicated HP staffs, with no specified professional competencies or a coherent hierarchy of job titles. Allocated HP resources were frequently shifted to other programmes. This resulted in a disconnect between national and provincial levels, which impeded communication and opportunity to develop a shared vision and coherent programme. We found some examples of successful HP organization and implementation practices, such as the tobacco control legislation. Overall, HP staff had limited agency and were often unable to articulate the vision for HP. Uncertainty about the role of HP has led to powerlessness, and feelings of resentment have generated demotivation and moral distress. HP voices were seldom heard and were repressed by dominant curative-focused structures. If leaders of HP continue to be embedded in such an institution, there is little chance of driving an effective HP agenda. Therefore, there is a need to engage policy-makers to integrate HP into the health system fabric. Establishment of an independent HP foundation could be one mechanism to drive multi-sectoral collaboration, contribute to evidence-based HP research and further develop health in all policies through advocacy.

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

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 1986 Ottawa Charter provided a comprehensive framework and enabled global recognition of professional HP practice. HP is defined as the process of enabling people to increase control over and to improve their health (World Health Organization, 1986). 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 in many countries by insufficient investment (Tangcharoensathien *et al.*, 2008). This hinders HP's ability to deliver on its promise of addressing key social, behavioural and other determinants of health (Bayarsaikhan and Muiser, 2007; Melville *et al.*, 2006; Sanders *et al.*, 2008). Given the international changing policy environment and efforts to strengthen health system performance, there is a need for more empirical evidence in understanding how HP is organized and implemented.

Across most countries, health systems are almost universally curative-focused. 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, 1998). Although health systems cannot be held entirely 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

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Key messages

- In the international context for the need for universal health coverage, health promotion (HP) is critical to help reduce the burden of diseases and demand for curative health services.
- In South Africa, while a HP structure and dedicated HP practitioners exist within the DoH, HP faced various structural constraints that hinder effective organization and implementation of reflective HP. The interaction of human agency with structural factors is critical to understand the institutionalization of HP.
- Despite evidence of pockets of agency among HP staff, there was a general limited ability across the health system to translate this across HP activities. HP staff within the DoH at all levels felt underappreciated and lacking in power to actually change their circumstances, indicating an external locus of control.
- The vertical structure of HP within the DoH at the national level in South Africa limits its ability for the integration of promotion and prevention in all aspects of the department's HP work and addressing social determinants of health.

implementing 'Health in All Policies' is complex (Kumar and Preetha, 2012; World Health Organization, 2009).

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 implement HP interventions and activities (Department of Health, 2014; Onya, 2007). Other scholars have reflected 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. The Alma Ata Declaration expanded the approach of the goal of health for all people, from a curative focus to a concern for public health. Inter-sectoral collaboration is the joint action taken by the health sector and government and non-government sectors to improve the health of populations (World Health Organization, 1978). However, there are challenges in re-orienting health systems towards the Alma Ata vision of primary health care (PHC), including supporting inter-sectoral collaboration for health that requires a systems thinking approach (World Health Organization and UNICEF, 2018). We used a broader institutionalist perspective to explore the case of HP within the Department of Health (DoH) in South Africa to understand the roles that institutional barriers play in preventing the strengthening of health systems in society.

Theoretical framework

Structure and agency—dimensions of the structuration theory (Giddens, 1991; 1984)—are useful 'sensitizing' concepts to provide an analytical lens to understand how 'context' in the constitution of health systems and individual behaviours are implicated in the ways HP is organized in South Africa. Both facets suggest ways of how knowledge and practice are structured to shape society (Dyck and Kearns, 2006). Giddens' structuration theory posits that human agency (the ability to deploy power or perform actions) and structure (the set of rules and resources elaborated through institutions) give rise to day-to-day practices (Giddens, 1984; 1991). Emphasis is placed on ways in which human actions and practices interact with structural constraints to reproduce and reinforce practices and structure in existing institutions (Dyck and Kearns, 2006). 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.

