A stress management programme for HIV and AIDS home-based care practitioners in Tshwane

by

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ABSTRACT

A STRESS MANAGEMENT PROGRAMME FOR HIV AND AIDS HOME-BASED CARE PRACTITIONERS IN TSHWANE

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The HIV and AIDS pandemic resulted in increased demands on the South African healthcare system and contributed to elevated stress levels among healthcare workers. Such experiences by healthcare workers, including home-based care practitioners, necessitated that employers in the HIV and AIDS field acknowledge that care-giving work is inherently stressful and feelings of distress were legitimate and not signs of personal weakness. An employee support intervention in the form of a stress management programme was implicated as being a potentially effective way of addressing workplace stress among HIV and AIDS home-based care practitioners.

Therefore, it was the goal of the study to design, implement and evaluate a stress management programme for HIV and AIDS home-based care practitioners in Tshwane. Social constructionism was adopted as the theoretical framework and research paradigm of the study. The study was applied research, specifically intervention research (IR), sub-type Design and Development (DD). The research approach adopted was mixed methods research. The convergent parallel mixed methods research design was implemented in Phase One (problem analysis and project planning) and Phase Four (early development and pilot-testing) of the IR process. More specifically, the quantitative research design

adopted in Phase One of IR was a non-experimental design, specifically the cross-sectional survey, while in Phase Four of IR the quasi-experimental comparison group pre-test - post-test design was utilised. The qualitative research design adopted was the instrumental case study in both Phase One and Phase Four of the IR.

Two populations participated in the study. The first population consisted of all HIV and AIDS home-based care practitioners in Tshwane working for non-governmental and community-based organisations, estimated to be about 300 people. The second population was the supervisors/ managers of the home-based care practitioners estimated to be about 30. Non-probability sampling methods were used to recruit participants for the study. In Phase One of the IR, purposive sampling was used to recruit HIV and AIDS home-based care practitioners (n = 35), while, with the supervisors/managers (n = 5), key informant sampling was adopted at each organisation in four regions of Tshwane. In Phase Four of the IR, volunteer sampling was utilised to identify participants: twelve (n = 12) participants were exposed to the programme (i.e., experimental group) and seven (n = 7) comprised the comparison group (n = 7). The two groups were identified from two different organisations in Tshwane rendering home-based care.

Quantitative data were collected in Phase One of the IR through a non-standardised self-administered questionnaire (measuring job satisfaction and dissatisfaction) and in Phase Four of the IR, the Oldenburg Burnout Inventory (measuring disengagement and exhaustion) was administered to the participants at pre-test and post-test levels. The qualitative data were collected through semi-structured interviews with interview schedules. In Phase One of the IR the interview schedules were used with both the home-based care practitioners and the supervisors/managers. In Phase Four of the IR, semi-structured interviews were conducted with the experimental group before and after exposure to the prototype intervention programme. Additional data were gathered through session evaluation forms.

The qualitative findings revealed that the (prototype) stress management programme was effective in mitigating the impact of workplace stress experienced by the HIV and AIDS home-based care practitioners. The participants reported improved ability to cope with

work stress after exposure to the intervention and this was expressed in post-test interviews and session evaluation forms.

The quantitative results, on the other hand, indicated that the intervention programme had a minimal effect in mitigating the impact of the workplace stress. The pre-test results revealed that the experimental group was more disengaged and exhausted than the comparison group. At post-test level the experimental group and comparison group reported the same level of disengagement, whilst the experimental group indicated slightly higher levels of exhaustion than the comparison group. Post-test scores minus pre-test scores on disengagement and exhaustion revealed that the experimental group was less disengaged but more exhausted after exposure to the intervention. The comparison group was more disengaged and exhausted at post-test. Association between disengagement and exhaustion and the participants' highest qualification level indicated that the group who had obtained Grade 12 and higher showed decreased disengagement from their work and slightly lowered exhaustion at post-test level as compared to the group who obtained Grade 8-11.

Based on the findings, it is recommended that the newly developed stress management programme be subjected to refinements and improvements to further establish its effectiveness in mitigating the impact of workplace stress among home-based care practitioners in Tshwane. Through the implementation of the refined stress management programme, the necessary adaptations to the programme can be proffered for implementation in similar field settings.

Key concepts

Acquired Immune Deficiency Syndrome (AIDS)

Convergent parallel mixed methods research design

Human Immunodeficiency Virus (HIV)

HIV and AIDS home-based care practitioners

Home-based care practitioners

Intervention research

Mixed methods research

Oldenburg Burnout Inventory

Social constructionism

South Africa

Stress management programme

Tshwane metropolitan municipality

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CHAPTER 1

GENERAL ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The human-immuno-deficiency virus (HIV) and acquired immuno-deficiency syndrome (AIDS) pandemic has been in existence for more than three decades now. Progress has been made in containing the pandemic, but there are still challenges to be overcome (Heunis, Wouters & Kigozi, 2012:294). The *Joint United Nations Programme on HIV and AIDS (UNAIDS) Fact Sheet - July 2018* reports that eastern and southern Africa remain heavily affected by HIV, accounting for an estimated 19.4 million of the estimated 36.7 million of people living with HIV worldwide as at the end of 2017 (UNAIDS Fact sheet, July 2018:1,4). It is further reported that the epidemic continues to be a concern in Southern Africa, with South Africa being home to an estimated 7.1 million people living with HIV (UNAIDS – South Africa, 2018:1).

As households in South Africa became affected by HIV and AIDS, there was greater need for care and support. With the shortage of professional health care practitioners, the greater burden of care for people living with HIV and AIDS remained with informal community-based carers (Majaja, Setswe, Davids, Clayton, Naidoo, Lewa & Simayi, 2009:1). Marais (2005:65) suggests that the post-1994 overhaul of South Africa's health care system was a bid to ensure that "care in the community" became "care by the community". As such, community-based care became part of the "continuum of care" which linked together the various levels and zones of the public health care system and other role players to provide an integrated service that addressed the basic needs of people infected with or affected by HIV and AIDS.

Over the last decade the National Department of Health allocated funds for the comprehensive response to HIV and AIDS. Non-governmental and community-based organisations in the HIV and AIDS field which trained and employed community and

home-based workers were among the main beneficiaries of this allocation. Consequently, a large grouping of lay health workers emerged. In addition, the government introduced the umbrella term "community health worker" for all lay community health workers and adopted a policy framework for their training and remuneration, in line with the National Department of Health Community Health Workers Policy Framework (2004) (Schneider, Hlophe & Van Rensburg, 2008:180).

In order to give background to the National Department of Health initiative of community health workers, it is important to highlight that it is linked to the Expanded Public Works Programme (EPWP). The EPWP is a project of the National Department of Public Works that aims to make available work opportunities for the unemployed from poor households. The programme employs workers on a temporary or on-going basis, either by government departments, contractors or non-governmental organisations. The EPWP creates work opportunities through four sectors, namely: infrastructure, the non-state, environment, and the culture and social sectors. For many, the programme provides the much needed work experience, the acquisition of relevant work skills and validates their ability to contribute to their communities (*Welcome to EPWP,* 2013:1; National Planning Commission, 2011:334). Of relevance to this study is the social sector. The social sector provides work opportunities for people to deliver social development services, which include home and community-based care. The overall co-ordinator of the sector is the National Department of Social Development, with the National Department of Health taking direct responsibility for the home and community-based care (*Welcome to EPWP,* 2013:1; National Planning Commission, 2011:334).

Assessments of self-initiated care projects reported that caregivers often lacked the basic resources needed to perform their tasks. Research findings have indicated that mental and emotional strains are amongst the major problems associated with the work of home-based carers (HBCs). Although constantly faced with emotional stress and physical fatigue, few, it seems, were able to benefit from the mental health services (Marais, 2005:68). The researcher, in her work as a trainer in the HIV and AIDS field, had discussions with lay counsellors and home-based care practitioners based in the Tshwane Metropolitan [it is the largest metro in Gauteng, of the nine provinces of South

Africa (*The Local Government Handbook…*, 2012:1)] area regarding workplace support. They unanimously raised concerns around poor support and, in certain instances, non-existent workplace support, in spite of the obviously challenging and demanding work that they did.

Sifile (2012:6) also reported in the *Sowetan* newspaper that about 5 000 community health workers in the Gauteng Province (Tshwane included), consisting of HIV and AIDS lay counsellors and home-based care providers, planned to stage a sit-in at the Department of Health's offices in Johannesburg on 15 July 2012, after being on strike since March 2012. The reason for such action was said to be the Department's failure to address their grievances, mainly low stipends (compared to the Kwa-Zulu Natal Province, where stipends are 200% higher) that were also sometimes paid late, and difficult working conditions in clinics. The employees often remained in such stressful working conditions as they perceived the work as being a potential avenue for better jobs (Lund, 2010:506).

Findings from a study in Tshwane among HIV and AIDS lay counsellors (which are also applicable to home-based carers), highlighted the need for a structured workplace support programme to assist them to cope with the psychosocial challenges of the work as there were none available (Kabamba, 2009:73). It could therefore be argued that there should be some form of organised employee support structure for home-based care practitioners in order for them to maintain good psychosocial health, to render quality services to people living with HIV and AIDS, and to mitigate the impact of the pandemic on communities. A stress management programme, which focuses on the identification of sources of stress as well as on personal and organisational methods of preventing and managing stress, seemed to be most relevant (Furnham, 2005:8).

A brief background on the circumstances that the HIV and AIDS home-based care practitioners worked in, and thus prompted the necessity of the study has been given. The next topic explains and defines the key concepts of the study.

1.2 CONCEPTUALISATION OF KEY CONCEPTS

The key concepts, extracted from the research topic need to be interpreted uniformly in this study as follows.

1.2.1 Stress management programme

This is defined as any organisational attempt to remove specific work stressors, reduce levels of perceived stress or lessen the psychological, physiological and behavioural impact of stress through symptom management (Sulsky & Smith, 2005:202). It is also defined as a programme that entails the identification of symptoms of strain and the introduction of methods to help individual workers, such as home-based carers, to deal with them. The programme normally includes workshops covering a wide range of topics and techniques designed to reduce physiological and psychological arousal levels associated with workplace stress (Weinberg & Cooper, 2012:104).

For the purposes of this study, a stress management programme is a work-based employee support and intervention programme focused on the identification and management of workplace stress with the goal of improving employees' coping strategies, morale and job satisfaction.

1.2.2 HIV and AIDS home-based care practitioners

This concept is divided into the following sub-concepts:

HIV: This is "A retrovirus that inserts itself into the DNA of its host, becoming a Trojan horse in the immune system and systematically weakening the host until the body can no longer efficiently fight the infection" (Abdool Karim, Abdool Karim & Baxter, 2010:45). Another definition is that it is a retrovirus that causes the acquired immunodeficiency syndrome, AIDS (Butterworth & Pearsall, 2003:644). This study conceptualises HIV as a virus that progressively weakens the infected person's immune system, eventually leading to an inability to fight infections.

AIDS: "Acquired Immune Deficiency Syndrome" is the result of advanced HIV infection and is characterised by opportunistic infections (Employment Equity Act 55 of 1998: Code of Good Practice on HIV and AIDS and the World of Work, 2012:4). Van Dyk (2005:3-4), on the other hand, defines AIDS as "…a collection of many different conditions that manifest in the body because the HI virus has so weakened the body's immune system that it can no longer fight the disease causing agents that are constantly attacking it, thus has the ability to kill the infected person in the final stages of the disease." In the context of this research, AIDS is a syndrome that results from a weakened immune system, in which case a person's health deteriorates to the point where he/she becomes dependent on others for care and eventually dies because of the body's inability to fight opportunistic infections.

Home-based care practitioner/s: home-based care entails the provision of needed health care to persons living with HIV and AIDS by a primary caregiver to a patient or family at home, often supported by a trained community caregiver (Uys, 2003:4). The National Norms and Minimum Standards for Home and Community Based Care and Support Programme (Department of Social Development [DSD]*,* 2007:8) defines home-based care as the "provision of comprehensive health and social services by community caregivers in the home in order to promote, restore and maintain a person's maximal level of comfort, social functioning and health." The researcher's view is that a home-based care practitioner is a formally or informally trained community caregiver who provides healthcare support to patients with chronic health conditions in the patients' homes with the aim of supporting and enhancing the patients' ability to cope with their health condition. In the study, the terms home-based care practitioner, home-based care worker and home-based carer are used interchangeably.

1.2.3 Tshwane

This is referred to as the City of Tshwane and it was established in 2000 through the integration of various municipalities that served greater Pretoria. It has 105 wards, 2.5 million residents and it is divided into seven regions. It covers 6 363 km^2 of the Gauteng Province, stretching 121 km from East to West and 108 km from North to South, making it the third largest city in the world (*City of Tshwane in …,* 2010:1). The City of Tshwane

is also described as a metropolitan area situated in the Gauteng province and the capital city of South Africa. It is the single largest metropolitan municipality in the country consisting of seven regions, 105 wards and 210 councillors (*The Local Government Handbook…,* 2012:1).

After this conceptualisation of the study, there follows a discussion of the rationale behind the study and the statement of the problem situation.

1.3 PROBLEM STATEMENT AND RATIONALE

A study in Malawi (a country situated in south-eastern Africa) among home-based caregivers of people living with HIV and AIDS highlighted the need for psychosocial support by citing, amongst other findings, that caregivers found caring for people living with HIV and AIDS emotionally burdensome and that support was mainly from the family (of the patients) and empathetic community members (Chimwaza & Watkins, 2004:803). A similar study in the Free State Province (one of the nine provinces in South Africa, situated in the centre of the country) reported that lay health care workers (home-based care workers included) complained to nurses about the fact that they perceived their psychological well-being as being neglected and therefore requested some form of workplace support (De Wet & Du Plooy, 2012:36). From the findings of these studies it was recommended that, in order to meet the psychosocial needs of community home-based carers working with people living with HIV and AIDS, it was necessary for stress relief therapies to be improved, because carers continue to be overwhelmed by the practical and emotional demands of care work in spite of available support services (Majaja et al., 2009:16; Orner, 2006:237).

From the above-mentioned literature it appeared that none of the authors presented a workplace support programme that has been proven successful in managing stress among lay healthcare workers in the HIV and AIDS field, specifically among home-based care practitioners. Furthermore, in the absence of a workplace support programme for HIV and AIDS home-based care practitioners, employers were left to use their own

discretion in terms of which stress management and employee support strategies to employ among the lists cited by various authors.

In terms of existing research in this area, the researcher consulted the (South African) National Research Foundation Nexus database (2012) for previous and current research projects in HIV and AIDS care. Out of a list of 192 research projects sourced, none was carried out in Tshwane. The (South African) Human Sciences Research Council database was also consulted. A similar research project was carried out in 2009, titled "Psychosocial support needs of community home–based carers working with orphans and vulnerable children and people living with HIV/AIDS in South Africa. Case of Red Cross Society". A sample was drawn from Alexandra to represent the Gauteng province, but no sample was drawn in Tshwane. As such, a lacuna was identified for a study focusing on HBCs in the Tshwane metro, focusing specifically on the identification of their workplace support needs, and the subsequent design and implementation of a stress management programme.

In order to address the stress-related workplace support needs of the home-based care practitioners, the researcher planned to work with home-based care practitioners from previously disadvantaged communities in the Tshwane area for the following reasons:

- The literature and research consulted indicated that, in spite of the need for a workplace stress management programme for HIV and AIDS home-based care practitioners, there were a few existing programme specifically for this target group.
- Secondly, although there has been a similar research project carried out nationally by the Human Sciences Research Council, Tshwane was not included in the sampling process. For the researcher this meant that the voices of HIV and AIDS home-based care practitioners in Tshwane were not being heard. The research study thus offered them the opportunity to give input to a programme that aimed to improve the workplace well-being of home-based care practitioners.
- Finally, the researcher targeted non-governmental (not for profit) organisations in Tshwane working with people living with HIV and AIDS. The home-based care practitioners working for the organisations and their supervisors/managers were

recruited as research study participants. Their inputs facilitated the identification of stress-related support needs in their area of work. The sourced inputs led to the design, implementation and evaluation (through pilot-testing) of the stress management programme that responded to the unique needs of the HIV and AIDS home-based care practitioners.

In light of the above-mentioned information, the following **research questions** guided the study:

- What are the workplace support needs of HIV and AIDS home-based care practitioners in Tshwane that could be addressed through a stress management programme?
- What are the main themes to be covered in the stress management programme for HIV and AIDS home-based care practitioners in Tshwane?
- To what extent does the newly developed stress management programme succeed in mitigating the impact of work stress experienced by HIV and AIDS home-based care practitioners in Tshwane?

1.4 GOAL AND OBJECTIVES OF THE STUDY

The **goal** of the study was to design, implement and evaluate a stress management programme for HIV and AIDS home-based care practitioners in Tshwane.

In order to achieve the goal, the following **intervention research objectives** were formulated:

1. to provide a theoretical framework that would guide and underpin how the research process would be conducted and data interpreted;
2. to assess the stress-related workplace support needs of the HIV and AIDS home-based care practitioners in Tshwane. The objective was broken down into the following sub-objectives:

    2(a) the identification and recruitment of home-based care practitioners and their supervisors/managers for participation in the research study; and

2(b) the identification and analysis of the workplace support needs expressed by the participating home-based care practitioners and their supervisors/managers.

3. to consult the relevant literature and existing effective stress management programmes in the healthcare field to gather additional information for the insightful synthesis of the data gathered from the study participants;

4. to design a stress management programme with clear procedures on how the intervention will be implemented using the information gathered from the participating home-based care practitioners, their supervisors/managers, literature and successful stress management programmes models in the healthcare field;

5. to implement and evaluate the prototype stress management programme to assess its effectiveness in supporting the HIV and AIDS home-based care practitioners in Tshwane in terms of workplace stress through:

5(a) recruiting sixteen to twenty participants for the pilot testing of the prototype stress management programme;

5(b) implementing the prototype stress management programme through pilot testing to establish whether the programme is practical and effective in meeting the identified needs; and

5(c) Analysing and interpreting both the qualitative and quantitative data gathered from the pilot testing

6. The last objective is to make recommendations, based on the qualitative findings and quantitative results of the pilot testing process, on the refinement and adjustment of the stress management programme for HIV and AIDS home-based care practitioners for future use.

1.5 OVERVIEW OF RESEARCH METHODS

The study is **applied research**, specifically **intervention research**, sub-type Design and Development. Design and Development seemed to be most suited for the research study because it allowed the researcher to start with a needs assessment, then design an innovative programme, pilot it and make recommendations for refinement for future use in similar settings (Thomas & Rothman, 1994:4). Although Design and Development consists of an integrated model of six main phases of intervention, this study focused only on the first four phases. They are: problem analysis and project planning (phase one); information gathering and synthesis (phase two); design (phase three); and early development and pilot testing (phase four) (Thomas & Rothman, 1994:9).

The research paradigm for the study was social constructionism. Its relevance to the study lies in its emphasis on a non-directive approach and the importance of subjective reality, allowing the researcher to discover how the research participants (in phases one and four) make sense of their social world and negotiate collective meaning, as well as the impact of that collective meaning within the broader social context, with specific focus on the workplace experiences (Burr, 2003:6; Rosenthal & Peccei, 2006 in Cunliffe, 2008:127).

Mixed methods was adopted as the research approach for the study, specifically the **convergent parallel mixed method design**, as it allowed the use of both the qualitative and quantitative approaches in phases one and four (of the intervention research (IR) process), thus ensuring that bias inherent in one method is neutralised by the other (Creswell, 2014:219-223).

The quantitative research design adopted during problem analysis and project planning (phase one) was the non-experimental design, specifically the **cross-sectional survey** (Weinbach & Grinnell, 2015:24). For early development and pilot testing (phase four) the **quasi-experimental comparison group pre-test - post-test design** was utilised (Fouché, Delport & De Vos, 2011:150). The qualitative research design, on the other hand adopted the **instrumental case study** in phases one and four, in line with social constructionism, the theoretical framework for the study (Fouché & Schurink, 2011:320).

Two populations participated in the study. The **first population** consisted of all HIV and AIDS home-based care practitioners in Tshwane working for non-governmental and community-based organisations. The National Norms and Minimum Standards for Home and Community Based Care and Support Programme (Department of Social Development, 2007:14-15) stated that all non-governmental and community-based organisations rendering HIV and AIDS home-based care must have a minimum of ten home-based care workers and one manager. Furthermore, the *Gauteng HIV-related Services Directory* (2012:77-122) cited approximately 30 non-governmental and community-based organisations rendering HIV and AIDS home-based care distributed in six regions of the Tshwane municipality. The population was therefore estimated at approximately 300 HIV and AIDS home-based care practitioners. The **second population** was composed of the supervisors/managers of the home-based care practitioners. The size of this population was estimated to be 30, based on the earlier cited minimum standards of the Department of Social Development.

Non-probability sampling techniques were used to recruit participants for the study. In phase one, purposive sampling was used to select an organisation per region to participate in the study. The same purposive sampling was also used to recruit HIV and AIDS home-based care practitioners working in these organisations to participate in the study. Furthermore, key informant sampling was adopted to recruit supervisors/managers of the home-based care practitioners (Padgett, 2008:53; Strydom & Delport, 2011:394). In phase four, volunteer sampling was utilised to recruit participants for the two groups (i.e., experimental and comparison group) who participated in the pilot testing of the prototype intervention programme.