The case of HP within the South African DoH is used to show how structure and agency enabled or constrained its institutionalization. Structure refers to the regularized relations between individuals and groups that result in social practices such as codes of conduct, organograms, and/or resources allocation that produce practices of human agents. Therefore, institutional structure can be both a constraint and enabler (Dyck and Kearns, 2006). Agency is based on the notion that an individual could have acted differently (Dyck and Kearns, 2006). However, structure and agency both result from intended and unintended consequences of human conduct (Giddens, 1989; Dyck and Kearns, 2006). Agency and structure are interdependent and their interaction governs the permanence of structures and reproduction of social systems (Figure 1) (Giddens, 1991). In this paper, we explored how the tension of structure and agency influenced the institutionalization of HP within the South African health system.

Methods

We chose a qualitative case study approach, with HP in the South African DoH as a case, to understand 'what' is happening, 'how' and 'why' (Sosulski and Lawrence, 2008). In this study, it was critical to map the status of HP within a government structure (what is happening), understand how HP is institutionalized within the South African health system (how it is happening), and consider structure agency theory factors to explain what and why it is happening in terms of HP, as well as how to possibly address it. Furthermore, we provide two case narratives that emerged from the data to help strengthen the interpretation of the data.

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 to ensure maximum variation (Figure 2): 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 organizations that was formed in 2011 to advocate and lobby for a HP agenda in the country (Perez *et al.*, 2013). Study sites are anonymized.

Data collection

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

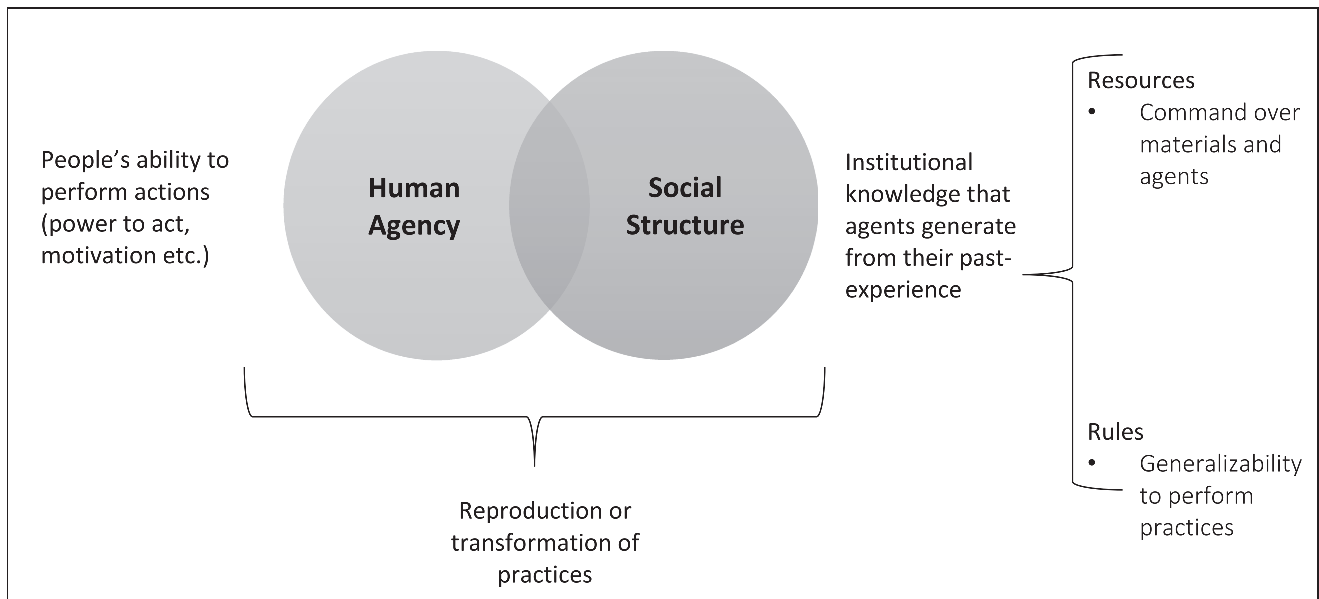

Figure 1. Structuration theory adapted from (Giddens, 1991)