The mixed methods approach was again implemented with data collection and analysis. The **quantitative data collection instrument** used in phase one was the **non-standardised self-administered questionnaire** which consisted of ten statements focusing on the incidence and the experience of workplace stress (burnout included) by the participants, measured through job satisfaction and dissatisfaction. In phase four the **Oldenburg Burnout Inventory** (Appendix X) was used and this consisted of sixteen statements that measured disengagement and exhaustion in the workplace (Demerouti

& Bakker, 2007). It was administered to the participants at pre-test and post-test levels. The **qualitative data** were collected mainly through **semi-structured interviews** with interview schedules. In phase one an interview schedule with ten questions was used with the home-based care practitioners whilst a shorter schedule of six questions was used with the supervisors/managers. With phase four, two interview schedules and session evaluation forms were used (with the experimental group only). The first schedule had twelve questions and was utilised before exposure to the intervention programme and the second schedule, with nine questions, after exposure to the intervention programme.

Quantitative data were analysed with the assistance of a statistician from the Department of Statistics (University of Pretoria) using the Statistical Package for the Social Sciences (SPSS), Version 24. In phase one, descriptive and association statistical methods were implemented, and other statistical tests such as the Shapiro-Wilk test, Levene's test for homogeneity of variances, one way analysis of variance (ANOVA) and Pearson correlation-coefficient (r) and Bonferroni test were used to analyse the data gathered from the non-standardised questionnaire. Bivariate analysis, was implemented in phase four to analyse the data gathered from the Oldenburg Burnout Inventory, at pre- and post- test levels (from the experimental and comparison groups), as the researcher was measuring the relationship between two variables, namely workplace stress and the prototype stress management programme (Rubin & Babbie, 2008:493, in Fouché & Bartley, 2011:266). Statistical tests used were the t-test for independent groups, and the analysis of variance (ANOVA).

Qualitative data gathered from the semi-structured interviews with both the HIV and AIDS home-based care practitioners and the supervisors/managers were analysed through thematic analysis in phase one (Roller, Mathes and Eckert, 1995:167 in Babbie & Mouton, 2011:492, 412). The same method of analysis was also utilised with data gathered in phase four from the experimental group. To ensure the trustworthiness and quality of the data, strategies of triangulation, peer debriefing and member checking were implemented (Babbie & Mouton, 2011:277).

An elaborate discussion of research methods, including the ethical considerations and limitations of the study is presented in Chapter 5.

1.6 CONTENTS OF THE RESEARCH REPORT

The thesis consists of eleven chapters and they are presented as follows:

Chapter 1: General orientation

The chapter gives an overview of what the study is about, including its context. The key concepts, the problem statement and rationale of the study and research questions are explained in order to familiarise the reader with what necessitated the study. The goal and objectives of the study are listed and the chapter concludes with a brief overview of the research methods.

Chapter 2: Home-based care and the HIV and AIDS pandemic

The chapter focuses on an in-depth literature review of the HIV and AIDS pandemic and its relationship to the evolution of home and community-based care for people living with HIV and AIDS, and an overview of home-based care and its place in the care continuum. A general discussion follows on the workplace stress experienced by both lay and professional health workers in the HIV and AIDS field and this then narrowes down to the documented workplace stress experienced by home-based care practitioners. The purpose has been to present a comprehensive picture of HIV and AIDS home-based care and the challenges they faced in rendering services to the patients.

Chapter 3: Stress management interventions

The chapter presents a detailed literature review on stress and its conceptualisation, models of stress, general overview of stress management programmes including individual-based and organisational stress management interventions. The chapter concludes with a discussion of stress management interventions in the healthcare field.

The purpose was to gain understanding of the concept of stress and its management, particularly in the healthcare field and also to use the insight in the development of the envisioned stress management programme for HIV and AIDS home-based care practitioners.

Chapter 4: Social constructionism: theoretical orientation of the study

The chapter starts with an overview of social constructionism, with specific focus on its description and origins. This is followed by a discussion of its key concepts and assumptions, a comparison with social constructivism theoretical framework and the relationship with social work research. Finally, its applicability and relevance to the study are considered.

Chapter 5: Research methods

The research plan and its implementation are presented in the chapter through a detailed discussion of the following: the research questions, research approach, the type of research overview of intervention research, specifically design and development, the mixed method research design, the study population and sampling methods, data collection methods, data analysis, the pilot study, ethical considerations and the limitations of the study.

Chapter 6: Qualitative research findings: problem analysis and project planning (Phase 1)

The chapter outlines the qualitative research findings emanating from the collection and analysis of data gathered from the research participants, namely, the HIV and AIDS home-based care practitioners (primary participants) and their supervisors/managers (secondary participants), who formed part of the need assessment process. The biographical data of the primary participants and the emerging themes and sub-themes

from the data are discussed, followed by a similar discussion of the data gathered from the secondary participants. Finally triangulation of both sets of data is discussed to identify patterns of differences and similarities.

Chapter 7: Quantitative research results: problem analysis and project planning (Phase 1) & data triangulation

The chapter focuses on the discussion of the quantitative results obtained after analysis of the data from the primary research participants. A discussion on the comparison between the participants' age, highest qualification levels, years of experience as home-based care practitioners, and their job satisfaction and dissatisfaction is provided to establish patterns of association. In line with the mixed methods approach, the chapter concludes with triangulation of the qualitative findings (Chapter 6) and quantitative results during the need assessment process. The outcome of the triangulation is incorporated into the development of the prototype stress management programme.

Chapter 8: The stress management programme for HIV and AIDS home-based care practitioners

A description of the prototype stress management programme is provided, including a detailed account of its five modules in order to familiarise the reader on what the programme entails.

Chapter 9: Qualitative research findings: early development and pilot testing (Phase 4)

The chapter presents the qualitative research findings from the pilot testing process through a discussion of the following: the biographical information of the participants; analysis and interpretations of data from the pre-intervention and post-intervention semi-structured interviews with themes and sub-themes; a presentation and interpretation of data from the sessions' evaluation forms; and a comparison of both pre- and post-

intervention data. The findings provided evaluative feedback on the effectiveness of the prototype intervention programme.

Chapter 10: Quantitative research results: early development and pilot testing (Phase 4) & data triangulation

The chapter sets out an account of the quantitative results recorded during pilot testing, with specific focus on a discussion of biographical information of the two groups of participants (the experimental and comparison groups), pre -and post-test results analysis and interpretation for both groups on the Oldenburg Burnout Inventory measurements, the comparison of the pre- and post-test results (of both groups) with the participants' highest qualification levels. It ends with the triangulation of qualitative findings and quantitative results of Phase 4.

Chapter 11: Key findings, conclusions and recommendations

Based on the key findings of the study, the conclusions drawn are elaborated on. In addition, recommendations are made with regards to the conceptual framework, structure and content of the stress management programme, policy change directive, social work training and practice. Lastly, recommendations for future research are also offered.

CHAPTER 2

HOME-BASED CARE AND THE HIV AND AIDS PANDEMIC

2.1 INTRODUCTION

This chapter focuses on a literature review of the HIV and AIDS pandemic, home-based care and the workplace stress experienced by both lay and professional health workers. The aim of the review was to gain insight into how the pandemic has shaped home-based care and its impact on the personnel rendering the service.

The current developments with regards to the impact of HIV and AIDS globally, in sub-Saharan Africa and South Africa, the overview of home-based care, spectrum of home-based care services, and the workplace stress among health care workers and home-based care workers in the HIV and AIDS field, are discussed.

2.2 HIV AND AIDS PANDEMIC: CURRENT TRENDS AND DEVELOPMENTS

The HIV and AIDS pandemic has been in existence for almost four decades now. Its impact is far more extensive than was predicted, reversing developmental gains, obliterating millions of lives, widening the gap between the rich and poor, and undermining social and economic security (Heunis, Wouters & Kigozi, 2012:294). This negative impact of the disease on individuals, families and communities cannot be overemphasised, meaning that one is either HIV infected or affected. It is for this reason that the health sector has to continue with preventative and curative interventions until this negative impact is minimised significantly, or at best eradicated.

There have been concerted efforts mainly co-ordinated by the Joint United Nations Programme on HIV and AIDS (UNAIDS), to turn the tide against the pandemic and eventually achieve zero infection rate. To achieve this, *UNAIDS* (2015:1)*,* in collaboration with member countries, formulated the following goals for 2011-2015:

- Reduce sexual transmission of HIV by 50%;

- Prevention of HIV among drug users;
- Eradicate new HIV infections among children and reduce AIDS-related maternal deaths;
- Improve access to 15 million people living with HIV to life saving antiretroviral treatment;
- Eliminate gender inequalities and increase the capacity of women and girls to protect themselves from HIV; and
- Eradicate HIV and AIDS related stigma and discrimination in all sectors of society
- Strengthen the integration of the HIV and AIDS-related services in global health and development efforts.

These goals challenged member countries to scale up their HIV and AIDS programmes such that they are preventative and holistic in approach. The developing countries, in particular, will have to be realistic in terms of the human and financial resources available to meet these goals. Furthermore, it will also take buy-in from all sectors of the society, especially politicians as they govern countries, to work together in ensuring that the fight against the pandemic, including its social and economic impact, is won. The then Secretary–General of the United Nations, Mr. Ban Kin-moon (UNAIDS 2015:13) reiterated that the pandemic has resulted in a mind shift of seeing health care as a human right and not a privilege. Societies have been forced to address the challenging issues of human rights, education, security, the law, gender equality and social inclusion, as the pandemic affects each of these issues.

Although progress has been made in terms of working towards attaining these goals, there is an urgent need to intensify HIV prevention programmes, to continue expanding access to treatment, to have robust and transparent governance and accountability for HIV and related health services to ensure that the goals are met within the stipulated timeframes (UNAIDS & Lancet Commission, 2015:1). The *Joint United Nations Programme for HIV and AIDS's 2016-2021 Strategy* (2015:3), embraced the intensification of prevention efforts, by urging for bold action to fast-track the unfinished agenda of the 2011-2015 strategy of drastically reducing new infections. The aim is to

bend the trajectory of the HIV and AIDS epidemic. The strategic directions that must be achieved by 2020 (UNAIDS, 2015:15) are:

- Fewer than 500 000 people infected with HIV;
- Fewer than 500 000 people dying from AIDS-related causes; and
- Elimination of HIV-related discrimination.

A discussion on current trends and developments with regards to the HIV and AIDS pandemic globally, in sub-Saharan Africa and South Africa, follows.

2.2.1 Global HIV and AIDS pandemic trends

HIV and AIDS continue to infect and affect people from all walks of life. This is a global pandemic affecting people mainly in their economically productive years and thus threatens the livelihood of all, both infected and affected. As a result of its indiscriminate nature, people are affected by what HIV and AIDS does to their significant others, neighbours and colleagues (Rooth, Stielau, Plantagie & Maponyane, 2006:96).

Since the beginning of the pandemic, it is estimated that 77.3 million people have become infected with HIV, with 35.4 million people dying of AIDS-related illnesses. Records indicate that new infections have dropped by 47% since the peak in 1996. Access to life saving antiretroviral therapy has been improved drastically, with 21.7 million people benefiting from the service in 2017. To date, it is estimated that 36.9 million people are living with HIV and AIDS globally (UNAIDS, 2018:1). Countries that were most affected by the pandemic, where there is usually high demographic growth, were urged to focus on preventing new HIV infections and expand access to antiretroviral treatment to ensure that the pandemic does not continue to claim more lives (UNAIDS & Lancet Commission, 2015:1).

Statistics show significant progress in working towards attaining zero infections, through increased HIV prevention programmes, other HIV mitigation programmes (e.g. prevention of mother to child [HIV] transmission) and the extension of antiretroviral treatment in low and middle income countries (Thomas, 2006:3174). It will take additional human and

financial resources to successfully contain or reverse the impact of the pandemic in decades to come (Thomas, 2006:3174).

2.2.2 Sub-Saharan HIV and AIDS trends

The HIV and AIDS pandemic affects most spheres of life. There are many effects of HIV and AIDS, but perhaps the most profound effects of HIV are on the psychological, social and economic health of the person, their loved ones and the community (Cogan, Klein, Magongo & Kganakga, 2005:2).

The sub-Saharan region, which consists mainly of developing countries (e.g. Zimbabwe, South Africa, etc.) still remains the worst affected by the pandemic, accounting for almost 70% of the global total of new HIV infections. The pandemic has overwhelmed the fragile health systems of the region especially the poorest countries (Mohammad & Gikonyo, 2005:2; UNAIDS, 2018:2). The pandemic has also changed who works and where, and what people and households spend their money on, which invariably is more on healthcare and sometimes also on funerals (Lund, 2010:498).

Awareness of the disease and a willingness to accept treatment have both increased the demand for healthcare services in an environment where the demand was already exceeding the supply of such a service in terms of human and material resources (Ogunmefun, Friedman, Mothibe & Mbatha, 2011:1). This implied that those infected with HIV, were reaching out and demanding the life-saving antiretroviral treatment so that they could continue to be active members of their families and communities.

Regional statistics show that as at 2017, there were an estimated 19.6 million people living with HIV in eastern and southern Africa. An estimated 800 000 new infections were recorded in 2017, whilst 12.9 million people living with HIV in the region have access to antiretroviral treatment (UNAIDS, 2018:4). This is evidence that systems that have been put in place were bearing fruit, although more still needs to be done.

Access to treatment in the region needs improvement as the service is not reaching all who are eligible and need it the most. There has been commitment though, from some

African leaders to improve HIV and AIDS health services by increasing investments in HIV treatments even in uncertain economic times (UNAIDS, 2012:1).

2.2.3 South African HIV and AIDS pandemic trends

The HIV and AIDS epidemic presented a major social and developmental challenge in South Africa. Although a cure is still remote, improved access to antiretroviral drugs has gone a long way to prolong the lives of those living with HIV and AIDS, thus reducing the negative effects of the disease on individuals, families and communities (Dickinson, 2006:6).

South Africa is said to have a generalised HIV epidemic that is transmitted mainly through sexual encounters. Its drivers include behavioural, social, biological and underlying structural and societal factors such as poverty, gender, inequalities, human rights abuses and migrant labour (Department of Health, 2011:22).

Recent statistics report that South Africa has 7.1 million people living with HIV and AIDS of whom 4.2 million are women, and 280 000 are children (UNAIDS – South Africa, 2018:1). In terms of access to treatment, South Africa was identified as the most progressive in sub-Saharan Africa, with at least 300 000 being enrolled as antiretroviral therapy recipients in 2011. This number has increased since then, due to the antiretroviral treatment expansion programme that has seen an increase of antiretroviral treatment facilities to 2 552 (Department of Health, 2011:8; UNAIDS, 2012:1). To date, approximately 63% of people living with HIV are reported to be on antiretroviral treatment (UNAIDS – South Africa, 2018:1).

The *National Strategic Plan for HIV, STI's & TB 2012-2016,* building on previous successes, formulated the following goals as strategic guidelines for HIV, STI's and TB activities for 2012-2016 (Department of Health, 2011:21):

- reduction of HIV infections by at least 50% using combination prevention programmes;
- initiating at least 80% of eligible patients on antiretroviral treatment;

- ensuring enabling and accessible legal services that protect and promote human rights for those affected by and infected with HIV and AIDS; and
- reducing self-reported stigma and discrimination related to HIV by 50%.

The accelerated prevention programmes which included the roll-out of antiretroviral treatment to those eligible, is evidence of commitment from government, business and civil society to reduce the negative impact of the pandemic on the wellbeing of the country. Furthermore, the *National Strategic Plan for HIV, TB and STI's 2017-2021*, emphasised that an effective response to the HIV epidemic that ensures high impact and value, has to utilise a combination of prevention programmes, treatment programmes and tackling the economic and social drivers of the epidemic (South African National AIDS Council, 2017:7). The strategic goals that specify impactful HIV and AIDS prevention and treatment imperatives (South African National AIDS Council, 2017:4, 6), are:

- Goal 1: Accelerate prevention in order to reduce new HIV infections – reduce new infections of HIV to less than 100 000 per year; and
- Goal 2: Reduce HIV-related illness and death by providing treatment care and adherence support for all - to ensure that by 2020, 90% of people living with HIV to know their status, 90% of people living with HIV receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy achieve viral suppression.

The National Strategic Plan (2017-2021), if implemented as intended, with continued working partnerships and the collaborative efforts of all stakeholders; government, business and civil society, will propel South Africa to make significant progress towards attaining the zero infection rate that is promoted by the United Nations.

The healthcare workforce is expected to have a working knowledge of the strategic goals as they impact directly on how they approach, think and roll out services to those affected by and infected with HIV and AIDS. Home-based care workers, who form part of the public healthcare workforce, are also expected to embrace efforts to reduce the impact of the pandemic. They witness the daily struggles of those infected with HIV in their daily work and thus have first-hand experience of its devastating effects.

A general overview showing who the home-based workers are, their roles and how they fit into the public healthcare sector, specifically, the HIV and AIDS sector, follows.

2.3 GENERAL OVERVIEW OF HOME-BASED CARE

Home-based care is, in a nutshell, a service that ensures that ill people at home, unable to access public health service because of incapacity and various other reasons, are able to do so through the service being delivered at their homes, or near their homes. This section deliberates on the definition of home-based care, how the service evolved in South Africa, the spectrum home-based care services and the demographic characteristics of home-based care workers and also the recruitment/selection criteria.

2.3.1 Definition

Home-based care is sometimes referred to as community home-based care or home and community-based care (Department of Social Development, 2007:3; World Health Organization, 2002:6). Seemingly, this emphasises that it is locally based and driven by the community.

Home-based care is thus defined as a form of care given to ill people in their homes, which includes physical, psychosocial, palliative and spiritual services. The overall aim is to provide quality health and social services that promote, restore and maintain the ill person's maximal level of comfort, social functioning, independence and health (Friedman, Mothibe, Ogunmefun & Mbatha, 2010:4; World Health Organization, 2002:6). It is a vehicle for ensuring effective and quality care and support services to those living with HIV and AIDS and other chronic illnesses in the community (Hlophe, 2006:193).

Another view is that home-based care is healthcare given to a patient in the home, either by a family member or friend, supported by a trained community caregiver. In ideal situations, the community caregiver is supported by a public healthcare sector multidisciplinary team to ensure that the needs of the patient are holistically met (Van Dyk, 2008:332). It can be regarded as an alternative to traditional institutionalised

healthcare focusing mainly on palliative care in the home and community (Moetlo, Pengpid & Peltzer, 2011:137).

The definitions therefore, emphasise that home-based care is a service rendered by lay health workers, in partnership with professionals in the public health sector, to patients who need extended care and those who are discharged early from hospital and can be effectively managed at home (Hlophe, 2006:195). The aim is to ensure that the ill persons receive a comprehensive service in the comfort of their homes and communities. The aim of home-based care, therefore, is to provide affordable and effective community-based care and support. Care of the ill and dying is moved from hospitals to people's homes, from healthcare professionals to community members (Van Rensburg, 2004:426). It has been noted that, although this is the case, the service is used predominantly by patients living with HIV and AIDS (Moetlo et al., 2011:138).

Home and community-based care services are said to include various aspects (EPWP Social Sector Plan, 2004:8). These are: early identification of families in need, orphans and vulnerable children and addressing the needs of child-headed households; linking families and care-givers with poverty alleviation programmes and services in the community; patient and family care, counselling, information giving and support related to HIV and AIDS and other chronic conditions; addressing discrimination and stigmatisation of those affected by or infected with HIV and AIDS and other chronic diseases. Lastly, family support in a form of capacity building, family planning, burials, support for children and social services advice.

The services are locally based and do not only address the felt needs of the target group but go beyond that by linking them with relevant public services, empowerment through information giving, practical assistance and also investing in changing community attitudes about those affected by and infected with HIV and AIDS inclusive of patients with incapacitating chronic conditions. The researcher is of the opinion that the service package seems to lack a preventative focus.

Home and community-based care draws its strength from the universality of families and communities. Almost every society has families that are centres of care for its members, both healthy and unhealthy. These families exist within communities where they

experience extended shared living, support and care that individual families cannot provide for themselves (World Health Organization, 2002:8). An assumption can therefore be made that "concern for the other" played an important role in shaping home-based care as we know it today.

2.3.2 Background information on home-based care in South Africa

The HIV and AIDS pandemic presented the health sector with a problem that the usual means of intervention and containing a disease of its magnitude were not successful in solving. The growing pandemic resulted in public health services being overstretched and families and communities being faced with the heavy burden of caring for those living with HIV and AIDS (Mabude, Beksinka, Ramkissoon, Wood & Folson, 2008:931). Additional challenges of the public health sector, including shortage of beds, inadequate numbers of public sector health professionals, lack of treatment and drugs made managing the disease a huge task. Furthermore, South Africa was in the process of on-going transformation of the public health services following the apartheid era (Campbell & Foulis, 2004:6). Many healthcare professionals found themselves unable to cope with the high workload of HIV and AIDS patients, and the only realistic way of dealing with the crisis was to use the resources that were available in the family and community (Van Dyk, 2008:332).

With the government only taking a pragmatic approach after the mid -1990s to address the needs of those living with HIV and AIDS, families and communities found themselves having to take the initiative of addressing the crisis brought about by the pandemic using faith-based and non-governmental organisations as vehicles of service delivery. The partnership between the public health sector and the informal sector was initially problematic with regards to the care of people living with HIV and AIDS, allegedly with the public sector shifting some of its responsibilities to the informal sector that was already over-stretched in terms of both human and material resources (Ogden, Esim & Grown, 2006:337). This situation then urged the health sector to establish a comprehensive intervention programme that would respond to the unique needs of HIV and AIDS patients.

The government subsequently mandated the Departments of Health and Social Development's Forum of Provincial Ministers of Executive Councils (MINMEC) to work on an intervention strategy. The MINMEC, amongst others, then adopted the home and community-based care programme as a viable strategy to fight against the pandemic. One of the compelling reasons for adopting this programme was that disadvantaged communities who had almost no access to the formal sector, were the most affected socially and economically by the HIV and AIDS pandemic (EPWP Social Sector Plan, 2004:9).

Through the collaboration of the EPWP (Expanded Public Works Programme), the National Department of Social Development, the National Department of Health, community-based and non-governmental organisations, home-based care workers provide an important human resource; assisting the government dealing with some of the practical problems around palliative care for patients living with HIV and AIDS (Wilson & Fairall, 2010:526). The programme therefore made it possible for patients and those affected to access the health and related social services in their own communities.

The success of home-based care thus lie in the successful partnership between communities and government where resources, skills, time, energy and funds are shared with all parties subscribing to the idea that the health of any community lies in its social and economic development (Department of Health, 2001:1). Home-based care, rendered by lay healthcare workers, filled a big gap in HIV healthcare. There was now a working link between formal and informal healthcare of affected patients (Schneider & Lehmann, 2010:61).

Home-based care is an important component of the continuum of care that was proposed by the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (Department of Health, 2003:54) which consists of prevention related interventions, voluntary counselling and testing, medical care and treatment by a dedicated and adequately trained medical team, psychosocial support, nutritional assistance, social support and community and home-based care.

The rationale behind the home and community-based care programme for HIV and AIDS was that, given the relevant support, all communities are capable of caring and supporting

their vulnerable families. Secondly, it was believed that a family-home environment is more conducive to, and appropriate for care and support for those living with HIV and AIDS and it made the pandemic a social and a community issue. Furthermore, institutionalising those living with HIV and AIDS had the potential to promote stigma, denial and discrimination would work against efforts to contain the disease. Lastly, the programme ensured that both the infected with and affected by HIV and AIDS were able to access integrated services within their communities (Department of Social Development, 2007:8).

Based on the rationale, the benefits of home-based care were identified as firstly, reduction in the demand for hospital beds and other public health resources at different levels of service. Secondly, the ill had the opportunity to spend their days in familiar surroundings and familiar people. Thirdly, it promoted a holistic approach to care and intervention. It contributed to job creation especially in the non-formal system. Furthermore, care of the affected persons was individualised and person-centred. Lastly, it ensured continuity and consistency in service, quality assurance and management (Department of Health, 2001:9-10).

The recipients of home and community-based care services, therefore, did not only benefit from healthcare where indicated, but also from social and psychological support within their families and communities. Additional support was also received from formal and informal health and social development workers (Ogunmefun et al., 2011:2). The home-based care thus played a role in ensuring quality and effective care and support for people living with HIV and AIDS and other chronic diseases (Hlophe, 2006:193). It also played an important role in accelerated roll-out of antiretroviral treatment as it provided the mechanism for assessing and supporting patients' adherence to treatment, reaching out to those who missed clinic appointments, providing palliative care and supporting the patient and family to ensure good quality of life (Department of Health, 2003:58). The service was preventative, curative and there was also long-term support to the beneficiaries to ensure that the attained optimal level of functioning was maintained and sustained.

In spite of its many benefits, home-based care had its share of challenges. Some of the challenges were: having to deal with a restricted social environment where people are reluctant to come to terms with the epidemic and its impact and prefer to cling to unproductive ideologies and customs; uncertainty about the future in terms of how long the epidemic would last given that there is no cure; service users growing dependent on the service and resisting any form of empowerment geared towards promoting being self-supportive. Sometimes there was fear and mistrust from the primary caregivers who perceived the home-based care worker as invading their privacy. There was also confusion around volunteerism versus paid work and in some areas there was fragmentation of services with no pulling together of resources for the benefit of the service user (Department of Health, 2001:10-11).

The challenges seemed to highlight that the HIV and AIDS took communities by surprise and it would probably take time for people to be equally committed to working together in ensuring that its impact was significantly minimised. Attitude and behaviour change would be necessary for this to happen and sadly, these are the most difficult to change in people.

Although it seemed that home-based care was targeted only at people affected by or infected with HIV and AIDS, the *National guidelines for home-based care/community based care* (Department of Health, 2001:3) clarified that some of the beneficiaries of the service are healthy people, at risk, or frail older persons, at risk persons with moderate to severe functional disabilities, persons recovering from illness needing assistance, terminally ill persons, and any other disadvantaged person/s in need of such care.

In summary, the HIV and AIDS pandemic prompted both formal and informal public health services to work in partnership and proactively review the shortcomings of services to people living with HIV and AIDS and similar debilitating diseases, and put together a comprehensive plan that best suited the needs of the affected patients and their families.

2.3.3 Spectrum of home-based care services

For many years, community care has been a cornerstone in the development of health services. It is a way of delivering services and enhancing the quality of life of

patients/clients in their communities where the service is easily accessible (Atkinson, 2009:156). Furthermore, it consists of a complex system of role players and is by no means supposed to replace hospital and institutional care (Morton, 2012:14).

The role players in home and community-based care are identified firstly as the formal system that includes the public health and social support services of doctors, nurses, psychologists, rehabilitation therapists and social workers. Secondly, there are the non-formal system consisting of non-governmental organisations, community-based organisations, faith-based organisations, traditional healers and leaders and thirdly, the private/business sector. Fourthly there is the informal sector including families, community health workers, volunteers and caregivers and, lastly, there are the service consumers who are the service beneficiaries (Department of Health, 2001:6-7). The service, consequently depended on a collaborative, cooperative, open and honest partnership relationship among the stakeholders. Each system and sector in the partnership needed to clearly understand its role to ensure that those who needed the service the most obtain maximum benefit of the joint efforts.

Furthermore, stakeholders had to adhere to certain principles of home and community based care (Department of Social Development, 2007:9). These are listed below.

Partnership and active participation: this included active community involvement in the development, implementation, monitoring and evaluation of the programme with the aim of instilling a sense of ownership. This implied that the service could not be imposed on the community. It had to be by the community for the community. Obtaining the cooperation of the community with such a sensitive matter could be challenging, but it had to be done. Furthermore, a working partnership between the government, communities and business sector had to be encouraged to ensure proper capacitation of the communities.

Volunteerism: this meant voluntary involvement of stakeholders in the programme. In poorly resourced communities sometimes people are looking more for jobs rather than volunteering their time. This volunteerism therefore had to be clearly explained, including the benefits to the individual concerned and to the broader community. Coercion needed be discouraged at all costs.

Non-partisan: the services are apolitical. Party politics have to be set aside as HIV and AIDS affects all indiscriminately. There should be no discrimination in terms of ethnicity, religion, gender and race.

Empowerment: the primary focus should be on capacity building and the empowerment of families and communities to care for those infected with and affected by HIV and AIDS. The purpose of the service should not be to hand out solutions to the community but to empower them with skills and knowledge to solve their own problems. That way the programme would become sustainable in the absence of visible support from government.

Universal access: No means test or any means of qualifying criteria should be used to determine access to the services offered by the home and community-based care programme. Public services are for everyone who needs them. Preferential treatment of certain sectors of the community should be highly discouraged.

Holistic: the programme had adopted an integrated approach which emphasised that the service was not for exclusive use for HIV and AIDS, but included other deserving vulnerable groups. Although initially targeted at people living with HIV and AIDS, it had come to light that there were other health needs in communities that could be addressed using the same home-based care approach and services thus, leading to the broadening of the service target group.

Development: the aim of the programme has been to empower service users to grow from being victims to victors who are capable of using lessons learned from the programme in a proactive and sustainable manner.

A shared vision among stakeholders through practising the mentioned principles, could increase the chances of the realisation of projected positive outcome of the home and community-based care programme. It should also be borne in mind that impactful home and community-based care services rest on three pillars (Department of Health, 2001:11), namely integrated management of referral service organisations, the training and development of community personnel, including professional and technical support staff and thirdly, integration into the district health system.

The pillars also emphasised the partnership that both government and civil society had to engage in to ensure the relevance, appropriateness and accessibility of services. Integration of services and training of personnel further highlighted the importance of making sure that all professional and non-professional staff knew what they were supposed to do and that there was no duplication of efforts and no room for trial and error.

Home-based care could be made available to communities in a number of ways. Uys (2003:5-7) identifies the models discussed below.

- The integrated home-based care model was introduced as a result of the increasing need for palliative care for people living with HIV and AIDS. The patient and family are serviced by a network of service providers in the continuum of care such as the local public healthcare facility, community caregivers, support groups, non-governmental organisations and the community at large. Highly trained and professionally supervised community caregivers and volunteers, through the network of service providers, empowered needy families and their neighbours with information and resources to enable them to keep ill patients at home (Defilippi, 2005:34). Figure 2.1 gives a graphic illustration of the model as follows:
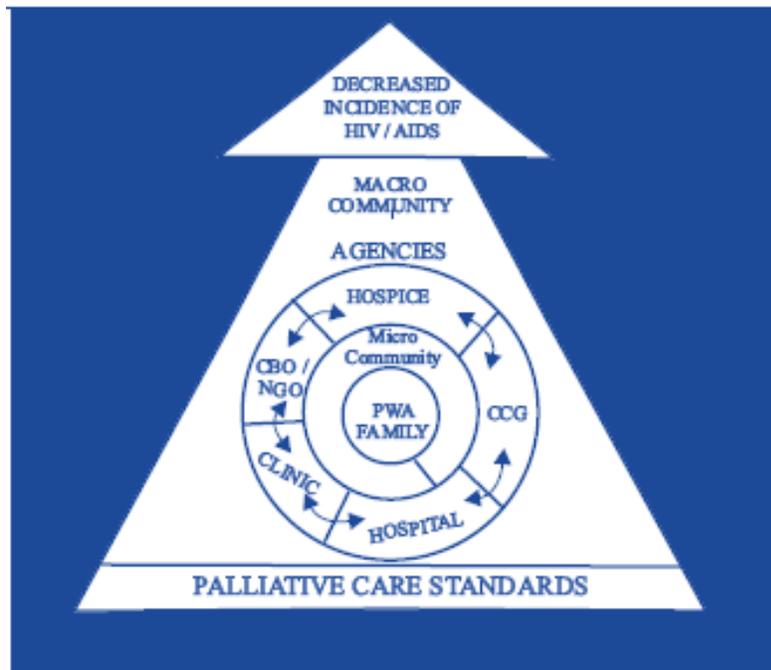
Figure 2.1: Example of an integrated community and home-based care model (Uys, 2001:76).

- Single service home-based care model services are rendered by a single health facility. It could be a government facility, private or non-governmental/community based organisation. Incidentally, many home-based care programmes started as single service facilities and, as they entered into partnerships with relevant organisations, were transformed into the integrated model.

- Informal home-based care model services to the patient are rendered mainly by caring family members, concerned neighbours and social networks. These people lacked the knowledge, skill and the emotional support that was needed for caring for an ill person at home. They tried to do their best for the loved ones in poorly resourced areas.

These models seemed to emphasise the fact that home-based care was better implemented as an integrated service as the other two models had limitations that, in the long run, might compromise the targeted beneficiaries of the service.

There is an approach that distinguishes between formal and informal models of home-based care. The informal home-based care has been previously explained, whilst the formal home-based care is care rendered to patients by a structured organisation or public health facility (Ncama, 2005:34). The formal home-based care was further divided in terms of the services they rendered (service model) or how they were structured (structural model) (Ncama, 2005:34).

Of particular importance to the study was the service model, as it was in line with the earlier mentioned definitions of what home-based care is. The service model consisted of a further two models, home visiting and comprehensive home-based care. Home visiting involved visits to patients by trained volunteers who engaged in basic health education, attended to the patient's care needs and other relevant home support services. Comprehensive home-based care on the other hand was similar to the integrated model. It was rendered by a structured and well established non-governmental/community-based organisation or public health facility that had partnered with similar organisations or public health facilities and other relevant government departments to ensure that patients receive a comprehensive service. It used well trained caregivers to provide basic healthcare to patients, which included basic counselling, medication compliance monitoring, assessment and referral of patients to relevant resources. Some even incorporated orphan care, social support and income generation projects (Ncama, 2005:35).

Another view was that there are five common models of care and support (Russel & Schneider, 2000:21-24) and these are listed below.

Funding; technical assistance and support programmes acted as umbrella bodies for the channeling of funds and assistance to communities and home-based care organisations. They focused on material and human resources capacity building of beneficiary organisations, including monitoring and evaluation of funded projects to ensure that the expected return on investment was realised for donors, beneficiary organisations and service users.

Secondly, advocacy and community mobilisation groups worked for the protection of the rights of service users and facilitated access to health and welfare services. They were

more like social action groups that lobbied for community participation and access to public services.

The third model was drop-in centres and support programmes which provided support groups and counselling, education, and often had an income generating activity. In other words these were day care facilities that catered for the needs of mainly unemployed people living with HIV and AIDS, empowering them through education, limited income to afford basic needs, and psychosocial support.

There were also community home-based care programmes, which provided the services of drop-in centres and also offered home visits to patients and their families, offering practical assistance and where necessary, supplied food parcels.

The fifth model was the comprehensive home-based care programme which provided an integrated service as previously explained (Ncama, 2005:35).

The criteria for the above-mentioned models, seemed to be based more on the services that they rendered and included models that covered a wide spectrum of services available to those requiring community and home-based care. The technical assistance and support programmes and the social mobilisation groups appeared to focus more on logistical support to service users rather than a direct health and social service that addressed the immediate needs of the patient/service user and his/her family.

The comprehensive - integrated model of community home-based care appeared to be the most common (Ncama, 2005:35; Russel & Schneider, 2000: 21-24; Uys, 2003:5-7). This suggested that it was the model that best met the goal and objectives of community and home-based care as it exemplified a working partnership between the public health and social services, community-based organisations, the community itself and the service users.

It is argued that the integrated model of community and home-based care, although comprehensive and holistic in approach, had a tendency to focus more on the patient rather than on the patient and the family, meaning that there was a need to integrate the domain of family care effectively. The family is usually the first line of support and therefore needs to be strengthened to support its vulnerable members. Partnerships in

service delivery should include a wider range of public and private sector services such as social security, key public health infrastructure, agriculture, nutrition, socio-economic and legal resources, and housing. Strong partnerships with similar organisations in the community or vicinity, are highly recommended. Although inclusion of all these partners might have financial implications, the expected outcome could ensure that the patient and family were protected, and able to survive and the impact of the service was sustainable (Mohammad & Gikonyo, 2005:13; Ogden et al., 2006:339-340).

In summary, community and home-based care, was initiated through the efforts of both communities and public health services to mitigate the impact of HIV and AIDS. The outcome of these efforts benefits not only those affected by and infected with HIV and AIDS, but also those needing primary healthcare and related social services that were not easily accessible in the past. Home-based care practitioners were the main foot soldiers who made this portion of the continuum of care possible. The next topic gives a picture of who these soldiers are.

2.3.4 Who are the home-based care practitioners?

South Africa has a history of ordinary citizens reaching out through volunteerism to assist those in need or less fortunate. The same altruistic behaviour seemed to be responsible for motivating people to make time and whatever resources they had available, to reach out to those infected with and affected by HIV and AIDS. The impact of the epidemic on the health and social wellbeing of communities was visible and could not be ignored. This concern for others, family members or neighbours, led to the birth of home-based care workers (Department of Health & Department of Social Development, 2009:10).

Home-based care practitioners, often referred to as home-based carers or home and community-based workers, are therefore a new group of healthcare workers whose formation was necessitated by the growing need for extra hands to care for those infected with and affected by HIV and AIDS. In 2004 the Department of Health introduced, through the Community health worker policy framework, an umbrella title for all lay healthcare workers in the public health sector of "community health workers" which also included

home-based care workers (Lund, 2010:499; Schneider, Hlophe & Van Rensburg, 2008:179).

The collaboration between the Departments of Health, Social Development and Labour's Expanded Public Works Programme – home/community based care (HCBC), provided opportunities for volunteer home-based care workers working with non-governmental/community-based and faith-based organisations to access the necessary skills, training and financial incentives that would help them to render quality services in the area of great need, the HIV and AIDS field. Additional beneficiaries of the programme were unemployed adult dependants of the terminally ill and people living with HIV and AIDS and not receiving a state pension. The ultimate goal was to provide them with a stepping stone to participation in the open labour market (EPWP Social Sector Plan, 2004:7,9,10).

In the recruitment of home-based care workers, the following criteria have to be adhered to (Department of Health & Department of Social Development, 2009:45; Schneider et al., 2008:182):

- Must be 18 years of age and above.
- Must meet the relevant legislative determinants.
- Education history should not be considered. An exception is made when the history is used to assess the applicant's ability to benefit from the skills development programme.
- They have to be residents of the communities within which they intend to work.
- They must have a support system in the form of non-governmental/community-based or faith-based organisation to which they are attached.

Home-based care workers and other lay healthcare workers, were therefore a group of flexible non-professionals supported by the government through training and stipends on the margins of the healthcare system. The Department of Health had not incorporated them into the civil service and was comfortable with using non-governmental/community-based and faith-based organisations as intermediaries. This created a problem of loyalty and accountability with regards to the home-based care workers as they operated within

the non-governmental organisations, but stipends were provided by the Department of Health (Schneider et al., 2008:187).

In spite of the unclear position in the public health system, home-based care workers (and other lay healthcare workers) had roles that they were expected to fulfil. Some of those roles included to encourage community members to determine health and social needs and take responsibility for ensuring that they were met by accessing available public resources; in collaboration with the community, to advocate for the improvement of the health and social wellbeing of the community and facilitate access of health and social worker personnel into households in need when required. Furthermore, they had to participate in health promotions, provide psychosocial support and refer to other sectors for services that were beyond their scope of expertise. They were also expected to provide medical/nursing care in the form of home-based care and palliative care for those in need of the service (Department of Health & Department of Social Development, 2009:30; Schneider, 2000:1). The scope of work was thus broader than just caring for the ill in the home and supporting for the family. There was an expectation to get proactively involved in community life through empowerment, advocacy and networking. Emphasis was more on preventative rather than curative services.

There seemed to be a disproportional representation of both genders among home-based care workers. A lack of male participation in the programme was visible. A reason for this seemed to be the gender segregation that had existed for decades that apportioned care work both in public and in the home to women (Fine, 2011:57-58). The burden of care for people living with HIV and AIDS ended up being the responsibility of women either as primary care givers, volunteers or home-based carers. Home-based care workers have therefore been found to consist mainly of African women, with little formal education and mostly from poor backgrounds (Fine, 2011:57-58; Lund, 2010:500; Mohammad & Gikonyo, 2005:4; Orner, 2006:237). It appeared then that the home-based care workers, based on their background, came to the programme with needs, which if not met, could compromise their ability to be fully committed to the demanding work of caring for HIV and AIDS patients and their families.

As they came mostly from poor backgrounds, home-based workers needed some form of income to sustain themselves and their families. The issue of remuneration for home-based care workers and other lay health care workers seemed unclear. There was a proposal that they should be paid either in kind or a stipend made available from government funding. A common practice by employers (non-governmental/community-based and faith-based organisations) of home-based care workers was that they either paid a salary or a stipend. There was also evidence that some employing organisations did not pay at all as the carers were regarded as "volunteers" (Lehmann & Sanders, 2007:24; Peltzer & Davids, 2011:67).

It has been found that home-based care workers have tended to be marginalised because they were invisible as they worked in people's private homes. Furthermore, they were less likely to complain about the unacceptable remuneration and working conditions because they viewed the work as a stepping stone to better opportunities in the public health sector. The poor working conditions and lack of job security had a potential to demotivate even the most committed home-based care worker. For the home and community-based programmes to be sustainable, carers had to be paid (Lund, 2010:506; Singh, Chaudoir, Escoba & Kalichman, 2011:843).

In order to remedy the situation, the Departments of Health and Social Development (2009:50) put together a proposal for the remuneration of community healthcare workers, a category under which home-based care workers fall, who are part of state funded home and community-based care organisations. The proposal put forward different remuneration rates for learner community healthcare workers, community healthcare workers and community healthcare worker supervisors. In addition, the employing bodies of community health workers were expected to comply with the Basic Conditions of Employment Act 75 of 1997. The researcher's view was that implementation of these proposals could go a long way towards improving the working conditions of home-based care workers.