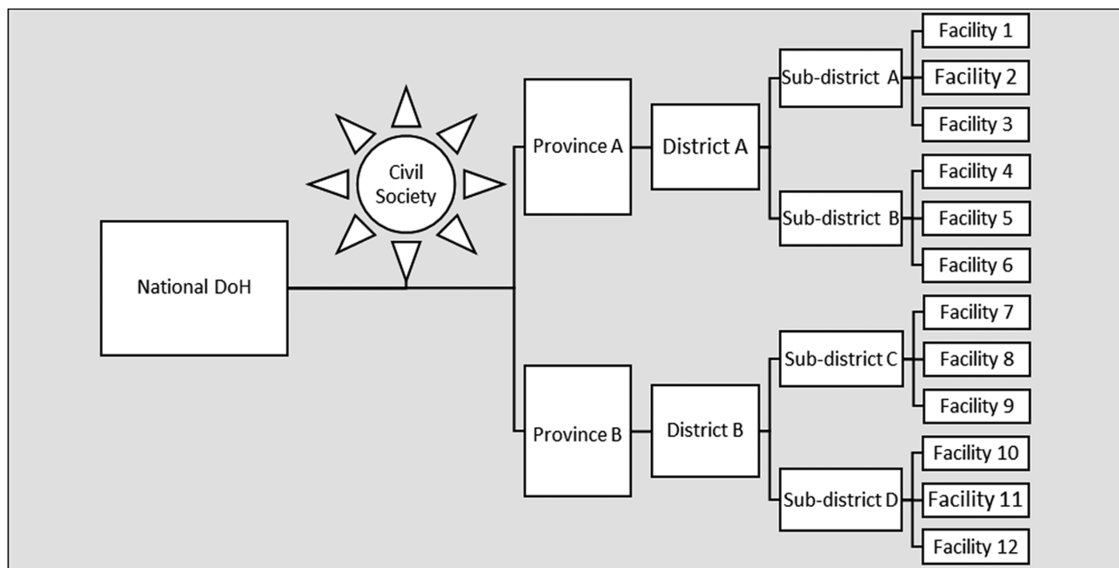

Figure 2. Sampling of study sites, ($n = 28$)

of DoH staff at national, provincial, and district/municipal levels and in PHC facilities for maximum variability, as shown in Table 1. We recruited an initial set of participants and added additional participants in a second stage based on what was emerging from the initial interviews. Following this approach, we believe that we were able to have insights at the different levels of the health system from the perspective of participants working at each of the levels. The mandate of the national HP directorate is to offer technical and strategic support, while provinces, particularly local levels (health districts or municipalities) implement HP activities (Department of Health, 2014). HP practitioners (HPPs) were involved in identifying which study setting to include, namely which sub-districts and clinic facilities (Rwafa-Ponela *et al.*, 2020c). Snowball sampling was used to recruit key HP participants external to the health system working in civil society organizations. Information-rich HP experts (Patton, 1990) in turn recommended other HPDFNet members for selection into the study. We used emails and 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 ill at the time of the study.

Data were collected from November 2017 to February 2018. We used qualitative methods including in-depth interviews (IDIs) and workshops allowing data triangulation. Figure 3 depicts how the data collection methods were combined. While IDIs were carried out at participants' workplaces, e.g. offices and clinics, workshops were conducted at centrally booked conference and meeting rooms. Only

Table 1. Participant demographics and study identifiers

Data source	Study ID	Participants	Number	Sex	Highest and lowest qualifications
External	*EX*	Key HP stakeholders	7	3 male 4 female	PhD Masters
National	*ND*	[a]Chief Director Cluster Manager	2	1 male 1 female	Masters
		HP Directorate staff	5	All female	Masters Bachelors
Provincial	*P*	Provincial HP Managers	3	All female	Masters Diploma
District	*D*	District HP coordinators	2	1 male 1 female	Diploma
Sub-district	*SD*	Sub-district HP coordinators	5	3 male 2 female	Diploma Certificate
Facility	*FM*	Facility managers	13	2 male 11 female	Masters Diploma
	HPP	Health promoters	12	All female	Diploma Some secondary
Workshops (national-district)	*FGD*	HP managers DoH managers	28	10 male 18 female	Masters Diploma

[a]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 ID is provided under the study identifier column.

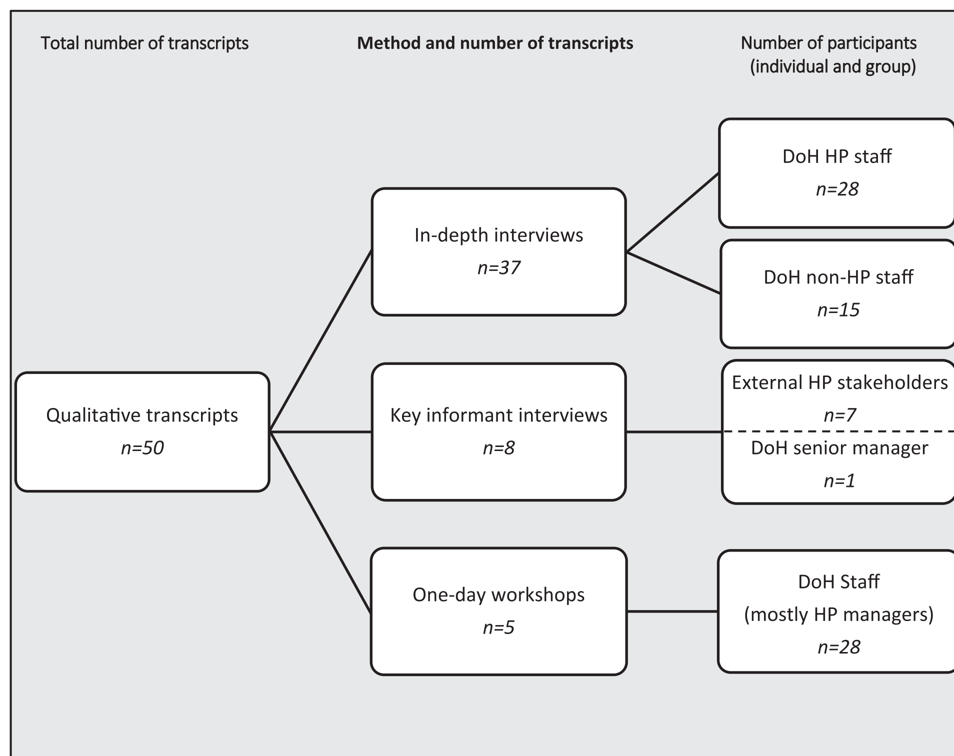

Figure 3. Mix of data collection methods and sampling

participants and researchers were present during data collection. The lead investigator (T.R.) conducted all interviews and used unique identifiers to anonymize the data. T.R. and N.C. 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. T.R. was a doctoral researcher, with training and experience in HP and qualitative research. Authors J.G. and N.C. were her academic supervisors with extensive experience and expertise in conducting qualitative research and data analysis.

Interviews

Thirty-seven IDIs were conducted with 34 individuals plus three group interviews (with 2–3 participants) among HP and non-HP DoH staff, while eight participants mainly from civil society (three from non-governmental organizations, four from academic institutions and one from DoH) were interviewed as key informants (KIIs). A semi-structured

interview guide was developed and adjusted for each health system level and participant type. The guide was pretested with a HP expert to ensure that the questions made sense and would generate discussion on the topics of interest. 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.*, 2020c). Some HP managers participated in both workshops and IDIs. Interviews lasted for an average of 60 minutes (30–120 minutes) (Rwafa-Ponela *et al.*, 2020c).