Home-based care evolved as a solution to a problem of care for those infected with and affected by HIV and AIDS in communities. It has grown to become a recognised field of work with home-based care workers formally trained and capacitated to fill the service

gap in the public health sector. Being part of the public healthcare service delivery workforce also meant that they were exposed to similar working conditions as those of the rest of the staff, specifically those who were rendering direct service. Looking at how the home-based care service evolved, it can be assumed that there was a high demand for the service whilst the supply of human resources to meet the demand was compromised. This is supposedly an environment that was conducive to stress as demand and supply seemed unmatched. To understand better the challenges of the healthcare workforce, discussion of work stress in the sector follows.

2.4 WORKPLACE STRESS IN HEALTH CARE

Workplace stress, sometimes referred to as occupational stress, is explained as an uncomfortable state experienced by an employee that necessitates behaviour change as a result of work-related stressors such as opportunities, constraints and/or demands (Beehr et al., 2000, in Potgieter & Peterse-Landman, 2011:232-233). A stressor, on the other hand, is seen as the external or internal force that triggers stress. Workplace stressors are cited as ranging from role conflict and ambiguity, work over- or underload to poor working conditions (Furnham, 2005:365;384). The emotional, cognitive, behavioural and physiological response to workplace stressors is influenced by the type of stressors experienced, available organisational and family support structures and the personality of the healthcare worker (Colligan & Higgins, 2014:92).

When the workplace stress is not addressed, it could lead to distress, burnout, psychological disorders, a sense of emotional depletion, reduced capacity for emotional control, anxiety, symptoms of depression and in some cases, irritability and anger (Engelbrecht, Bester, Van der Berg & Van Rensburg, 2008:24; Parikh, Taukari & Bhattachrya, 2004:118). Furthermore, these mental health challenges might potentially overspill and impact the general wellbeing of the healthcare worker and his/her family, thus showing the far reaching consequences of work stress (Halpern, 2005:163).

The health of any community in many ways determines its progress and prosperity. Restructuring in the general healthcare sector in the last few decades has led to new

expectations and demands with regards to the quantity and quality of patient care (Hansson, Vingard, Arnetz & Anderzen, 2008:70). With the institution of the new democratic government in 1994, the South African healthcare system experienced transformation as well, and one unified public health system was established. A large section of the population that had been deprived of basic healthcare started to benefit from the newly introduced free healthcare services with primary healthcare services focused more on women and young children (Engelbrecht et al., 2008:17; Lund, 2010:497).

South Africa, like other sub-Saharan countries, experienced an increase in diseases, communicable and non-communicable. Some were acute whilst others were chronic, and are associated with underdevelopment. The result was the increased demand for service provision and the need for adequate workforce to deliver the service. The challenge was that, although the region carried 25% of the global burden of disease, it had only 1.3% of the global healthcare workforce (Naicker, Plange-Rhula, Tutt & Eastwood, 2009:60). It was thus important to have human resource planning, and development that would ensure that the expected health outcomes were achieved and the expectations of service users of quality service were met (Matsoso & Strachan, 2011:50). There had to be a balance between the need for and supply of healthcare services. It has to be noted though that human resources tended to be costly and in most instances accounted for the largest expenditure of any healthcare system (Sanders & Lloyd, 2005:77).

When compared with other similar developing countries, South Africa showed a much lower ratio of healthcare workers per 10 000 population, implying that there was a concerning shortage. Furthermore, it was noted that the unequal distribution of healthcare professionals per 10 000 members of the population in urban versus rural areas and public versus private healthcare had stayed the same in the past 15 years. Urban areas and private healthcare were better resourced and therefore advantaged (Matsoso & Strachan, 2011:52).

One of the contributing factors for the staff shortage was that the country was not retaining the healthcare professionals it produced (Matsoso & Strachan, 2011:52). The trend seemed to be that qualified healthcare professionals migrated from public health services

to private, whilst others left the country. Those who left, mostly emigrated to developed countries, resulting in both human resources and brain drain (Van Niekerk, 2006:1). The impact of both patterns still resulted in staff shortage in the sector, with the public health service being worse off (Bester & Engelbrecht, 2009:105). Within public health, rural areas appeared more disadvantaged with the recruitment and retention of health professionals being hampered by rundown facilities, poor management and lack of basic medication and other basic resources (Van Niekerk, 2006:1).

The staff shortage, according to healthcare professionals, was driven mainly by unfavourable working conditions. These were cited as being: poor remuneration, taxation workload, poor infrastructure, low morale in the workplace, excessive workload, and difficult relationships with management. The risk of contracting disease, personal safety, a lack of opportunities for professional development, crime and political violence (Bester & Engelbrecht, 2009:115; Pandleton, Crush & Lefko-Everett, 2007:40; Van Niekerk, 2006:1). Another study stated that healthcare professionals experienced a troubled conscience when they could not provide the quality service that they knew they were capable of because of compromising working conditions (Glasberg, Eriksson & Norberg, 2006:393).

Studies conducted among nurses and nurses' aides revealed that high work demands, role ambiguity, difficult interpersonal relationships, the lack of positive reinforcement in the form of rewards or recognition for a job well done and having to cope with death and the dying concerns of patients were some of the difficult challenges they faced almost daily in the healthcare field. A study among psychiatrists and mental health workers yielded similar results in terms of what they experienced as unsatisfactory working conditions (Forthgill, Edwards & Burnard, 2004:54).

In addition, the working life span of healthcare workers had changed in the last decades mainly because of changes in their working patterns, growing morbidity and mortality rates (mortality due to biological hazards), staff turnover and ageing. These factors impacted negatively on the quality of care, disrupted the functioning of the healthcare system, reduced team efficiency and caused the loss of valuable skills and knowledge (World Health Organization, 2006:97). All these factors caused frustration among the

healthcare workers and affected their ability and motivation to deliver quality services (Bester & Engelbrecht, 2009:115; Eriksen, 2006:434). These unfavourable working conditions did not only hamper service delivery, but were major contributing factors to work related stress among healthcare professionals (Marine, Routsalainen, Serra & Verbeek, 2009:2).

Healthcare workers were and are generally exposed to a number of health and safety hazards in the workplace. Some of the hazards were physical hazards which included noise, slips and falls, biological hazards, as in exposure to infections, and psychosocial hazards such as shift work, violence and stress. Because they cared for the ill and injured, they were sometimes expected to ignore their own vulnerability to these hazards and sacrifice their own wellbeing for the sake of their patients (World Health Organization, 2015:1). Healthcare work can be risky and the extent of the risk largely depended on the healthcare facility where one worked. Healthcare workers in high risk settings have to be alert and aware of these hazards and find ways to cope which can be a challenge if workers have high workloads and limited resources. It is thus critical to protect the occupational health of healthcare workers to maintain adequately trained and healthy healthcare workers (World Health Organization, 2015:1).

Furthermore, there was a tendency for the healthcare sector to measure programme effectiveness and quality through patient-based indicators without factoring in the occupational health of the healthcare worker. A stressed workforce would inevitably find it difficult to render quality service to the patients, giving an impression that the programme was not effective whilst the main contributing factor was the context within which the programme was being implemented (Wallace, Lemaire & Ghali, 2009:1714).

Given the on-going challenges that healthcare workers faced in their work environment, healthcare service providers, especially the public sector, need to provide work settings conducive to providing a better balance between demands required from the workers and rewards they receive in return and provision of the necessary support services (Conway, Campanini, Sartori, Dotti & Costa, 2007:638). The benefits of such interventions include reduced absenteeism and turnover and creation of a committed workforce as they would be assured that they matter (Halpern, 2005:158).

Another view was that, in order to address staff shortage and improve productivity, focus should not only be on training more healthcare professionals, but also on decreasing migration through the adoption of better retention strategies, improved worker health, reducing time wastage that is fuelled by absenteeism and ghost workers, efficient performance management systems, the upgrading of public health facilities and visible appreciation of healthcare professionals (Van Niekerk, 2006:1; World Health Organization, 2006:112). Implementation of the strategies mentioned might significantly improve the healthcare workers' ability to cope with stressors inherent in healthcare work and feel confident about the difference they make in the lives of their patients.

The Department of Health has formulated a health human resources strategy, as a way of addressing some of the workplace challenges that healthcare workers have faced in executing their duties. Eight priority areas, whose focus could significantly improve the general wellbeing of healthcare workers and the public health system are: facilitating accountable leadership and governance; healthcare workforce planning; re-engineering the workforce to meet the needs of service users; accelerating the revamping of education, training and research; strengthening and professionalising the management of human resources and prioritising health workers' needs; creating infrastructure for workforce and service development; ensuring professional quality care through oversight, regulation and continuing professional development and improving access to healthcare professionals and healthcare in rural and remote areas of the country (Matsoso & Strachan, 2011:53).

Implementation of these strategic priority areas would require commitment of and buy-in from all relevant stakeholders including recipients of the service. Government would need to make resources available to ensure that the public healthcare system would be properly revitalised and revamped, and the health status of the population would be improved, through sufficient numbers of healthcare workers who were knowledgeable and dedicated.

In summary, healthcare work is both fulfilling and challenging. In most instances the challenges are outside the workers' scope of control and thus need management to create work environments through relevant support structures that allow workers to do

their best and achieve the expected high standards of service. The HIV and AIDS field has seemed more affected by the staff shortages in light of the fact that a cure for the disease is still not available. Patients therefore stay in the healthcare system for extended periods of time whilst staff is also expected to attend to other patients needing primary healthcare services. There should be visible action and commitment from government to address the mentioned challenges through co-ordinating proactive solutions to the existing inequalities in human resources in healthcare, including the HIV and AIDS field (Halpern, 2005:85).

2.5 WORKPLACE STRESS IN THE HIV AND AIDS FIELD

Public healthcare services are among the essential services that every community needs. For this service to work, it needs dedicated and motivated healthcare workers who are willing to provide the service without reservations. In the field of HIV and AIDS, stressful working conditions might make it difficult for the health workforce to stay motivated.

The HIV and AIDS pandemic resulted in increased demands on the South African healthcare system that was already in a crisis due to shortages of human, financial, and physical resources, especially in the public health sector. The situation was aggravated by the high expectations of the population after 1994 when a promise of "a better life for all" was made by the new democratic government. The upscaling of antiretroviral treatment in the previous few years had also added more pressure to a healthcare system that was already over-stretched (De Wet & Du Plooy, 2012:30; Marchal, De Brouwere & Kegels, 2005:300). Patients on antiretroviral treatment are living longer and have better quality of lives because of the life-saving drugs, but still need on-going medical care because of their susceptibility to opportunistic infections (Oyeyeni, Oyeyeni & Bello, 2006:197).   This situation contributes to elevated stress levels among health workers, especially those working in the HIV and AIDS field, resulting in professional frustration, higher absenteeism and low staff morale (Marchal et al., 2005:301; Sanders & Lloyd, 2005:85).

In sub-Saharan Africa, working in the HIV and AIDS field became an occupational hazard with a high attrition rate among healthcare workers due to illness and death. The main reason for this was that the region was hard hit by the pandemic and turning the tide was taking time (UNAIDS, 2014:2). The health of the healthcare workers was compromised by exposure to the virus, because they worked with infected patients. The risk of contamination could be real or perceived due insufficient provision of protective gear and supplies like disinfectants. As a result, healthcare workers tended to shy away from HIV testing for fear of a positive result. Instead of disclosing, they suffered in silence for fear of stigma and discrimination. Furthermore, the high demand for the care of infected patients indirectly affected the healthcare workers' emotional, physical and mental well-being (Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, Kwaak & Van der Wilt, 2007:145; Marchal et al., 2005:300,301; World Health Organization, 2006:107).

The main stressors common among healthcare workers in HIV and AIDS care have been identified as heavy patient flow, unpredictable patient load, uncertainty, over-involvement with patients, and secrecy and the fear of disclosure about HIV positive status and exposure to infection with HIV. Furthermore, emotional exhaustion and fatigue were common as a result of, amongst others, meeting death and misery on a daily basis without sufficient compensation and encouragement. It has also been reported that sometimes patients had unrealistic expectations of healthcare workers. A case in point was where nurses were expected to assist financially with burial of an HIV and AIDS patient and supply food for poor affected families which were both non-health related tasks (Sanders & Lloyd, 2005:81). The unrealistic expectations sometimes came from management, where workers were supposed to offer psychological support to patients for which they were ill-equipped whilst their own psychological support needs were neglected (Dageid, Sedumedi & Durkert, 2007:4, 20).

Lack of knowledge and skills in working in the HIV and AIDS field was also cited as a stressor, particularly by nurses. Relevant training was not provided and in instances where it was provided, only a few nurses were trained and this was not on-going to keep up with the trends. The high staff turnover did not help the situation. This caused frustration and impacted on their confidence and self-efficacy in doing their work (Zulu &

Lehmann, 2004:45). Additional studies among nurses revealed that they experienced secondary stigma as a result of working in close contact with HIV and AIDS patients. The stigma tended to strain their family relationships and left them feeling angry and frustrated about the work they did. There were also feelings of helplessness, in light of the terminal nature of the diseases in its last stages. Limited knowledge about the disease, and the lack of emotional and technical support served as additional challenges of working in the HIV and AIDS field (Bester & Engelbrecht, 2009:105; Dieleman et al., 2007:140; Smit, 2005:27).

Studies have also shown that people offering healthcare services to HIV positive patients tended to be more prone to developing burnout syndrome than those working with cancer patients. It is further mentioned that the level of dependence of the patient was frequently higher in the area of HIV, demanding more intense levels of care. A contributing factor was that HIV and AIDS patients were often brought to healthcare facilities in the advanced or terminal stage of the disease thus requiring more attention than the average patient (Benevides-Pereira & Das Neves Alves, 2007:566; Marchal et al., 2005:301). The stress of caring for the dying patients, and the exposure to human suffering and grief predisposed the healthcare workers to burnout and compassion fatigue (Engelbrecht et al., 2008:19).

The burnout syndrome is explained as being a process which results from extended stressful situations. It is a multi-dimensional syndrome formed by three factors: emotional exhaustion, depersonalisation and diminished personal accomplishment. Emotional exhaustion is mental and physical fatigue. Depersonalisation is being impersonal and indifferent to patients, and diminished personal accomplishment is expressed through feelings of insufficiency and demotivation (Maslach & Jackson 1986, in Benevides-Pereira & Das Neves Alves, 2007:566). Another view is that burnout is a persistent negative work-related attitude evidenced by exhaustion, fatigue, poor motivation, job dissatisfaction and development of other inappropriate behaviours in the workplace. It develops over time and its main cause is the discrepancy between intentions and realities within the job (Schaufeli & Enzman, 1996, in Engelbrecht et al., 2008:16).

Burnout, if undetected from the onset, may impact negatively on the healthcare worker's emotional, psychological and physical health and this may inevitably affect both his/her personal and work life. Furthermore, it does not only compromise the quality of service of the burned out worker, there is evidence that it sometimes has a "contagion effect" where colleagues also end up being burned out. Workers therefore need to be empowered through the necessary support from management to find fulfilment and meaning in their work, thereby significantly reducing the risk of developing burnout (Benevides-Pereira & Das Neves Alves, 2007:570; Dageid et al., 2007:5-6).

Protecting the healthcare workers in the HIV and AIDS field from the concerning impact of burnout and work stress is crucial in ensuring that the services they render to the patients remain effective (Cheung & Chow, 2011:712). Intervention strategies to manage workplace stress and burnout include, increasing the number of healthcare workers through the introduction of assistants, aides and semi-skilled workers, improving the provision of medical equipment, making healthcare work attractive through improving the remuneration and status of the healthcare workers, caring for the carer programmes in a form of stress management programmes, debriefing services where possible, support groups, and having human resources policies that ensure retention of the healthcare workers (Dageid et al., 2007:21; Marchal et al., 2005:303). Formal and informal recognition of above average dedication and commitment to work is another way of minimising work stress (Smit, 2005:28).

Resourcefulness of knowledge and skill in dealing with the demands of HIV and AIDS work could be addressed through the re-orientation and reskilling of existing staff and additional support staff who would be recruited to fill the staff shortages (Matsoso & Strachan, 2011:54). With regards to occupational hazards such as exposure to the HI-virus and other infections, safe nursing and surgical procedures and techniques have to be introduced with sufficient waste disposal equipment, adequate barrier techniques, easily accessible and available post exposure prophylaxis and care and support to HIV-positive healthcare workers with HAART (Marchal et al., 2005:302).

The challenges of working in the HIV and AIDS field are many and healthcare workers seem to have found ways to continue doing their best despite these challenges, risks and

potential hazards inherent in this line of work. It is interesting to note that healthcare workers (nurses in particular) indicated that although the work was highly stressful, they valued the feelings of empathy they have towards their patients, feelings of fulfilment in making a noticeable difference in the lives of their patients and a sense of moral obligation to protect and preserve life where possible (Smit, 2005:28). Positive verbal feedback from patients, support from management, gaining new skills and knowledge from HIV and AIDS work are also cited as being additional motivators in this field of work (Bester & Engelbrecht, 2009:113-114). In summary, the HIV and AIDS field is quite stressful, but there are positive outcomes to assisting those in need and success stories.

The next topic deliberates on the workplace stress as experienced by the target group of the study, namely, the home-based care practitioners.

2.6 WORKPLACE STRESS AMONG HIV AND AIDS HOME-BASED CARE PRACTITIONERS

The severity of the HIV and AIDS pandemic triggered interest in palliative and home-based care in Africa. That is evidenced by various national and pan-African home-based care initiatives, especially among informal healthcare work (Amoran, Ogunsola, Salako & Alausa, 2012:1). Home-based care practitioners form an integral part of the informal healthcare workforce.

Home-based care practitioners, like other healthcare workers in the HIV and AIDS field, found themselves working with the most challenging health problem, in circumstances where poverty and hopelessness were prevalent. The potential for demotivation was high given the fact that often there was little recognition for the work they did. It was sometimes referred to as the "dirty work" which was not regarded as real work and thus undermined, whilst they rendered a much needed service to those on the margins of society (Rohleder & Swartz, 2005:401). Efforts to have formal support structures for the home-based care practitioners were recommended, but were quite patchy. In the meanwhile, they had to continue working in conditions of strain and hardship (Campbell & Foulis, 2004:3; Campbell, Nair, Maimane & Sibiya, 2007:512, 514).

It has been reported that psychological support and disease experience for people living with HIV and AIDS seemed to be worse as compared to patients with other diagnoses also requiring home-based care. As a result caregivers, in this case home-based care workers, reported that rendering services to people living with HIV and AIDS was time consuming and stressful. The stigma around HIV and AIDS amplified the patients' experience of rejection and left them emotionally vulnerable. The worker had then to assist the patient with psychosocial support in addition to the other health needs that he/she might present with (Moetlo et al., 2011:138). In addition, home-based care workers reported that they found trying to care for terminally ill or dying patients who literally died in their hands, traumatising. Sometimes family members of the patients would blame them for the death (Dageid et al., 2007:11).

Studies have further revealed that carers experienced the work as being emotionally demanding and draining and thus affecting their mental health. Some home-based care workers reported that they found the work exhausting, overwhelming and stressful to the point of having thoughts of leaving the job. Some commented about the guilt and despair they experienced when they had to work within the poor living conditions in which some of their patients lived. The ever increasing workload, in spite of the availability of antiretroviral drugs, was also a concern. Furthermore, home-based care workers were frustrated by the unrealistic expectations of some of the families of the patients they serviced. They knew their main role was in teaching the families skills and imparting knowledge to care for their ill member practically, but they found themselves being compelled to do more (Dageid et al.,2007:11-12; Hlophe, 2006:200-201; Orner, 2006:238).

Other studies found the following stressors among home-based care workers; difficulty coping with non-compliance with antiretroviral treatment among their patients especially those that they were emotionally attached to, having to work with HIV positive children, young people, rape victims and suicidal patients, challenges with being only empathetic to their patients and not sympathetic, the burden of keeping patient information confidential, no matter how emotionally charged and lastly uncertainty about various situations (Held & Brann, 2007:213; Peltzer & Davids, 2011:68). Home-based care

workers are expected to work within the communities that they live in which made it difficult to for them to adhere to the principles of emotional non-involvement, a non-judgmental attitude and confidentiality in respect of their patients and families they worked with. Home-based care workers also raised concerns around the physical strain of caring (walking to patients' homes and bathing bed-ridden patients) and the psychological and emotional problems they were experiencing as a result of watching the gradual deterioration of HIV and AIDS symptomatic patients and those who were terminally ill (Hlophe, 2006:208). It is only natural to feel sad and tired when one is constantly exposed to suffering and loss while doing one's job. In some instances they even neglected their need for sustenance because of the demands of caring for such patients. Without support, this could lead to burnout (Defilippi, 2003:28; Thomas, 2006:3179). Burnout is said to result from the interplay of the interpersonal and institutional sources of occupational stress and exposure to emotionally engaging clients, and represents debilitation that can obstruct the caregivers' ability to provide the expected quality of services (Galek, Flannelly, Greene & Kudler, 2011:634). Furthermore, it is seen as a syndrome that is associated with work stress experienced often in the helping/caring professions in the fields of healthcare, religion and education (Arman, Hammarqvist & Rehnsfeldt, 2011:295).

Symptoms associated with HIV and AIDS-related burnout may be physical (for example, headaches), behavioural (for example, irritability) or cognitive and emotional (for example, pessimism and sadness) and physiological (for example, unstable blood pressure, ulcers, muscle tension and headaches) (Cogan, Klein, Magongo & Kganakga, 2005:2; Colligan & Higgins, 2006:93). Burnout also impacted on their sense of efficacy as they struggled to perform their duties effectively. Rather than apportioning the problem to the high workload, carers sometimes internalised the cause and blamed themselves leading to guilt (Galek et al., 2011:636-637).

Furthermore, there are contributing factors to stress and burnout among HIV and AIDS home-based care workers which are highlighted in Figure 2.2 and are divided in terms of individual factors, workplace factors and patient and family factors.

Individual factors	**Workplace factors**	**Patient and family factors**
- Limited or no training in healthcare and or home-based care.	- High workload	- Denial of HIV-positive diagnosis
- Differing stress tolerance levels	- Physical strain	- Unrealistic expectations (e.g. assistance with funeral arrangements)
- Ethical dilemmas, e.g. being non-judgmental.	- Lack of support from management	- Blaming the carer for death of patient
- Majority coming from disadvantaged communities with limited options in the open labour market	- Repeated exposure to trauma (e.g. death, suffering, etc.)	- Treatment non-compliance of patients
- Gender vulnerability regarding safety and physically strenuous work as most of them are women	- Little recognition of work done	- Limited resources
	- Work seen as the "dirty work," thus low status	- Difficulty in dealing with death and dying
	- Unclear position in healthcare hierarchy, volunteerism versus paid work	
	- Secondary stigma from working with HIV-positive patients	

Impact on home-based workers

Behavioural: irritability, fatigue, slow in carrying out tasks

Physiological: unstable blood pressure, ulcers, muscle tension, headaches

Psychological / emotional: pessimism, sadness, demotivation, guilt, emotionally drained

Figure 2.2: Contributing factors to burnout among home-based care workers

The illustration (Figure 2.2) reiterates that the home-based care worker's ability to cope with workplace stress is impacted on by the interplay between individual factors which is the person's capacity to cope depending on their background, and workplace factors. This refers to the organisation's resources available to capacitate the person to do his/her job well and meet the minimum requirements and lastly the patient and his/her family's expectations of care and support. Should any of these factors compromise the home-based care worker in the execution of his/her tasks, then there is a likelihood that there might be behavioural, physiological and psychological reactions and symptoms as listed in Figure 2.2.

Most caregivers mentioned that they coped with these work challenges by relying on friends, colleagues and/or family for support. In spite of this, they continued to feel overwhelmed by the work (Marais, 2005:68). It is therefore important that, for the sake of their morale and self-confidence, caregivers at all levels know that their work is recognised and valued, and that they are supported (Van Dyk, 2005:330). Home-based care in the HIV and AIDS field requires sensitivity and genuine care for patients and their families. When genuine care is eroded by burnout and low morale, the carer is not able to do his/her best thus compromising the patients' chances of recovery (Benevides-Pereira & Das Neves Alves, 2007:569-570).

The Employment Equity Act 55 of 1998: Code of Good Practice on HIV and AIDS and the World of Work (2012) recommended that one way employers could promote a healthy and safe working environment is to endeavour to provide counselling and other forms of psychosocial support to workers infected with and affected by HIV and AIDS. The stressful work environment that home-based care practitioners found themselves in, therefore, necessitated the incorporation of "care for the caregiver" into home-based care programmes. The "care for the caregiver" programme could be in the form of fixed debriefing sessions, scheduled psycho-social support provided by trained professionals, and personal/emotional supervision during working hours (Uys, 2003:28). Additional intervention strategies to improve the stressful working environment of healthcare workers in HIV and AIDS care are as follows (Dageid et al., 2007:21-22):

- The need for emotional support must be recognised, and appropriate and sustainable debriefing mechanisms must be put in place.

- Time and resources must be made available for healthcare workers to receive regular professional debriefing and guidance, with specific focus on how to deal with the emotional challenges of working in HIV and AIDS care.

- Support mechanisms must be put in place for personal and professional growth.

It appears that home-based care in the HIV and AIDS field is potentially stressful. The cited literature highlights, though, that there are strategies that employers could implement to minimise the stress and possible burnout that the HIV and AIDS home-based care practitioners may be exposed to.

2.7 SUMMARY

The HIV and AIDS pandemic is still continuing to impact on the lives of those infected and affected globally and also in sub-Saharan Africa. The UNAIDS, together with member countries, have formulated a strategic plan emphasising prevention initiatives and prolonging the lives of those infected through the upscaling of the roll-out of antiretroviral therapy to mitigate this impact. From the cited literature it is clear that significant progress has been made, but the war against the pandemic is far from over.

One of the major challenges of successfully eradicating HIV and AIDS in society, especially in sub-Saharan Africa, is the limited financial and human resources to carry out a comprehensive service that ensures that all those affected and infected receive the needed service. Staff shortages and stressful working conditions in the healthcare sector, and especially in the HIV and AIDS sector, have been identified as major drivers of the situation.

As an effort to address the staff shortage in the HIV and AIDS field, home and community-based care workers were introduced into the healthcare workforce as lay healthcare workers mainly to service patients in their homes and communities who might otherwise

not have access to formal public health services and those that would be better off cared for at home rather than in hospital. They became an integral part of the integrated community and home-based care model, a comprehensive and multi-disciplinary approach to service delivery to those affected by and infected with HIV and AIDS.

The home-based care workers, consisting mainly of women from disadvantaged communities, continue to make a valuable contribution in ensuring that HIV and AIDS patients and their family are able to maintain an acceptable level of functioning within their limitations and a decent quality of life. They are also the unsung heroes in the promotion of adherence to antiretroviral treatment. All these achievements have come with unfavourable working conditions, mostly stressful, exhausting and emotionally draining to the point of burnout. Psychosocial support is imperative to ensure that the home-based care workers stay motivated, committed and fulfilled in their work.

The next chapter focuses on various stress management interventions that might be utilised to provide the psychosocial support needed by the home-based care workers.

CHAPTER 3

STRESS MANAGEMENT INTERVENTIONS

3.1 INTRODUCTION

The previous chapter focused on workplace stress in the healthcare sector, specifically within the HIV and AIDS field. This chapter continues the deliberations on workplace stress through a review of the literature on stress and its conceptualisation, and an overview of stress management interventions and the theoretical foundations upon which the interventions are based.

The purpose of the discussion is to expand understanding of and insight into the concept of stress, mediating factors in coping with stress, and possible ways of managing it, both at an individual and organisational level. The ultimate goal is to incorporate the knowledge gained in the shaping of the stress management programme for HIV and AIDS home-based care practitioners.

3.2 STRESS AS A CONCEPT

The word "stress" is used almost on a daily basis and it seems to vary in terms of how it is interpreted. Under this heading, a definition of stress, how individuals respond to stress, the impact of workplace stress on organisational functioning and models of stress are discussed in order to present different perceptions and allow a broader understanding of the concept. There is also an explanation of mediating factors in coping with stress that help to further understand why different individuals, in some instances, respond differently to the same stressful situation.

3.2.1 Definition of stress

The demands of modern life seem to be putting pressure on an average adult through the ever increasing expectations in both personal and work life. This creates a fertile ground for stress. Unfortunately, technological advances have not done much to ease the pressure (Mickel & Dallimore, 2012:65). Defining stress can be problematic as in some instances, definitions seem to refer both to the source of and impact of stress (Nel & Spies, 2006:34). Sometimes reference is made to a stressor, the challenging situation that triggers stress, and strain, the individual's response to prolonged stress, in relation to stress (Griffin & Clarke, 2011 in Ganster & Rosen, 2013:1088). It is thus important to clarify what stress is so that it can be dealt with realistically and in an adaptive manner.

Stress is defined as a reaction to a perceived imbalance between pressure placed on an individual and the available coping resources for that particular situation (Cranwell-Ward & Abbey, 2005:25; Weinberg, Sutherland & Cooper, 2010:54). Stress is also described as "a subjective psychophysiological state characterised by a combination of high arousal and displeasure …" (Routsalainen, Serra, Marine & Verbeek, 2008:169). Another perspective is that stress is largely influenced by the circumstances in which people find themselves and therefore it can be understood as a common response to environmental change, a psychological response to failure to deal with a problem, a feeling of sustained anxiety and a non-specific response to the daily demands of life (Stranks, 2005:1-2). From a simplistic point of view, stress is said to emanate from the daily challenges that individuals have to face. Some are easier than others to deal with, some challenges bring joy whilst others bring pain, but have to be faced irrespective (Nel & Spies, 2006:34). The cited definitions seem to suggest that stress is a response to a situation.

Some authors are specific to the concept of workplace stress. A description of workplace stress includes "being overworked and not having enough hours in the day" (Kinman & Jones, 2005:107). Workplace stress is also defined as "a process by which workplace psychological experiences and demands produce both short- and long-term changes in physical health" (Ganster & Rosen, 2013:1088). Another view is that the conceptualisation of workplace stress has been broadened not only to include environmental factors in the workplace that contribute to stress, but also to take into

consideration aspects of the employee and the labour market context. An example would be a situation where the employee is experiencing stress because the amount of effort, time and energy he/she puts into the job is not compatible with the rewards received (Kivimaki, Virtanen, Elovianio, Kouvonen, Vaananen & Vahtera, 2006:432).

There is also a view that stress can also be explained in terms of the intensity of the demand or pressure to which the individual is subjected. There is hypo-stress where very little demand is put on the individual resulting in boredom, apathy and frustration. Eu-stress, sometimes referred to as good stress, occurs when optimum demands are put on the individual and it stimulates one to use hidden mental and physical abilities, resulting in fulfilment. Hyper-stress on the other hand, is a result of excessive demands put on the individual and he/she cannot cope and feels out of control (Cranwell-Ward & Abbey, 2005:28-29). Distress is explained as the unbearable stress, where the individual is under prolonged unpleasant pressure. It can negatively impact on the general well-being of the individual if not attended to (Colligan & Higgins, 2006:90). It thus appears then that how an individual deals with stress also depends on their ability to cope with the given amount of stress at that time.

It is further ascertained that in order to deal with the stress successfully that one is experiencing, individuals must acknowledge the existence of the stress, their personal physiological response to it, the circumstances that produce the stress response and their own personal coping mechanisms (Stranks, 2005:2). Response to stress therefore seems to be individualistic and each person responds to the same stressful situation or stressor (source of stress) differently. The researcher concurs with the view that the individual has to see the situation or the demand as stressful, meaning one's frame of reference and worldview largely influence what one perceives as stressful and not stressful. A deliberation on the various ways that individuals respond to stress follows.

3.2.2 Stress responses

Stress, presumably a daily occurrence, seems to be experienced and responded to differently in spite of the circumstances that an individual finds her/himself in. A study in rural Limpopo further ascertained that socio-economic status did not play a determining factor in terms of whether stress was experienced more or less than with another individual (Crouch, 2008:72).

Once the individual has acknowledged the situation as being stressful, it is argued that there is a physiological reaction to it. The physiological reaction is initiated by adrenaline and non-adrenaline produced by the adrenal glands which provide the body with the necessary resources and energy to engage in a flight or fight response to the stressor (Cranwell-Ward & Abbey, 2005:34). The flight or fight responses are primitive, involuntary, adaptive and important for survival. Unfortunately in the workplace, there is no room for physical fight or flight from work stressors. The employee has to find alternative ways to deal with the situation (Cranwell-Ward & Abbey, 2005:34; Weinberg et al., 2010:62).

Common changes brought about by the hormones mentioned are increased heart rate, elevated blood pressure, the increased air flow to the lungs, dilated pupils and hair standing on end. There is also improved memory, reduction of sensitivity to pain and heightened general performance. These physiological changes apply only to acute stress. In cases of chronic stress, the opposite effect happens (Allvin, Aronsson, Hagstrom, Johansson & Lundberg, 2011:183; Sulsky & Smith, 2005:15).

In addition to physiological responses, the individual reacts psychologically to stress. Psychologically, the employee may present with "psychological flight" in a form of presentism (meaning being at work but very unproductive), may display symptoms of depression, anxiety, demotivation, pessimism and general resentment of the workplace, which may affect relationships with colleagues (Colligan & Higgins, 2006:96). The same responses were experienced by lay healthcare workers in a study where they mentioned that they had emotional and psychological problems as a result of the strain of working with patients living with HIV and AIDS (Hlophe, 2006:208). Table 3.1 below gives a

synopsis of the common physical, cognitive, emotional and behavioural responses to distress, including workplace stress (Mujtaba & McCartney, 2010:83).

Table 3.1 Stress responses

Physical responses	Cognitive responses	Emotional responses	Behavioural responses
- Fatigue - Change in appetite - Insomnia - Elevated blood pressure - Feeling of weakness - Headaches - Stomach or intestinal distress - Muscle aches - Accident prone in coordination - Shock symptoms	- Blaming - Poor attention span - Memory problems - Hypervigilance - Distractibility - Poor abstract thinking - Intrusive images - Negative attitude - Negative self-talk - Looking for magic to solve problems	- Anxiety - Uncertainty - Inappropriate emotional response - Feeling overwhelmed - Agitation - Irritability - Easily discouraged - Nervous laugh - Apathy - Distrust of others	- Withdrawal - Emotional outbursts - Increased alcohol or substance use - Antisocial acts - Increased startle reflex - Low productivity - Intolerance of others - Nagging - Inability to rest - Clamming up

Source: Mujtaba & McCartney, 2010:83

Table 3.1 demonstrates how exposure to prolonged stress can lead to various physiological illnesses such as headaches, muscle pain, fatigue, poor sleeping patterns and accident proneness. If not attended to, these may result in serious health concerns. This view was supported by a study on work stress where the findings revealed that there was a strong link between work stress and ill-health which is commonly evidenced by minor psychosomatic complaints (Kinman & Jones, 2005:117). In the field of home-based care, it has been found that the responsibilities of caring for the ill increased the carer's susceptibility to recurring distress and adverse health effects (Hirst, 2005:705).

The cognitive and emotional responses, on the other hand, highlight how prolonged stress can negatively impact on the individual's general functioning both at work and in their personal life. This was validated by a study among HIV and AIDS lay healthcare workers who raised concerns over emotional exhaustion and/or compassion fatigue as a result of over-involvement with patients who needed support for the emotional trauma associated with living with HIV and AIDS (Visser & Mabota, 2015:174-175).

Behavioural responses to stress, which include changes in work habits, absenteeism, irritability, indecisiveness, changes in personality and social behaviour and poor work performance, are what others in the workplace and in social settings observed directly from the stressed individual and may spark concern about the individual's wellbeing (Stranks, 2005:12).

The afore-mentioned responses clarify how stress can immobilise the individual to perform below expectations. The opposite is also true in that stress can also motivate individuals to achieve beyond their perceived limitations; it just depends on what kind of stress the individual is exposed to (Zunker, 2008:196). In the HIV and AIDS field, employers need to acknowledge that the care-giving work is inherently stressful and that feelings of distress are legitimate reactions to their experiences, rather than signs of personal weakness (Van Dyk, 2005:327).

Stress, does not only impact on the individual. There is also an organisational impact and presumably it is for this reason that the management of organisations make an effort through relevant stress management programmes to mitigate this impact on both the

individual and the organisation so that it is able to be productive in meeting the needs of their service users. A discussion of the organisational impact of stress follows.

3.2.3 Impact of employee stress on the organisation

Workplace stress, as earlier explained, has the ability to incapacitate employees and in return, to affect the organisations general output. If not addressed through relevant strategies, workplace stress amongst employees may lead to difficult interpersonal relationships among colleagues in the form of hostility and conflict, decreased productivity and absenteeism (Colligan & Higgins, 2006:96). Staff turnover has also been cited as a consequence of workplace stress. Staff turnover is costly as, whilst preparing for an exit, the employee is less likely to be productive. Replacement also has a cost in terms of recruitment, the appointment of suitable staff and in-service training. The new staff member normally starts being productive months after being employed. In such a situation, the organisation is likely to experience a loss of earnings which impacts on its profitability and ability to meet its deliverables (Halpern, 2005:159; Noblet & LaMontagne, 2006:346). Another concern is that multiple health problems associated with chronic work stress, such as memory loss, may pose a safety risk depending on the type of work the stressed employee is doing (Halpern, 2005:166).

Organisations in the HIV and AIDS field are also not spared the impact of workplace stress on their day to day functioning. Stressful and unsatisfactory working conditions were the main drivers of healthcare workers leaving this field of work, resulting in staff shortages in an already overstretched workforce (Marchal, De Brouwers & Kegels, 2005:301). The loss of healthcare workers often outstrips the normal production of such workers which creates a vicious cycle of staff shortage, overworked staff and inability to meet the country's healthcare needs. Furthermore, most of the staff that leave are experienced in the HIV and AIDS field and thus rob the healthcare service of both informal and tacit knowledge that is almost impossible to regain (Marchal et al, 2005:301; Naiker, Plange-Rhule, Tutt & Eastwood, 2009:51-52).

Having highlighted the impact of workplace stress on organisational functioning, specifically, in relation to productivity and profitability, a discussion on the models of stress follows to give a clearer perspective on the understanding of the concept stress.

3.2.4 Models of stress

In as much as there are different types of stress, there are also models that explain what stress is. In the context of this study the focus will be on a brief overview of such models, not an extensive discussion. Only five models, namely, the response-based model, the stimulus-based model, the interactionist model, the demand–control model and the caregiving stress model will be discussed because of their relevance and popularity in the understanding of work stress (Allvin et al., 2011:174; Pearlin, Joseph, Mullan, Semple & Skaff, 1990:585; Sulsky & Smith, 2005:37; Weinberg et al., 2010: 57-65).

- The **response-based model** of stress is said to have its origins in medicine, and as a result, has a physiological perspective to the concept. The model proposes that stressors are stimuli that trigger a stress response in the individual (Weinberg et al., 2010:58). Hans Selye is credited as a pioneer in the conceptualisation of the response-based model with his view that stress is the body's non-specific response to any stressor to which it is exposed. The responses result in physiological changes that occur in stages, depending on the duration of the exposure to the stressful situation. These stages are perceived as a syndrome and referred to as **"General Adaptation Syndrome"** sometimes referred to as GAS (Cranwell-Ward & Abbey, 2005:34; Selye, 1956:54,64; Weinberg et al., 2010:59).

  The GAS consists of three stages, namely alarm, resistance and exhaustion stages (Selye, 1956:31). The *alarm stage* is the initial and immediate psych-physiological response to the stressful situation and the body is mobilised to cope with the perceived threat. Should the stressful situation persist, the *stage of resistance* is initiated. Sometimes this second stage is referred to as the adaptation phase. The defence mechanisms are activated and the body moves into a higher level of functioning using energy reserves heavily. It assumed that, through dealing

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with the daily demands of life, individuals go through the alarm and the resistance phases many times which accounts for the resilience that some people develop. It has to be noted though, that the *resistance phase*, although sometimes necessary, can be both psychologically and physiologically exhausting (Cranwell-Ward & Abbey, 2005:35; Selye, 1956:54, 64; Weinberg et al., 2010:59).

Continued exposure to the stressful situation eventually renders the acquired coping mechanisms ineffective thus kick starting the final stage, *exhaustion phase*. It starts with the repeat of the alarm stage reaction and if the stress persists, the individual feels burned out and generally drained. He/she needs to replenish the lost energy and regain an acceptable level of functioning. As a result, the individual may experience cardiovascular, respiratory, digestive and muscular problems and some immune system impairment. Such symptoms were also confirmed by HIV and AIDS home-based care workers and are seen as emanating from the stress of the work they did (Cogan et al., 2005:2). The remedy for this situation is usually complete rest to allow regeneration (Cranwell-Ward & Abbey, 2005:36; Selye, 1956:31; Weinberg et al., 2010:62).

Although this model recognises that response to stress can also be psychological and behavioural, it does not pay much attention to this. An assumption can therefore be made that one of its limitations is that its conceptualisation of stress is narrow and thus does not provide a full understanding of the concept. It ignores the strong emotions, such as fear and anger that normally accompany stress. There is also a view that it is too simplistic and that it is not a given that the individual's response to stress will always follow the stages of the adaptation syndrome (Sulsky & Smith, 2005:24; Weinberg et al.,2010:63). The researcher then, is of the opinion that the same limitations are applicable in terms of understanding stress in the context of the HIV and AIDS home-based care workers, as the model focuses mainly on physiological responses to the exclusion of other important contributing factors such as the pessimism and sadness, that sometimes emanate from working with dying patients (emotional and cognitive responses), to the understanding of the concept of stress (Cogan et al., 2005:2).

- The **stimulus-based model** of stress on the other hand, largely influenced by physics and engineering, proposes that stress is like a force exerted on an individual. This model was previously extensively used in understanding work environment stress. It is suggested that, on average, individuals find ways to cope with the force, but should this exceed their tolerance levels, then distress sets in (Weinberg et al., 2010:64-65). In the case of HIV and AIDS home-based care workers, they identified "forces" such as the unmanageably high patient load and a lack of resources that did not change in spite of the roll out of antiretroviral treatment (Dageid et al., 2007:11). The main limitation of this model is that it only focuses on the stress stimulus. It therefore has a narrow focus and compromises any understanding of the causes and impact of stress on employees (Weinberg et al., 2010:64-65). According to the researcher, it appears that the model does not explain the physiological, psychological and behavioural impacts of distress and what remedial action can be taken once the individual cannot cope with the excessive force. Furthermore, it seems to have the same limitations as the response-based model with respect to its applicability to the HIV and AIDS home-based care field.