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 1-day workshops among national, two provincial and two district levels selected in the study. These consisted of between three and nine participants, mostly HPPs to maintain homogeneity of the group. Twenty-eight DoH staff participated in the workshops: 6 national, 6 provincial (three HP managers and three non-HP managers) and 16 district and sub-district HP coordinators. Workshops as a data collection method in this research generated both qualitative and quantitative data (consensus scores on institutional capacity). The quantitative findings have been reported elsewhere (Rwafa-Ponela *et al.*, 2020a). 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. This allowed rich and in-depth HP data to be collected. The duration and level of engagement of these data collection activities provided insight into the institution's capacity that go beyond typical group discussions. On average, workshops lasted for about 480 minutes (360–600 minutes) (Rwafa-Ponela *et al.*, 2020a).

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.*, 2020c) 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.

Analysis of data

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. Data analysis was done in two stages. Firstly, we used an interpretivist approach to inform our inductive analysis and understanding of the data (Vaismoradi *et al.*, 2016). This was followed by using the domains of Giddens' sociological structuration theory as a framework for organizing the emerging themes, so as to elucidate how structure and agency had 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). 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 organized under emerging themes, through a systematic process as follows: (1) labelling of qualitative quotes, (2) grouping quotes into first-order sub-categories and (3) categorizing 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 reoccurring themes and other patterns in the data; sixteen first-order sub-themes emerged. Figure 4 shows the category names. T.R. developed a codebook, which was verified by the other two researchers involved in this study. She then performed initial data coding, which was reviewed by the two researchers who have extensive knowledge of 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 to enhancing trustworthiness and reliability of the data. Triangulation across all data sources and methods enabled integration of findings.

Findings

Characteristics of study participants

DoH staff (28 HP and 15 non-HP personnel) from national to facility level and civil society representatives ($n = 7$) participated in the study. Table 1 shows participants' socio-demographic characteristics.

Structure

Occupational class and organogram uniformity

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' [Focus Group Workshop (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 of uniformity for provincial-level 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).