- The **interactionist model** addressed the shortcomings of the response-based and stimulus-based models by emphasising that stress needs to be seen as an integrated, interactive process that has psychological, physiological and behavioural domains. When a situation is viewed by the individual as stressful, it is evaluated using psychological, physiological and behavioural coping responses to deal with the situation. The model further explained stress from five key viewpoints, namely there is cognitive appraisal of the stressful situation which is basically the individual's subjective view of the situation. The second is experience, meaning that the perception of stress is influenced by previous exposure to the situation, existing coping mechanisms and the perceived ability to deal with the situation. A typical example would be the assertion that HIV and AIDS home-based carers experience repeated exposure to deaths of patients as stressful and emotionally draining. The absence of counselling to deal with the loss makes it difficult for them to cope (Shaibu, 2006:93). Thirdly, the intensity of the demand or

pressure of the stressful situation could be actual or perceived. Fourthly, there is the availability of social support networks to cushion the individual should they not be able to cope. Lastly, there is the "state of stress" where the individual acknowledges that he/she cannot meet the demands of the situation with the available coping mechanisms (Weinberg et al., 2010:57-65; Zunker, 2008:197-198). The model thus proposes a holistic view to the stress and highlights that workplaces need to engage this way of thinking to be able to address successfully the stressful situations that workers face in the day to day execution of their duties. The model, according to the researcher, argues that, for the workplace challenges of the HIV and AIDS home-based care workers to be adequately understood, all five viewpoints have to be taken into consideration. This seems to imply that, before treating the home-based care workers as a group, they need to be treated first as individuals. How one experiences stress and their coping mechanisms and support systems is something which has to be factored in. In practical terms this would mean that one of the concerns raised by an HIV and AIDS home-based care worker that she is stressed by the unrealistic expectations of patients that she should be "jack of all trades," (meaning tending the patient's self-care needs, household chores and other home-based care work), need not be generalised to other carers doing the same work without properly investigating the matter (Thabethe, 2011:789).

- The **job demand-control model** of Karasek (1979) is regarded as one of the best organisational stress models (Sulsky & Smith, 2005:37). The model proposes that stress emanates from the interplay of the effects of the job demands and the range of decision-making latitude (control) available to the employee. If the job demands are high and the decision-making latitude is low, the employee is more likely to present with stress. The same is likely to happen if the job demands are low and the decision-making latitude is high, as the employee may be stressed by the under-stimulation (Allvin et al., 2011:174; Karasek, 1979:287; Sulsky & Smith, 2005:37). The researcher is of the view that this situation could be demonstrated in the HIV and AIDS home-based care workers' frustration and demotivation which are a result of their work being labelled as inferior and thus undermined. There is

a need and demand for their services by those marginalised by society and thus not reached by mainstream health services, but at the same time they are not recognised for the value that they add in the healthcare service delivery system (Rohleder & Swartz, 2005:401). In short, this means that the job demand is high but decision-making latitude is low. The model has its shortcomings in that it only focused on the two constructs (job demands and decision latitude) in its explanation of work stress. There is a suggestion that the decision latitude could have been linked with occupational level as in most instances, the higher the position in the organisation, the higher the decision latitude (Sulsky & Smith, 2005:39).

- The **caregiving stress model** is particularly important in the study as it focuses exclusively on the stress experience of those who care for the ill, which is the main purpose of home-based care. Pearlin et al. (1990:583-584) explain that caregiver stress in most instances occurs as a result of changes in the role of the caregiver due to the on-going deterioration of the health of the patient. What was manageable care for an ill patient at home, may change to be a demanding and extraordinary burden of care. Pearlin et al. (1990:585-590) proposed that caregiver stress is a process and that the model focuses on identification of, and the process of, how these conditions give rise to stress in caregivers. They postulated that the caregiving stress has four domains, namely (a) background and context of stress, (b) the stressors, (c) the mediators of stress, and (d) the outcomes of stress. The domains are graphically illustrated below in Figure 3.1:
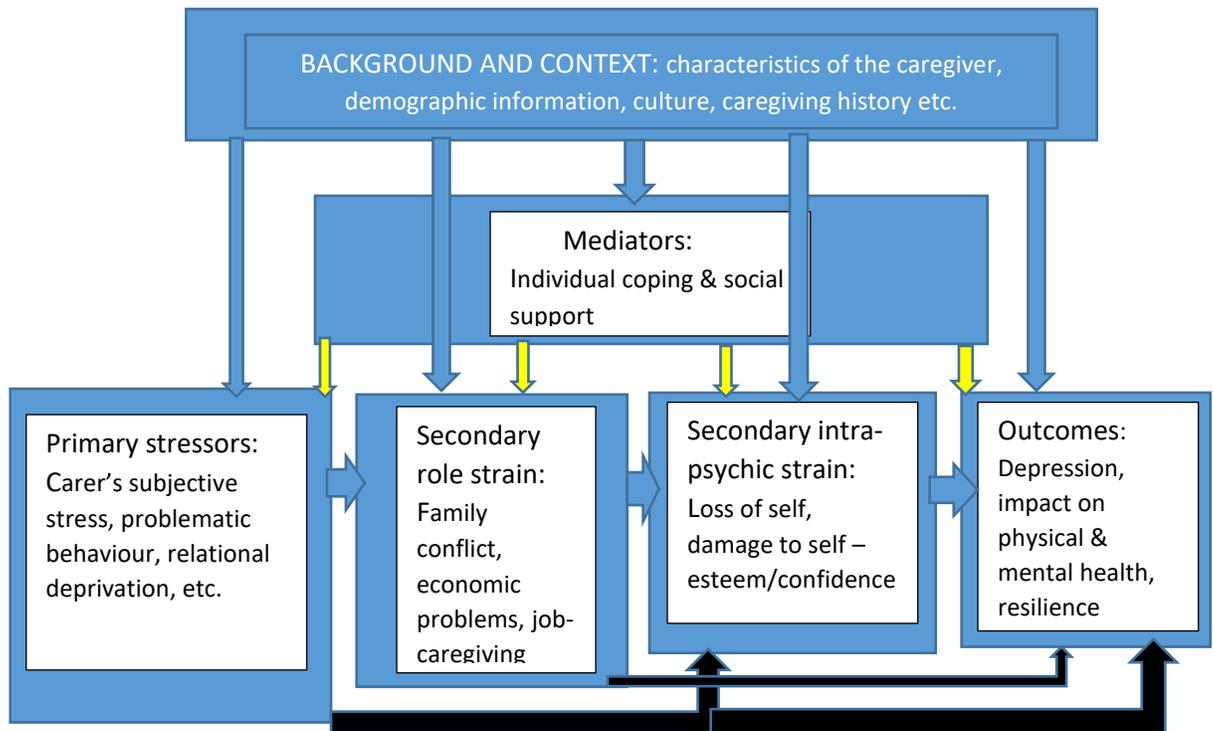
Figure 3.1 Pearlin et al. (1990) caregiving stress model

With regards to the background and context of stress, the focus is mainly on the characteristics of the caregiver, that is, demographic information, culture, socio-economic status, history of caregiving, educational level, available personal and social resources and close networks. All these factors play an important role in understanding how a caregiver manages or does not manage the stress associated with caregiving work. Stressors, which are regarded as central to the model, are discussed as primary and secondary stressors of caregiving (Pearlin et al., 1990:586). Primary stressors are those that emanate from the needs of the patient and the extent of care. For example, there are patients who are mobile and others bed-ridden, meaning the levels of care are different and presumably so will be the stress levels. Secondary stressors on the other hand are divided into role strain and intrapsychic strain. Role strain is strain that results from conflict between the caregiving role and the caregiver's social life, the strain is from outside of the caregiving role. A typical example is the conflicting demands of the caregiving work

and the caregiver's own family responsibilities (Moremi, 2012:33). Intrapsychic strain, is said to be precipitated by the ever increasing demands of caregiving work and role strain that, in most instances, may lead to the caregiver to start doubting and lose the confidence she/he has about the quality of her/his work which is a fertile ground for symptoms of depression.

The mediating conditions, which buffer or protects the caregiver against stress, include existing coping mechanisms that the caregiver already possesses depending on her/his background and context and the social support networks that the caregiver has access to, either within the organisation she/he works for and/or within the broader community (Pearlin et al.,1990:589). Lastly there are outcomes, which basically refer to the caregiver's ability to continue doing the work diligently in spite of being subjected to the stress processes of caregiving. The caregiver's background, the magnitude of the stressors and mediating conditions all contribute to the outcomes of the stress process. There are some caregivers who cope better than others, and there are those for whom the caregiving work might lead to emotional and physical distress. In their effort to be there for the patient, the caregivers might unintentionally hamper their own health and well-being (Akintola, 2008:357; Pearlin et al., 1990:590). The researcher's opinion is that this model gives comprehensive insight into the unique challenges that caregivers are faced with and also agrees with the cited literature that how individuals cope with workplace stress differed from person to person.

An overview of the cited models, according to the researcher, seems to suggest that in understanding work stress, the focus needs to be on circumstances and conditions in the work environment that predispose employees to stress. This is best illustrated by the stimulus-based model, the demand–control model and the caregiving stress model. The response model, on the other hand, seemed to be more focused on the physiological impact of stress and very little attention is given to resilience factors in individuals that might mitigate the impact of the stress and enable them not to go through the general adaptation syndrome. The theory that seemed to give a far more holistic view of stress is the interactionist model that stresses that stress cannot be explained from one dimension

but multi-dimensionally. Therefore, the interactionist model seemed to be the most relevant and comprehensive for general application whilst the caregiving stress model seem to be relevant for the healthcare setting, in particular, HIV and AIDS home-based care.

In an effort to relate the models to the stress experienced by HIV and AIDS home-based care workers, the comment by Sr Munro of the South African Catholic Bishops Conference Aids Office at a workshop for caregivers that, "it can be quite stressful for everyone concerned, dealing with sickness and dying, and then having to make ends meet in what are often poor households where few if any of the adults are working," seems to capture the reality of their working conditions (The Southern Cross, 2015:9). The researcher's interpretation is that, although there was no mention of how the home-based care workers responded psychologically, physiologically or behaviourally to the stressful situation, it appeared to be quite difficult and probably rendered existing coping mechanisms ineffective. More so that it seemed that there were limited and/or non-existent support networks.

The cited perspectives and models of stress have offered more insight into the concept of stress, particularly with reference to HIV and AIDS home-based care workers. This knowledge is important for the management of organisations as it would assist them to better with their employees better as they would understand how stress impacts on individual employees. An explanation of circumstances that lead individuals to respond differently to the same stress, that is, why some individuals cope better than others, is given in the next section.

3.2.5 Buffers against stress

Earlier discussion has highlighted how stress is part of daily life and how people need eustress for growth and stretching of capabilities. Distress also occurs and it prepares individuals through acquisition of relevant coping mechanisms to deal with future distress. These are stress buffers or mediators, which are basically coping mechanisms and strategies that individuals have adopted earlier on in their lives, to deal with daily

challenges and stress, be it personal or work-related. These range from social support, self-efficacy, optimism, to hardiness to stress. Amongst the mentioned buffers, social support has been validated by research studies as playing a significant role in enhancing the general wellbeing of employees and protecting them from the adverse effects of stress (Furnham, 2005:371; Linden, 2005:108; Mujtaba & McCartney, 2010:105; Weinberg et al., 2010:239; Zunker, 2008:209). For the purposes of this study, only social support will then be reviewed.

3.2.5.1 Social support as a buffer against stress

Social support is explained as an exchange of care and concern for the other between two or more people. Social support may be in a form of an informal support system through friends and family or formal through support services rendered by professionals in the workplace or support groups or community ties. The informal support seems to be more permanent and long lasting than the formal, as the formal is determined more by where one works and lives (Linden, 2005:109). There is evidence in work environments where there are functional formal support systems, the ability of the employee to cope with stress was much better than in tense and highly competitive (destructive competition) environments (Zunker, 2008:209).

For a supportive environment to exist in the workplace, it was suggested that the following conditions should be prioritised: from the point of staff recruitment and selection, supportive relationships and networks should be emphasised to the new staff, training of managers and supervisors in promotion of the culture of support and this should reflect in their management style and lastly, access to occupational health, counselling services, social networks within and outside the organisation and self-help groups should be encouraged (Weinberg et al., 2010:239-240). These are formal support systems that assure employees that the organisation cares about their wellbeing to the extent of nurturing a caring culture within the organisation and providing a safety net for any stress-related challenges they might be facing. Such support goes a long way in lightening the stress load.

A distinction was further made between the different kinds of social support, namely emotional support, informational support and instrumental support. *Emotional support* was verbal or non-verbal expression of concern and affirmation for the other, resulting in restored self-esteem, the boosting of self-confidence and generally feeling better about oneself. *Informational support* involved sharing information with those who needed it for guidance and advice on what to do to regain control of their challenging situation. *Instrumental support* on the other hand, was providing material assistance to a colleague such as money, transport, food (etc.) to bring immediate relief to a stressful situation (Linden, 2005:109; Mujtaba & McCartney, 2010:105-106). These forms of social support are therefore needed by individuals to cushion them, from time to time, so that they are better able to cope with the negative impact of stress in both their personal and work life.

In summary, it seems there is support for the view that individual employees do have different and unique stress tolerance levels, based on their socialisation and/or life experience. The researcher is of the opinion that such experiences may influence an individual to have either a high, medium or low stress tolerance level and this has to be factored in when formulating stress interventions.

With the concept of stress having been explained at length, the next topic then focuses on an explanation of what a stress management programme is, including commonly used individual and organisational interventions for dealing with workplace stress.

3.3 ADDRESSING WORKPLACE STRESS THROUGH STRESS MANAGEMENT PROGRAMMES

Workplace stress can be psychologically, physiologically and financially costly to both the employee and organisation if not properly addressed. Employers are therefore encouraged to take responsibility for assisting those experiencing stress (Colligan & Higgins, 2006:96; Mickel & Dallimore, 2012:76).

This section explores what stress management programmes entail, some theoretical foundations of such programmes and associated stress management interventions. The aim is to integrate an understanding of stress as a concept with an exploration of available

options concerning what can be done in the workplace to mitigate the negative impact of stress, in return, achieve quality work-life balance for HIV and AIDS home-based care practitioners.

3.3.1 Description of a stress management programme

A stress management programme is explained as a preventative and curative organisational action plan, formulated to address the causes of stress with the aim of promoting a healthy working environment for both the employee and employer (Weinberg et al., 2010:153-154). Stress management programmes usually aim to promote an understanding of stress, its causes and effects on both the employees and the organisation, to provide means to identify, measure and evaluate stress, and to engage in stress reduction programmes at both employee and organisational level to promote a healthy working environment (Stranks, 2005:139-140).

Organisational intervention programmes contain measures to change the work environment, work tasks or working methods, whilst employee interventions are aimed at teaching individuals personal skills and techniques to reduce stressors at an individual level (Sulsky & Smith, 2005:202; Marine et al., 2009:3). Examples of organisational interventions include reducing stressful working conditions, practising participative decision-making, providing emotional support to employees and participating in wellness programmes. At the employee level, individuals may build a support network, meditate, engage in physical exercise and practise relaxation techniques (Furnham, 2005:385; Sulsky & Smith 2005:203).

There is support for a stress management programme that is focused on both the employee and the organisation as it is assumed that if an employee reacts negatively to stress (presented as burnout or absenteeism), and this will impact directly on organisational functioning. Therefore, improving employee wellbeing ideally should be a joint effort between the employees and the organisation (Cartwright & Cooper, 2009, in Van Dick and & Haslam, 2012:3; Weinberg & Cooper, 2012:104). It was further argued that, because of the multi-faceted nature of stress, it is unlikely that a single approach

(intervention focusing only on the work environment/organisation or the employee) would provide optimal stress management in the workplace (Mimura & Griffiths, 2003:14).

In planning and designing a workplace support programme that is conducive to physical, psychological and social wellbeing of employees, it is suggested that a number of factors be considered. The first of these is the identification of work-related stress hazards, its symptoms and potential causes in the organisation, including assessment of the risk factors for each hazard and potential causes of stress in the organisation. Special attention needs to be given to those in safety sensitive positions by involving all the role players in developing employee wellness solutions, plans, standards and governance thereof. Lastly, implement and regularly evaluate the employee wellness plan (Potgieter & Pieterse-Landman, 2011:229; Stranks, 2005:145).

Another view was that, when planning stress management programmes, in addition to identifying the causes of workplace stress, existing social and chronic stressors in the personal life of employees should be considered. Secondly, there must be an examination of what has to change in the workplace and the skills needed to maximise the coping capabilities of employees. It is essential to explore knowledge, skills and habits that have to be adopted to act as effective stress buffers and finally to consider the teaching of physiological arousal reduction skills (Linden, 2005:79). Some of the benefits of such inclusive programmes for the organisation included contented and productive staff, low absenteeism, healthy relationships between managers and employees and low staff turnover (Stranks, 2005:146).

The researcher's view is that the cited literature on what a stress management programme entails seems to be in agreement that, for any programme to work, both the employees and the organisation have to be studied. Secondly, needs assessments in the form of stress audits are also emphasised, indicating that there is recognition that there is no one size fits all and therefore such programmes must be customised to their particular context, work environment and individual employees' perception of and ability to cope with work stress. To ensure that a programme meets the unique needs of the organisation and employees, it needs to be structured, scientific, measurable and to have

been proved to be applicable to a variety of workplace settings, including the healthcare field. An overview of a stress management interventions thus follows.

3.3.2 Stress management interventions

Stress management interventions, as previously cited, need to be directed at both the organisation and the employees to ensure that they are effective and that they promote maintenance of a healthy workforce and workplace. The literature consulted cites various options for both employee and organisational interventions. At the organisational level, interventions include the points mentioned below (Cranwell-Ward & Abbey, 2005:89; Furnham, 2005:372-373; Potgieter & Pieterse-Landman, 2011:249; Robbins & Judge, 2015:589-591; Weinberg & Cooper, 2012:89):

- The first issue is the promotion of employee participation and involvement through the improvement of organisational communication: initiatives in the workplace, that ensure that employees are involved in important organisational decisions, especially those that affect them, can create a sense of control and empowerment for the employees which is vital in obtaining their support in workplace stress management interventions (Weinberg & Cooper, 2007:257).
- There must be supportive organisational practices and structures.
- On-going training is required and this may include upskilling to ensure that employees keep abreast with advances in their respective fields and also to encourage innovation. Training could also include coaching and skilling in stress awareness, prevention and coping (Cranwell-Ward & Abbey, 2005:87; Weinberg & Cooper, 2007:257).
- Promotion of organisational citizenship must be achieved.
- The frequently cited interventions are job redesign and employee assistance programmes.

There were also various viewpoints when it came to interventions that are targeted at individual employees. These are identified as stress audits, time management, lifestyle management (exercise and diet), problem-solving skills training programmes, with

relaxation through meditation and cognitive behavioural therapy being the most popular interventions (Furnham, 2005:372-373; Linden, 2005:91-102; Potgieter & Pieterse-Landman, 2011:249; Robbins & Judge, 2015:589-591; Weinberg & Cooper, 2012:89). Furthermore, relaxation was cited in a study as being one the most credible interventions that promoted self-care among healthcare workers, in particular, those in the nursing field, given the difficult working conditions they faced daily (Kravits, McAllister-Black, Grant & Kirk, 2010:138).

It is evident then that organisations have a variety of interventions to choose from when formulating a stress management programme. For the purposes of this study, detailed discussion of interventions will only be on the frequently cited individual and organisational interventions, namely, relaxation-meditation, intervention cognitive-behavioural therapy (individual interventions) and job redesign and employee assistance programmes (organisational interventions).

3.3.2.1 Individual interventions

Individual stress management initiatives are primary directed towards individual employees with the aim of strengthening their coping mechanisms so that they can proactively deal with workplace stress. The focus was mainly on relaxation through meditation and cognitive behavioural therapy interventions.

(a) **Relaxation through meditation** is an eastern approach to stress reduction and release of muscle tension and is quite popular in the field of organisational stress management. It involves clearing one's thoughts of external stimuli and concentrating on a state of peacefulness which results in significant changes in heart rate and blood pressure, thus achieving a state of deep relaxation (Furnham, 2005:373; Robbins & Judge, 2015:591; Sulsky & Smith, 2005:222). Meditation, a form of deep relaxation, requires being in a quiet place where there are no distractions, assuming a comfortable sitting position, taking deep breaths, and in the process, mentally going through tightening and relaxation of several body parts, especially those that are affected the most by stress, letting one's mind and

body float, ignoring any outside interruptions and using the same deep breathing techniques to get back to the "awake" state (Stranks, 2005:69-70; Sulsky & Smith, 2005:223). Meditation, therefore, requires the employee to make time to do this, either during office hours or outside office hours. The success of this intervention also depends on the organisation allowing employees to do this, especially during office hours, and making a venue available for employees to use as not just any venue can be used. The venue should be suitable for the exercise.