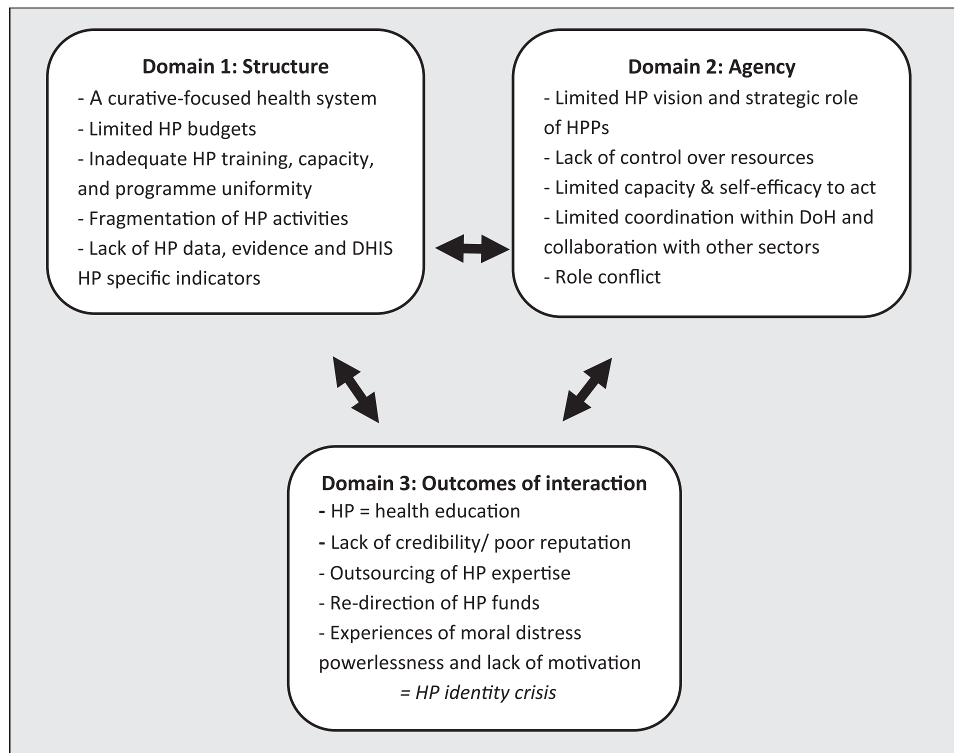

Figure 4. Structure-agency in the institutionalization of HP within DoH

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 reported working on an accreditation system for its practitioners:

> *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.

Data and evidence

Although HPPs collected data on their activities for programme purposes, 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).

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 limited and 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 other disease-specific programmes. These often considered the HP directorate as 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, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome and tuberculosis (TB), violence, injuries and trauma, maternal and 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).

Analysis reported elsewhere showed that limited capacity in budgeting was a major challenge, with few resources and a limited budget available to conduct HP activities at any level of the health system (Rwafa-Ponela *et al.*, 2020a,b).

Vertical HP 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 of HP financing within the DoH.

The implementation of HP activities in siloes led 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.

A curative-focused health system

Many participants felt that curative health care 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).

Agency

HP strategic vision and leadership

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. Planning for HP was limited to the use of the 'health calendar' or health awareness days to guide activities. The health calendar includes international and national dates to commemorate or focus on particular conditions such as diabetes or mental 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).

Analysis presented elsewhere highlighted the challenges faced by frontline HP practitioners regarding the implementation of a health system strengthening initiative, the deployment of community health workers, as there were insufficient guidelines on their role. There was an overlap between the roles of community health workers and health promoters working at facility level (Rwafa-Ponela *et al.*, 2020b). However, we found one example of a HP activity where the HP directorate at the national level had shown strategic vision (Case Narrative 1).

Case narrative 1: leadership in tobacco control legislation

The national HP directorate is responsible for tobacco control legislation. Some attributed this to the agency of a former health minister (Nkosazana Dlamini-Zuma) with the support of the 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).

Collaboration and coordination

Facility-based HPPs had better collaborations with various stakeholders at community level. However, the NDoH placed insufficient effort in creating and sustaining partnerships at national level:

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).

Due to limited resources, national HP office was no longer able to hold face-to-face meetings with all provinces—this meant that it was not possible to have a coordinated and strategic approach. As a result, provinces and districts tended to implement health education on different topics depending on the day. 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). The national HP directorate has no way to hold provinces to account. The two levels of government are acting independently.

Despite overwhelming discourse about lack of HP budgets, one district HP manager had successfully motivated senior district managers to recruit new HPPs and purchase equipment to conduct HP activities (Case Narrative 2).

Case narrative 2: 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 [the 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'.

Ability of lower cadres to insist on their HP role

Although facility managers viewed the presence of HPPs at PHC level as important, 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).

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 3 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 5, 6. We fought so they could take us to level 5 (IDI-BP002HPP_Health Promoter).

This is an example of collective power to act and change the status quo for HP. However, 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'. South African public servants' salary categories mainly range from level 1 to level 12 (Department of Public Service and Administration, 2008). A salary scale of level 5 represents an entry point position for professionals. This means in 2020, the minimum income for HPPs was R29 350 (US$1950) per year at an hourly rate of R14 (US$0.90).