There is a relatively new and promising stress reduction intervention that also involves meditation, namely, mindfulness training. It has particular relevance to the healthcare field as it shares the same values as most healthcare professions, for example, sensitivity, non-judgemental attitude, interconnectedness and awareness of self and others (Mackenzie, Poulin & Seidman-Carlson, 2006:105,108). **Mindfulness-based stress reduction**, developed by Kabat-Zinn and his colleagues, is defined as "the awareness that emerges through paying attention on purpose, in the present moment and non-judgementally to the unfolding of experience, moment by moment." It is often referred to as insight meditation as the participant is challenged to contemplate the here and now in a deep and penetrative manner (Kabat-Zinn, 2003:145-146). It was initially designed as an alternative and complementary intervention for patients with various diagnoses who were not responding to conventional medicine and thus had been referred to the meditation by their medical doctors. Its success in bringing relief to referred patients led to the expansion of the programme to non-clinical settings (Mackenzie et al., 2006:149).

Mindfulness stress reduction is explained as a psycho-education programme that takes eight weekly sessions of about three hours where participants are taught various prescribed meditation techniques that they practise in the sessions, and are thereafter expected to continue practising them in their ordinary day to day activities such as eating and driving. The key elements of mindfulness stress reduction were cited as being: (a) it takes place in a group format; (b) it is non-goal orientated; (c) there is expectation of relief from discomfort; (d) participants are

expected to participate actively in the process and take responsibility for ensuring that they benefit from the programme; (e) participants have to be fully committed to the programme as they are expected to continue with the techniques even after the mandatory eight weekly sessions; (f) acquisition of a variety of meditation techniques; and (g) learning about the relationship between stress and illness (Irving, Dobkin & Park, 2009:62-63).

Mindfulness-based stress reduction seems therefore to focus on challenging individuals to use their own personal resources, accessed through meditation, to achieve relief and adaptive escape from what is causing distress in their lives in the here and now. Another observation about this stress reduction intervention seems to be that it requires on-going long-term commitment, as, even after one has completed the sessions, there is an expectation to continue applying what one has learned (Irving et al., 2009:62). The expected on-going use of the skill appears to be quite relevant to the healthcare field where the nature of the work is mostly inherently stressful. The healthcare workers may then use the skill to deal proactively with workplace stress on an on-going basis resulting in prevention of chronic stress and burnout.

(b) **Cognitive behavioural therapy (CBT)** has been cited as being another successful individual stress management intervention, more effective in managing workplace stress than most organisational intervention initiatives (Hoffman, Asnaani, Vonk, Sawyer & Fang, 2012:436). It is a psychotherapeutic intervention based on the assumption that as human beings have the power to change how they think, feel and believe about challenging situations including the work environment such that it is not disabling but enabling. It contends that when people become unhappy and stressed about a challenging situation, it is the beliefs and attitudes that they have about the event that cause them to be anxious and miserable, not the challenging situation itself. If they change their beliefs and attitudes towards the situation, they are more likely to respond in a way that is sensible and constructive and recognise that the situation is temporary and controllable. The goal is a general improvement in overall functioning and

proactively managing the effects of the self-defeating thoughts (Choudhury, 2013:5,35; Furnham, 2005:377; Hoffman et al., 2012: 427; Potgieter & Pieterse-Landman, 2011:250).

It was further proposed that CBT is based on the assumption that focus should be on overt behaviour that is displayed in the present moment. For the treatment to be effective it has to be incorporated into both cognitive and behavioural intervention strategies and the process has to work in a goal directed, active and prescriptive manner with the individual taking ownership of the change that has to take place (Hoffman et al., 2012:427; Zunker, 2008:221). The approach does not preoccupy itself with the history of the faulty perception, but on how it influences the individual's perception of the present situation.

CBT consists of two psychotherapeutic techniques, namely, **cognitive therapy** and **rational emotive behavioural therapy** (Choudhury, 2013:5). **Cognitive therapy**, sometimes referred as cognitive restructuring, focuses more on what an individual thinks about a challenging situation. These thought processes initially tend to be faulty and influence how the individual reacts to the situation. The goal of cognitive therapy is to assist the individual to start thinking differently, in a more adaptive manner. This is achieved by challenging both the faulty thoughts and their causes, then replacing them with more realistic, healthy and adaptive thoughts. Constructive self-talk was cited as being one of the effective techniques that could be used to achieve this modification. This technique teaches individuals to shift from self-defeating self-talk to self-enhancing self-talk that can improve work performance and eliminate anxiety (Choudhury, 2013:19; Potgieter & Pieterse-Landman, 2011:251; Zunker, 2008:221,223).

Rational emotive behavioural therapy takes the cognitive behavioural therapy one step further by arguing that an individual's thought processes may be either rational or irrational. Irrespective of their orientation, the rational/irrational thoughts influence perception of reality. Rational thoughts are sensible and flexible, whilst irrational thoughts distort reality and may lead to anxiety and distress. Therapy therefore aims to teach individuals how to identify the irrational thoughts and

beliefs, mentally challenge them and replace them with rational self-enhancing thoughts and beliefs. Irrational thoughts that one internalises and unawares applies these to the workplace, need to be challenged as they may create unnecessary stress and tension for the individual and those that he/she comes into contact with during the execution of duties (Choudhury, 2013:6; Zunker, 2008:216).

Rational emotive behavioural therapy uses the ABCDE model to work with individuals to assist them to challenge the irrational thoughts and their causes and adopt rational ones. The acronym ABCDE stands for: **A** – the activating event; **B** – belief (irrational) one has about the event; **C** - consequences (painful emotional and behavioural consequences of the irrational thought); **D** – disputing the irrational thoughts and beliefs one has about the event and replacing them with rational and adaptive thoughts; and **E** - a new effective rational way of thinking and approach to life, that is, the adoption of a life-helping belief system (Ellis, 2007 in Choudhury, 2013:13). Disputing is said to involve three steps: detecting, debating and discrimination. This process prompts the individual to identify the irrational thoughts, debate their adaptiveness and realism and convince himself/herself that change is necessary for a healthy mind (Ellis, 2007 in Choudhury, 2013:13; Zunker, 2008:225).

In short, CBT argues that it is the self-defeating thoughts that are the main contributing factors to work stress. The approach can be used effectively to assist individual employees to change these self-defeating thoughts that interfere with the achievement of both individual and organisational imperatives to those that promote an environment that is conducive to productivity and satisfied employees and employer (Choudhury, 2013:72).

The researcher's opinion is that an added benefit of acquiring stress management skills in the workplace, is that they can also be applied in individuals' personal lives. Improvement is thus of general functioning not just of workplace functioning. At the same time implementation of the interventions seem to require a reasonable investment in terms of time, human and financial resources for the facilitation of the mentioned stress management intervention strategies, a constraint for not-for profit organisations. This

situation could urge such organisations to be creative in terms of how to customise and trim the interventions so that they benefit from the essential core elements of programmes without incurring costs beyond their affordability. These are not the only options available; there are organisational interventions too that are discussed next.

3.3.2.2 Organisational interventions

Job redesign and employee assistance programmes (EAPs) are identified as being among the working organisational strategies for dealing with stress. These interventions target the work environment to make it conducive for job satisfaction and productivity.

(a) **Job redesign** essentially entails redesigning employees' work such that it is always stimulating and fulfilling to the employees, and does not become repetitive and monotonous. In order to achieve this, the job can be redefined by increasing or decreasing its scope and/or complexity. Decreasing scope/complexity may offer the employee the opportunity for specialisation. A job scope/complexity increase may, on the other hand, offer the opportunity to do more in terms of controlling the planning, execution and evaluation of the work, often referred to as job enrichment. Job rotation may also achieve the same results. Giving employees meaningful work, autonomy, involvement in decision-making and regular feedback on performance are other job redesign strategies that could ensure that employees are meaningfully engaged and stimulated in the workplace (Furnham, 2005:373; Potgieter & Pieterse- Landman, 2011:253; Robbins & Judge, 2015:591).

Furthermore, job redesign also provides solutions to employee concerns such as overload, low control and role ambiguity (Cranwell-Ward & Abbey, 2005:89). It appears then that, for the job redesign to work, it is important that both employer and employee keep the communication lines open. The redesigned job has to meet the needs of both employee and employer and that can, in most instances, be facilitated by structured open and honest communication. Job redesign for HIV and AIDS home-based care workers could be problematic as a stress management strategy in light of the fact that there is documented evidence that

their work tend to be unregulated and, in some instances, they even work without supervision (Lehmann & Sanders, 2007:13;20). The researcher is of the opinion that the employee and his/her supervisor/manager have to know and understand the job description (of the HIV and AIDS home-based care worker) before any constructive changes can be made to it. In organisations where proper supervision and support structures exist, job redesign can prove to be a viable option, more so that it seems it can be implemented without financial costs.

(b) An **employee assistance programme** (EAP) on the other hand is an organisation sponsored support programme that is mainly targeted at employees who are experiencing distress. It focuses on the prevention, identification and resolution of employees' emotional, physical and productivity challenges (Employee Assistance Professionals Association, South Africa Branch, 2015:1-2; Potgieter & Pieterse-Landman, 2011:253). Such programmes may be staffed internally, or outsourced based on the organisations' informed preference. As programmes have to meet the needs of a specific organisation, it is recommended, that before such a programme is put into place, a need assessment involving all parties be carried out. This is to ensure that the best programme for the organisation is formulated, in line with its characteristics and resources. This approach to programme formulation facilitates ownership and utilisation by the programme beneficiaries (Cranwell-Ward & Abbey, 2005:90; Robbins & Judge, 2015:592; Sulsky & Smith, 2005:218-219).

It was further suggested that an effective EAP should be outcomes-based and have the following components: a vision statement, programme goals and objectives, programme timelines, a budget, communication plan, employee involvement and leadership commitment, protection of employee confidentiality, effective publicity of services on offer, and an implementation and evaluation plan (Potgieter & Pieterse-Landman, 2011:253-254; Weinberg & Cooper, 2012:113). Putting all these systems in place can be a costly exercise which may be beyond the affordability of most not-for-profit organisations (Sulsky, 2005:219). This may

imply that this option may not necessarily be viable for the target group with which that the research project is involved.

A brief explanation of two organisational stress management interventions has been given to shed some light into tried and tested organisational initiatives to deal with workplace stress. This has also explored their applicability to the target organisations of the research study.

To conclude, the researcher is of the opinion that popular individual and organisational stress management interventions have been presented to highlight those available options that organisations may use to address stress. As the study is about stress in the healthcare sector, the next topic explores stress management interventions that are commonly used in this field of practice.

3.4 OVERVIEW OF STRESS MANAGEMENT INTERVENTIONS IN HEALTHCARE

The healthcare field is cited as among the most stressful fields of practice with burnout being common. When workers are either stressed or burned-out, it is usually the patient who bears the brunt of poor and sub-standard service. In spite of this awareness, few steps were taken to remedy the situation through preventative and/or curative interventions (Irving et al., 2009:61-62).

The literature consulted cites a limited number of reviews of stress management interventions for healthcare workers globally, with nurses being the most widely studied in terms of stress and burnout intervention programmes. In some instances the researchers referred to healthcare workers whilst in essence their respondents were mainly nurses and their aides (Fearon & Nicol, 2011:35; Mackenzie et al., 2006:108; Marine et al., 2009:2; Parikh et al., 2004:115; Routsalainen, Serra, Marine & Verbeek, 2008:169-170; Siu, Cooper & Phillips, 2013:2-3). There were few studies done with student psychologists (Barnett, Baker, Elman & Schoener, 2007:603; Shapiro, Brown & Biegel, 2007:105), medical doctors/students (Redwood & Pollak, 2007:42) and community care workers (Hitzipapas, 2013:4-5; UNAIDS, 2007:7). In light of the limited studies in this field, the researcher's focus is on the frequently cited stress management

interventions for professional healthcare workers, namely, **mindfulness-based stress reduction** and **psycho-education,** which are individual orientated interventions and interventions for community healthcare workers (lay healthcare workers), namely, **aerobic laughter therapy** and **"preventing carer burnout programme."**

3.4.1 Stress management interventions for professional healthcare workers

The popular stress management interventions for this target group are explained as follows:

a) **Mindfulness-based stress reduction** has already been described on as a popular relaxation method (as an individual stress management intervention). Its relevance and appropriateness in the healthcare field have been supported by studies which indicated that self-reports by research participants repeatedly commended the technique as a self-care strategy that was effective in reducing the psychological symptoms of stress, enhancing coping mechanisms, and promoting empathy and relaxation (Irving et al.,2009:65; MacKenzie et al.,2006:108; Shapiro et al., 2007:106).

A typical mindfulness-based stress reduction intervention (adapted from Kabat-Zinn et al., 1982) that was used with healthcare workers consisted of an eight weeks programme of two hourly sessions (Shapiro et al., 2007:108). Participants were trained in the following five techniques:

- Sitting meditation: here the focus is on concentrating on the sensations of breathing whilst alert to physical sensations, thoughts and emotions.
- Body scan: this involves concentration on body sensations from head to toe whilst observing the physical sensations in each region.
- Hatha yoga: here the purpose is to strengthen the musculoskeletal system and enhance mindful awareness. This is achieved through learning specific stretches and postures.
- The guided loving-kindness meditation is practised through experiential compassion towards self and others.

- Finally there is the teaching of formal practices that bring mindfulness to day to day life.

The researcher's view is that one benefit of mindfulness-based stress reduction was that it equipped healthcare workers with skills that seemed adaptable to their unpredictable, pressurised and stressful work environment. Any time when they needed "a break" they could then harness those stress relieving techniques without taking too much time.

b) **Psycho-education**, as explained by Kravits et al. (2010:132), is an individual stress management intervention that was used with nurses to promote general physical and mental wellbeing in light of the work stress that they are regularly exposed to. It was a once-off intervention that consisted of a six hour session that used adult teaching and learning principles, that were interactive and outcomes-orientated. The primary interventions were relaxation, guided imagery training, art exploration and the creation of a personalised wellness plan. These interventions are clarified in Table 3.2 as follows:

Table 3.2 Structure of psycho-education intervention

TOPIC	INTERVENTION
1. Significance of self-care	- Psycho-education - Introduction to stress diary and wellness plan - Poem and art reflection
2. Stress and stress response	- Psycho-education - Guided deep breathing and positive intention practice
3. Creation of a wellness plan	- Art directive exploring coping strategies - Initiate writing wellness plan - Grounding exercise practice
4. Coping options	- Art directive exploring challenges and options for managing challenges - Progressive muscle relaxation practice
5. Completion of the wellness plan	- Refine and complete wellness plan - Guided imagery practice

Source: Kravits et al. (2010:133)

Table 3.2 demonstrates, according to the researcher, that although the primary purpose of the intervention was psycho-education, other relevant techniques have been factored in to ensure that the intervention is not only theoretical, but that there were soft skills that the participants acquired to complement the knowledge gained and these made the intervention comprehensive and effective. Furthermore, research findings support psycho-education intervention as a viable self-care strategy for nurses and presumably for other healthcare workers too (Kravits et al., 2010:138).

3.4.2 Stress management interventions for community healthcare workers

The available stress management interventions that community healthcare workers participated in are:

a) **Aerobic laughter therapy**: This programme was implemented with care workers of orphaned and vulnerable children working at a non-governmental organisation in Soweto, Gauteng province. The use of the programme as a stress management was prompted by the realisation that, although the care workers found their work rewarding and fulfilling, they were not spared from the work-related stress that came with working in the HIV and AIDS field (Hatzipapas, 2013:29-30). Aerobic laugher therapy training was provided by the In Happiness Foundation and they describe it as a stress management programme where "participants learn to practice aerobic laughter techniques that enable therapeutic healing laughter without jokes or comedy" (Gee, 2013:1). There is no standard programme as each intervention is tailor-made for the participants. Although it was reported that the programme played a significant role in the reduction of the care workers' stress symptoms, there was no mention in the study of the content of the intervention the participants were exposed to (Hatzipapas, 2013:69). This, therefore, according to the researcher, represented a limitation in terms of replicability and/use with a similar target group, in this instance, HIV and AIDS home-based care workers.

b) **Preventing carer burnout programme** is part of the best practice model collection of the *Joint United Nations Programme for HIV/AIDS* (2007). The model is based on a programme by the Inter-Mission Care and Rehabilitation Society (IMCARES), a faith-based non-governmental organisation in India which serves the health and welfare needs of people in poorly resourced and disadvantaged communities. Their services include care for those infected with and affected by HIV and AIDS (UNAIDS, 2007:7-8). The approach is preventative and focus more on practical activities rather than a programme. The following are listed as stress management interventions for the care workers and other direct service staff (UNAIDS, 2007:35-37):

- **Wednesday is an open day:** the day is set aside for relaxation, prayer, attending training and discussing any family or work matter that may negatively impact on performance.

- **Setting targets:** there is regular assessments of workload with staff involvement to ensure that the workload is realistic and attainable.

- **Shared responsibility for the work and case sharing:** this is mainly to provide support for staff when they are working with a family that is in crisis. Other team members are expected to assist the specific care worker dealing with the crisis.

- **Clearly defined working hours:** care workers are not expected to work overtime unnecessarily. The last thirty minutes of the day's shift are allocated to debriefing within the team.

- **Faith is central to their work:** all staff engage in both morning and afternoon devotions. It promoted cohesion and support for one another, including dedication and commitment to their work.

- **Practical care of the carers:** the organisation from time to time organises family activities that carers and their families participate in. When a carer is not well, he/she is given all the support he/she needs to get back on his/her feet, which includes regular visits by colleagues. The aim is to promote a "work family" environment.

It was further ascertained that these measures have gone a long way in enhancing job satisfaction and reducing stress among the carers. The organisation acknowledges that this intervention may not be suitable for some organisations, but provides an example of available options. IMCARES further emphasised that it is through management's flexibility, transparency and dialogue that the physical, psychological and spiritual needs of care providers could be met (UNAIDS, 2007: 29;39). The researcher is of the opinion that the IMCARES intervention programme is an organisation-led initiative and does not necessarily equip employees with stress management skills. Furthermore, the intervention is not a programme, but more a set of procedures that the

organisation has to put into place to manage and/or prevent stress and burnout. Given the limitations of not being a programme and possible challenges of using the procedures as is with similar target groups, the researcher is of the opinion that it is not in line with what the study is hoping to achieve for the HIV and AIDS home-based care workers in terms of a stress management programme.

The brief discussion of the afore-mentioned stress management interventions in the healthcare field, according to the researcher, highlights the need for more studies in this area of stress management especially among lay healthcare workers such as HIV and AIDS home-based care workers. The information gathered, although limited, made a meaningful contribution in assisting the researcher to formulate a stress management programme for the HIV and AIDS home-based care workers.

3.5 SUMMARY

Stress, it seems, is an everyday occurrence. Selye (1956:vii) sums this up by stating that "no one can live without experiencing stress all the time. The same stress which makes one person sick can be an invigorating experience for another." The meaning of this seems to point to the fact that there is stress that is enabling, that is eustress, and distress that is disabling. The discussion on the concept of stress, where definitions and models of stress were covered, highlighted how the perception and experience of stress differs from one person to the other. The individual's existing coping mechanisms, previous exposure to the similar stressful situation, resilience factors, available support systems, context etc., all have a bearing on how one copes with a stressful situation.

Although the importance of eustress is recognised in both personal and work life, the focus of the chapter was mainly on distress in the workplace. The workplace is an environment that is conducive to stress mainly because it is a setting where individual employees have to fit into an organisational culture and structure they did not create and were not socialised in. The work setting is not designed to meet individual preferences and as employees they are expected to meet performance targets set by management for which they are remunerated.

In order to meet basic survival needs for self and/or dependents, adults have to work and use the earnings to meet the needs. In most instances is not about choice, it is about survival, and for that reason, individuals find themselves having to work and in the process, somehow being exposed to stress and they have to find ways to cope with this. It is not only individual employees who bear the brunt of workplace stress, organisations are also impacted by stressed employees who struggle to be productive, resulting in loss of earnings by the organisation. The importance of buffers in coping with workplace stress was further elaborated on, which highlighted the role of optimism, self-esteem, self-confidence and a viable social support network in mitigating the impact of stress.

To address stress and manage it in the workplace successfully, both individual and organisational interventions were explored. Individual interventions focus on upskilling employees to enhance their individual coping mechanisms. Organisational interventions on the other hand, are those that the organisation puts in place to ensure that a healthy work environment is as stress-less as possible, promotes job satisfaction and fulfilment and has productive employees.

The interventions mentioned appear to have been modelled around profit making organisations that do not necessarily seem to have time, human and financial resources constraints. HIV and AIDS home-based care practitioners are in the not-for-profit sector and implementing interventions such as an employee assistance programme can be challenging in terms of the human and financial resources required for this. The fact that they do not have resources for a comprehensive stress management programme does not mean that the carers are immune to stress. Furthermore, stress management programmes implemented in the healthcare field were also briefly discussed and challenges with their limitations cited, in addition to the fact that there are few such studies.

Both the employing organisation and employees, it seems, would need to work in honest partnership to agree on a stress management programme with either individual and/or organisational interventions that are effective, relevant, appropriate and affordable in terms of time, human and financial resources. The interventions should be able to provide the support needed by home-based care workers, recognising both their strengths and

limitations in coping with work stress that is peculiar to the HIV and AIDS field (Akintola, 2008:364).