Discussion

We have described that a structure is in place for the organization and implementation of HP within the DoH. However, HP practitioners have operated within challenging conditions for many years, evidenced by structural constraints of a curative-focused health system and a limited strategic vision for HP. Figure 4 shows the outcomes of interaction between structure and agency in the institutionalization of HP within the South African DoH. While dedicated HPPs existed, they lacked specified HP competencies or a coherent hierarchy of job titles within the DoH organogram. Despite the availability of resources needed to support the continued employment of HPPs in the structure, HP implementation was compounded by redirection of funds and parallel implementation of HP activities, by other well-resourced programmes, particularly at the 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 4). While we found some examples of successful HP organization and implementation, such as tobacco control legislation, overall HP staff have limited agency (Domain 2, Figure 4). HPPs were often unable to articulate the vision for HP, ensure collaboration between the national HP directorate and provinces, or hold provinces to account. Further limited agency among some facility-based health promoters was indicated by inability to convince clinical supervisors that their focus should be HP activities rather than administrative duties. Many HPPs blamed the national HP directorate for lack of leadership in the programme.

The structural constraints described in the study interacted 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 equated with health education (Domain 3, Figure 4). The DoH HP programme in South Africa lacked credibility. As a result, HP activities particularly at the national level were outsourced to external consultants and funds re-directed to curative care, which are structural elements. This led to HPPs at all levels feeling demotivated and powerless or having lower agency to be able to make changes to the existing structures. While actors have the capacity to transform such disabling social systems that are built on the notion of power in human agency (Dyck and Kearns, 2006; Sriram *et al.*, 2018), in sum, HP suffered from an identity crisis, as its potential contribution in the health system was undervalued (Domain 3, Figure 4). This may be an unintended consequence of the actions of human agents in the health system (Dyck and Kearns, 2006). 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 structure and agency barriers to the institutionalization of HP in the South African health system are adequately addressed, efforts toward the implementation of the national HP policy are likely to fail.

One of the structural constraints outlined in Figure 4 is the lack of training among HPPs in South Africa. Inadequate training of staff deployed into dedicated DoH HP posts has been historically noted (Onya, 2007; Coulson *et al.*, 1998; Wills and Rudolph, 2010). Skills and educational qualifications of HPPs differed resulting in capacity gaps (Coulson, 2000). The current study observed that this phenomenon is still the case. Nearly a decade and a half 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, HP efforts tend to fall on the wayside, where human resource shortages and long clinic queues are evident (Alcalde-Rabanal *et al.*, 2017). The existence of some commitment towards HP within government structures and it promise in public health gains provides a basis for future development of the profession, during health system strengthening efforts.

Given the 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 in many other countries (Alcalde-Rabanal *et al.*, 2017), as observed in Domain 3 of Figure 4. We found that there was a strategy towards the implementation of HP within DoH, e.g. in the use of the 'health calendar'. Yet, these efforts were not enough to spearhead HP to required standards of enabling health, which is beyond awareness raising. 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 at all DoH levels within a myriad of structural constraints. However, HP staff showed some commitment to the work that they do.

Agency demonstrated in tobacco control by the HP directorate at NDoH (Case Narrative 1) was enabled by decisions that originated in the post 1994-democratic era in South Africa (Global Health Delivery Project, 2011), when DoH prioritized tobacco control. The HP directorate was delegated with the responsibility, supported by a non-governmental organization: the National Council Against Smoking. The director of HP was involved in the government's negotiations on the World Health Organization Framework Convention on Tobacco Control which resulted in South Africa becoming a signatory in 2003 (World Health Organization, 2015) and the development of tobacco legislation. As a result, the HP directorate has always had a sense of ownership of the tobacco control programme. The structural support and delegation of authority resulted in a sense of agency that was transferred to different incumbents in the position (an example of how structure and power came together to shape institutionalization). By comparison, in other areas, the HP directorate is bypassed or consulted rather than being given responsibility for leading. For example, our study showed that some HP activities undertaken by the Non-Communicable Diseases cluster were outsourced, despite the HP directorate implementing healthy lifestyle activities. In this context, the environment is disabling for the HPPs at the national level due to limited delegated authority and the structure, which requires that they report to another level of further reduced leadership. On the other hand, evidence of agency of one sub-district manager demonstrated that the individual characteristics could make a difference (Case Narrative 2). This showed that where individual HP agency has occurred, it is about having a sense of power. Results from the current study highlight that greater agency is possible at national level than within clinics. This might suggest different strategies to consider moving forward. For example, HP leadership on tobacco control may be easier as the policies were not implemented through the curative-oriented services but rather regulated the tobacco industry and created smoke-free public places, which were implemented across sectors. Some HP activities related to non-communicable diseases that were implemented in the broader system within communities and some HP activities were outsourced.

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 (all three domains, Figure 4). 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 the 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 a need to strengthen HP norms and practices in ways that would integrate HP into the fabric of the health system. The 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, 2014). 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 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). This shows the need to leverage the tension between structure and agency within a social system (Gesler and Kearns, 2002).

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 semi-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, they will always lose the tussle for resources (because of the notion that 'The Department [DoH] cannot leave people who are sick without care' EX007_National Manager indicating the priority to treat people in need rather than to invest in prevention'). In a context

Box 1. Recommendations from the study

- Visionary and strategic leadership is required within the DoH for HP, particularly at the national level to provide structural solutions, motivate staff and better coordinate activities for greater HP activity effectiveness that drives HP towards its role in public health and social determinants of health at all levels of the health system.
- The national and provincial HP communication gaps could be bridged by the holding of routine monthly meetings using other media like virtual or remote meetings via online platforms, as opposed to face-to-face ones that require expenditure of limited finances to cater for staff travel, conference room booking and/ or catering.
- Every health worker needs to implement HP activities with the support of dedicated and skilled HP cadres at each level of the health system.
- The national HP directorate needs to finalize the human resources for HP structure, as well as advocating for a curriculum for HP training, qualifications and accreditation of current and future staff to be recruited. This may also help increase recognition of the profession and strengthen its identity in the health system.
- Capacity strengthening of HPPs is required at all levels. Current HP staff require routine in-service training and capacity-building workshops.
- Given the entrenched structural constraints in the DoH, a radical solution could be the implementation of a HP foundation. A HP foundation will help drive the HP agenda to gain agency, both within DoH and externally. This entity would coordinate multi-sectoral collaboration for HP and support research at various levels for the generation of locally-based HP data and evidence.
- If a HP foundation were to be implemented, a sustainable HP financing mechanism would need to be assured. Ring-fenced financing would circumvent the redirection of HP budgets. Funds for HP activities could come from the South African HP levy collected from taxation on sugar-sweetened beverages or excise tax on tobacco, alcohol and other harmful substances.

that limits the structure of HP organization and the agency of staff to implement activities, HP will always be a Cinderella service (suffering from neglect) without an ostensible commitment. HP needs to be independent of the curative services in order to gain agency in other HP areas, find its identity in the health system, and provide the required strategic oversight. Therefore, the establishment of a HP foundation may be one of the mechanisms, which could 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.

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 1-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 1-day workshops in order to share narratives of success. The research was conducted at 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 strengthened the results, such as those outside HP but within the DoH.

Conclusion

Although a HP structure and dedicated HPPs exist at the South African DoH, HP faces various structural constraints and limited agency among its practitioners. This impeded its organization and implementation within the 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. In this regard, 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. The establishment of an HPF through government stewardship could be one mechanism, which may address some of the gaps.

Data availability statement

Data are available from authors upon reasonable request.

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Author's contributions

T.R. collected the data, conducted data analysis and write-up of initial drafts of the manuscript. J.G. contributed conceptually to the analysis of the manuscript and commented on progressive drafts of the manuscript. N.C. contributed to the data collection, analysis, writing and commented on manuscript drafts. All authors approved the final draft of the manuscript.

Ethical approval The University of Witwatersrand's Human Research Ethics Committee (Medical) approved ethical clearance of the study (M170654). Permission to collect data was provided by the national and two provincial DoH, and the

two district health offices. Participation in the study was voluntary. Participants were provided with full information about the aims of the study. They gave written consent to participate and be audio-recorded. We ensured anonymity of study participants by using unique identifiers.

Conflict of interest statement Authors have no competing interests to declare.

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