In light of the above-mentioned summary, the study required a theoretical grounding in order to ensure sound empirical research outcomes that make a meaningful contribution to research knowledge. The next chapter then gives a discussion of the theoretical framework, social constructionism, which guided the study.

CHAPTER 4

SOCIAL CONSTRUCTIONISM: THEORETICAL ORIENTATION OF THE STUDY

4.1 INTRODUCTION

The chapter focuses on providing a response to the first objective (Objective 1) of the study, which is:

"To provide a theoretical framework that guide and underpin how the research process would be conducted and data interpreted."

The researcher has adopted the social constructionism theoretical approach/research paradigm. The reasons for doing so were that it allowed for the use of a non-directive approach to interaction with research participants, especially during data gathering, which the researcher believed it would give a clear picture of the reality of the participants' workplace challenges (Burr, 2003:6). Furthermore, its notion of the importance of subjective reality would allow researchers to discover how the participants make sense of their social settings and negotiate collective meaning, as well as the impact of that collective meaning within the broader social context (Rosenthal & Peccei, 2006 in Cunliffe, 2008:127).

In order to gain a better understanding of the relevance of the theory to the study, this chapter focuses on an overview of social constructionism, including its origins, relevance to social work and the application thereof to the study.

4.2 OVERVIEW OF SOCIAL CONSTRUCTIONISM

Under this heading the researcher focused on deliberating on what social constructionism is, its origins and place within the social sciences and the key concepts and assumptions.

The purpose is to familiarise the reader with background information on this theoretical framework.

4.2.1 What is social constructionism?

The literature consulted seems to allude more to a description of social constructionism rather than a definition. It is proposed that there is a challenge in having a definition of the approach as it draws from a number of disciplines within the social sciences and humanities such as philosophy, psychology, sociology and linguistics. As a result, it does not have a single feature that distinguishes it from the rest. It is regarded as one of the broad schools of thought in the social sciences, making it multi-disciplinary in nature (Burr, 2003:2,6; Lock & Strong, 2010:6,8). Social constructionism therefore, is an overarching theoretical framework (in the social sciences and humanities) for a number of emerging approaches that are presenting critical and radical explanations to the understanding of human social behaviour (Burr, 1998:1).

According to Hibberd (2006:2) social constructionism can be broadly explained as "the social assembling and arranging of parts, in discrete stages into larger structures for a certain purpose. Concepts, theories, scientific practices and bodies of knowledge can be socially constructed." Another view is that it is an epistemological perspective that is concerned with how knowledge, truth, objectivity and insights are socially constructed and understood (Andrews, 2012:1; Gergen, 2001a:2). Furthermore, the approach is credited with encouraging looking at reality from a different perspective to challenge common sense knowledge about the world we live in (Freedman & Combs, 1996 in Botha, 2002:13).

The researcher's understanding of the theory is that it proposes that, when engaging in a study, it is imperative that the researcher should not have pre-conceived ideas and thoughts concerning what the rhythm of a given setting or social environment is. Understanding and knowledge of that particular setting will evolve and eventually construct as she embraces the role of being a non-judgmental researcher.

In an effort to understand what social constructionism is and its unique identity within the social sciences, the researcher is of the opinion that its origins need to be deliberated on. The next topic will then explore how the theory evolved and was shaped from the 18th century to present day.

4.2.2 History of social constructionism

The origins of social constructionism can be traced back to the 18th century, specifically, the "enlightenment era" whose advocate was Emmanuel Kant, a philosopher. Kant challenged the long-standing belief that events and reality can only be explained from a religious point of view. Kant postulated that human beings are capable of structuring their own reality and experience through reasoning and associated mental activities, without having to be channelled into a pre-existing way of doing things. This meant that he viewed human beings as free and therefore they could transcend laws of nature and that they were not subjected to them as was the practice in those times. He thus introduced a philosophical perspective in the search for the truth (Burr, 2003:10; S*tanford Encyclopaedia of Philosophy*, 2016:1; Weinberg, 2008:18).

The enlightenment era was then followed by the modern era which was mainly an attempt by those in the arts also to find a working alternative of appraising their work. Around the same time, another movement, the structuralists were born, represented by Karl Marx in sociology and Sigmund Freud and Jean Piaget in psychology. The structuralists argued, through their theories, that the social world and reality can be explained from a single point of view or structure. In Marx's case it was class relations structure of the haves and the have-nots that emphasised the materiality of the human condition, in psychology it was an all-inclusive underlying psychic structure that was used to explain human behaviour (Burr, 2003:11; Cunliffe, 2008:124; Weinberg, 2008:23). The researcher's opinion is that structuralism seemed to have overlooked the political-socio-economic and other influences that could impact on the individual's view, interpretation and understanding of reality.

In order to be relevant to the changing needs of post-industrial society, a counter movement was established, led by philosopher Friedrich Nietzsche, namely, postmodernism. Postmodernism therefore rejected the tenets of both modernism and structuralism, particularly the notion that reality can be understood in terms of single-focused theories and metanarratives. It proposed that in pursuing the truth, there has to be "honest questioning of all doctrines that drain life's expansive energies, however socially prevalent those views might be" (Burr, 2003:10, 12; *Encyclopaedia of Philosophy*, 2016:1; Koro-Ljungberg, 2008:221). Another influential theorist to post-modernism was Michel Foucault, whose work was highly influenced by Nietzsche. His main focus was on the relationship between power and how it impacted social relations, individual and collective behaviour. He equated knowledge and power and proposed that power is embedded in social relations. (Anderson & Grinberg, 1998: 332,334; Bertens, 1994:7; Drolet, 2004:20).

Although Kant, Marx and Nietzsche had differing perspectives on reality and pursuit of truth, they allegedly agreed that acquisition of knowledge is mainly the individual's prerogative rather than an imposition from the external environment (Burr, 2003:12). Individuals had the privilege of making own objective observations, assessments and reasoning and if they supported their assumptions with facts, they could influence society's view of reality (Gergen, 2001b:51). The researcher's view is that they put the individual in the control seat. He/she could determine own understanding and perception of what is happening around him/her and should this be convincing, he/she could even influence others. Foucault on the other hand proposed that the unequal power relations in society did not only control what individuals could do, but also what they were allowed to know. This implied that there were imposed restrictions in terms of how individuals accessed and acquired knowledge by those in power (Thompson, 2004:83).

Although initiated by social philosophers like Kant and Nietzche, social constructionism, as it evolved, was shaped by sociologists, specifically those who subscribed to the intellectual tradition of the "sociology of knowledge" as espoused by Berger and Luckmann (1966) (Burr, 2003:13; Cunliffe, 2008:124-5). Berger and Luckman (1967) were particularly interested in ways that knowledge was shaped by social processes and

that human beings used language to assign meaning to the world. This language is learned from other people through the process of socialisation. In a nutshell, sociology of knowledge was concerned with the analysis of how reality is perceived and explained from a socio-cultural perspective of any given community. In other words, it perceived an individual as a social being whose interaction with others guided what he/she and the society would eventually define as reality (Berger & Luckmann, 1967:1, 26; Best, 2008:42; Burr, 2003:12).

It is suggested that this sociology of knowledge was heavily influenced by Mead (1934), a social psychologist (Burr, 2003:13; Lock & Strong, 2010:11). From a social psychology perspective, he introduced to social constructionism the important role of the relationship between the individual and the society in shaping behaviour and frame of reference, how complex social interrelations and interactions are vital for the survival of society, and the pivotal role played by language which makes all these social acts possible (Mead, 1970:6-7,189,228). Furthermore, the sociological term "symbolic interactionism" was based on Mead's assertion about how thought process are social in nature and arise from acts of communication such as significant and non-significant gestures (Mead & Von Uexkull, 2010:122). It appears, according to the researcher, that, there was agreement and common understanding in the evolution of social constructionism that the individual is mainly regarded in a social context. He/she may have own perceptions of reality, but this will be analysed within the social context that he/she is part of.

The sociology of knowledge, given the influence of social psychology, also concerned itself with how the individual adapts to the social environment. It suggested that each individual is born with a predisposition to adapt to society. He/she had to use the predisposition to adapt and be a functional member of the society. It was suggested that, to be a member of a society, the individual had to internalise its culture, norms, values and any other system or activity that defined that society. All this societal "knowledge" is acquired through the process of socialisation, facilitated by a common shared language. The overall aim of the sociology of knowledge therefore, was acquiring knowledge and understanding of how reality is constructed in society by all members of the society irrespective of their socio-economic standing or any other criteria that might be used to

classify people (Berger & Luckmann, 1967:3,129,130; Best, 2008:42). The researcher's understanding is that Berger and Luckmann (1967) highlighted the critical role that society plays in the understanding of how people construct reality. They have to be part of something, a society, where they feel they belong and their opinions matter for them to construct reality in a way that is meaningful to them.

To conclude, social constructionism seem to resonate well with those who were marginalised by science as they were thinking differently, challenging those who saw themselves as experts of the truth. The framework provided a school of thought that the marginalised could identify with and use as a launch pad for their progressive ideas that included the pursuit of equality and social justice which were not mainstream (Gergen, 2001a:8).

The researcher is of the opinion that as its evolution is characterised by radical thinking. It seems to fall short of being a comprehensive framework with easily identifiable distinguishing basic assumptions. It thus appear to have a loose structure. A discussion of the key concepts and assumptions of social constructionism follows to give a clearer picture of what holds this framework together.

4.2.3 Key concepts and assumptions of social constructionism

Social constructionism is credited with creating an environment that allowed individuals to challenge and critique the authority that was bestowed on scientific explanations of reality and phenomena democratically and freely (Gergen, 2001b:52). As it drew influence from a number of social sciences, it does not have a unique identity. It does not have at least one feature that distinguishes it from other theoretical frameworks. There is not a single characteristic that all constructionists have in common. For this reason, social constructionism is referred to as a "broad church" with key assumptions and tenets that the theory has been founded on (Burr, 1996:2; Burr, 2003: 2, Lock & Strong, 2010:6).

Social constructionism therefore consists of the following tenets (Burr, 2003: 3-8; Lock & Strong, 2010:6-9):

- **It is concerned with meaning and understanding as the central feature of human activities:** the meaning of social reality is attained through the use of language. Language, therefore, is a medium of knowledge formation. The theory proposes that the same language may be used to describe a phenomenon (in the generation of knowledge), but the explanation may differ and sometimes be inconsistent from one individual to another (Lock & Strong, 2010:6; Touminen & Savolainen, 1997:82). For the researcher, the theory proposes that language is the main medium that human beings use to facilitate a collaborative effort of meaning making successfully.

- **It has the view that meaning and understanding have their beginnings in social interaction and in shared agreements:** this means that meaning is constructed within communities by individuals. In other words, through the daily interactions between people in the course of social life, versions of knowledge and the psychological fabric of social reality are constructed. This knowledge and understanding, is then communally shared, as it is seen as belonging to all, and not to specific designated individual or individuals (Burr, 2003:4; Freedman & Combs, 1996:23; Gergen, 2001a:2; Lock & Strong, 2010:7; Touminen & Savolainen, 1997:83). The researcher's understanding is that social constructionism, by its nature is concerned with the construction of meaning occurring within social transections among people, not necessarily about what individuals in their private space, do.

- **Ways of meaning-making, being inherently embedded in socio-cultural processes, are specific to particular times and places:** meaning and understanding of events are context-bound, and are socio-economically, culturally and historically relative. Social constructionism furthermore encouraged self-reflection and evaluation of meaning, including openness to reconstruction, as realities are not stagnant but forever changing. What is so at present may change meaning given the passage of time (Burr, 2003:4; Gergen, 2001b:221; Lock & Strong, 2010:7).

- **People are self-defining and socially construed participants in their shared lives:** People do not have pre-defined characteristics within them that objective methods can seek to delineate. It is for this reason that it is alleged that social constructionists are against essentialism. They object to the tendency to classify or categorise individuals based on some identity or characteristic (for example, race, gender, disability, etc.) they share with others (Burr, 2003:6; Gergen, 2001a: 173-174; Lock & Strong, 2010:6-7). It appears, then, according to the researcher, that the theory perceives individuals in their own right. Preconceived ideas, stereotyping and prejudice are not entertained.

- **Adoption of a critical perspective:** that is, a concern with the operations of the social world and the political apportioning of power that is often accomplished unawares, so that these operations can be changed and replaced with something just. Basically, the theory is not so much concerned about a reliable, valid and objective explanation of processes as most theories do, but rather on how such processes function and their impact and how the possible negative impact can be mitigated justly. It challenges the face value acceptance of views and assumptions about the social world and encourages a critical appraisal of these (Burr, 2003:3; Lock & Strong, 2010: 8-9).

- **Knowledge is sustained by social processes:** social interactions, particularly language, are of great interest to social constructionists. The theory proposes that language facilitates daily interaction and the exchange of views and opinions about the social world among people and in the process, knowledge is constructed. It is not concerned about the thought processes about knowledge, but rather, the knowledge outcome from the negotiations and sharing among people in a social environment (Burr, 2003:4; Young & Collin, 2004:376).

- **Knowledge and social action go together:** this means that construction of knowledge is not immune to the influence of those who hold power in any given society. Those in power dictate what behaviour is acceptable and unacceptable. Social constructionism, through social action (prompted by critical thinking) engages those in power, from time to time, to evaluate/assess the appropriateness

of what they consider acceptable and unacceptable (Burr, 2003:5; Young & Collin, 2004:376). It therefore, in the researcher's opinion, continuously challenges the powers that be always to make an effort to be evolving in a manner that is relevant, appropriate and adopt changes that are in line with societal values and imperatives.

- **Language as a form of social action:** social constructionists suggest that language should not only be seen as a vehicle of communication, it should also be seen as a form of action because it can have practical consequences. A typical example is when an individual is instructed to do something practically. The words in that case are transformed into action. This way of thinking is contrary to other schools of thoughts, particularly psychology that views language as being a mere expression of thoughts and emotions (Burr, 2003:8).

The afore-mentioned tenets highlight some of the common beliefs of social constructionists which appear to be the core of the theoretical framework. There seems to be an over-arching theme according to the researcher, namely, specific focus on the social rhythm of the community and how this rhythm is used as a vehicle for the construction of shared meaning and understanding of reality, with language being a medium of the construction. The researcher further deduces that social construction seems to promote collaborative efforts among communities which could be labelled as being some form of "levelling of the playing field" where every community member's input matters.

These seven tenets are not the only pillars that best hold social constructionism together. Gergen (2001b:47-50, 228-236) also cites six working assumptions of the theory that are important in the understanding of the theory. They are explained as follows:

- **The terms by which we understand our world and self are neither required nor demanded by "what there is:"** It is assumed that, individuals can and should construct their own reality without being influenced by what already is. Through language, they may create their own alternative worlds without having to conform to any pre-existing set of rules or knowledge (Gergen, 2001b:47). The researcher

understands this to mean that free thinking and expression are encouraged, that is, thinking "out of the box."

- **Our modes of description, explanation and/or representation are derived from relationships:** the author argues that the language used in attaining meaning and understanding of reality is shaped by the way it is used in relationships with others and the environment. This inter-relatedness gives meaning to the language. In other words, what words mean, is defined through relationships that people have with one another and the environment in which they find themselves (Gergen, 2001b:48).

- **As we describe and explain, we fashion our future:** As language is bound within relationships, the relationships are also influenced by the socio-cultural environment. Language is used to maintain the status quo in society of what works and, should there be a need for change, generative discourses are employed. Such a discourse does not only challenge existing structures or practises, but also propose solutions (Gergen, 2001b:49). Thus, the researcher's view is that it does not only critique, but also generates solutions.

- **Social constructionism does not seek to be a final word:** the framework is born out of critical thinking and thus does not subscribe to the mentality that there is one true explanation of reality. It encourages critical but collaborative exploration of meaning of the social world, by interested parties in a spirit of inclusivity and thus entertaining all points of view (Gergen, 2001b:228).

- **It is relativistic:** social constructionism subscribes to the thinking that all explanations of meaning need to be looked at in context. It respects all traditions of value such as religion, spirituality, politics and social orientations. It does not see one as being above the others, but all having equal legitimacy in their own right. In short, perspectives are evaluated based on their relative context (Gergen, 2001b:231).

- **Recognition of meaning fragility:** words used in language can assume different meanings as these are negotiated as the conversation progresses. This implies that depending on context, words can have multiple readings (Gergen, 2001b:236).

The researcher's view is that, the assumptions, although also highlighting the importance of social interaction and connectedness in the understanding of reality, seem to focus more on the role of language in facilitation of social relationships and construction of reality. Language is described as a medium that allows relationships within society to be formed and maintained. It is also through language that the status quo, if not working for the society, can be challenged and changed proactively, thus creating a new reality in the process. In as much as communities and societies are not static, the same is assumed of language.

To conclude, the researcher is of the opinion that social constructionism although radical, is concerned with ensuring that all people's voices are heard and there is mutual respect among community members as they construct reality. It thus appears prudent to explore how social constructionism, with its emphasis on subjective reality, relates and compares to other orientations in the social sciences.

4.2 SOCIAL CONSTRUCTIONISM AND CONSTRUCTIVISM

Referring to the cited authors (Burr, 2003; Freedman & Combs, 1996; Gergen, 2001a & 2001b; Lock & Strong, 2010; Touminen & Savolainen, 1997; Young & Collin, 2004), an assumption can be made that social constructionism, is not necessarily a stand-alone framework devoid of any influence from or relationship with other disciplines in the social sciences and humanities. The framework is therefore regarded as being among the main approaches to social science research as it is humanistic and rejects the scientific method that is preoccupied with facts, replicability and the generalisation of research findings. Social science research studies human beings in everyday social life, not a controlled environment (De Vos, Strydom, Schulze & Patel, 2011: 5).

Among existing approaches to social science research, the researcher has decided to compare and contrast constructivism and social constructionism as they are sometimes used interchangeably as if they are synonymous. The dominant view is that, in essence, they do differ in, amongst others, the basic tenet of explanation of how reality is constructed (Best, 2008:61; Burr, 2003:20). Constructivism focuses on meaning making

and the constructing of social and psychological worlds through individual and cognitive processes, whilst social constructionism emphasises that social and psychological worlds are made real through social processes and interaction (Young & Collin, 2004:375). The focus of this topic is therefore mainly on delineating what constructivism is and how it differs from social constructionism.

Constructivism is described as an approach that is a growing offshoot of developmental and cognitive psychology and it identifies more with the notion of individual cognition in terms of formulating a worldview or conception of reality. It was largely influenced by the psychologists Piaget and Kelly, and argues that the individual's perception and interpretation of how they construct reality start with the thinking process, in the individual's mind. The individual is therefore central to what he/she perceives as the "truth" and not necessarily influenced by others on what and how to think. Perception and knowledge of the world are seen as constructs (Flick, 2014:76; Gergen & Gergen, 2008:173; Young & Collin, 2004:374-375).

Constructs, according to constructivism, are abstractions, generalisations, formulations and idealisations that each person formulates differently as he/she actively creates his/her own meanings from events. Applying this way of thinking to the research process results in moving from individual perspectives to broad patterns and eventually to broad understanding of social phenomena (Burr, 2003:19; Creswell & Plano Clark, 2011:40; Flick, 2014:76). The researcher's view is that the literature cited does bear witness to the fact that constructivism is an approach with sound foundations and its own merits and therefore should be treated as such. There is more to constructivism, as cited in literature, which will be explored in terms of how exactly it differs from social constructionism in Table 4.1 (Burr, 2003:20; Gergen,2001b:237; Gergen & Gergen, 2008:173; Young & Collin, 2004:375-377).

Table 4.1 The differences between constructivism and social constructionism

Constructivism	Social constructionism
1. It is individualistic in its approach.	The approach is rooted in social processes and social relationships. It is relational.
2. It is committed to dualist epistemology and ontology as it suggests that the individual has to integrate meaning and then adapt this meaning to the environment.	It is seen as anti-essentialist and anti-realist with regards to ontology and epistemology.
3. It is concerned with the cognitive processes of meaning construction.	It is not concerned with cognitive processes that accompany knowledge.
4. It is shaped mainly by one discipline, psychology.	It is shaped by multi-disciplinary sources in both social sciences and humanities.
5. It does not give a clear stance on critiquing.	It openly challenges orthodox and positivist assumptions.
6. Within the approach there are sub-approaches, with the popular ones being radical constructivism, moderate constructivism and social constructivism.	It covers a wide range of views which could be referred to as the "family of social constructionism." Examples of members range from empirical social constructionism to contextual social constructionism.

The differences between constructivism and social constructionism have been clarified and it appears that although they are different, they have some family resemblance in that constructivism does not completely reject the social relational paradigm but prioritises the individual's thought processes about reality. Social constructionism on the other hand comes across as a much broader framework with a firm foundation from various disciplines in the social sciences and humanities. Both theories are said to be still evolving and maybe there is a chance that they may merge into one "constructionist family" (Young & Collin, 2004:378).

To conclude, social constructionism, is extensively used in qualitative social research approach. The orientation shape how the researchers pursue the study of social phenomena by ensuring that they are not rigid and impositional but open-minded and are able to gather trustworthy data that significantly broadens the social sciences' knowledge base. Furthermore, it also guides researchers as they access the intimate details of people's lives in order to be ethical and non-exploitative in their search for knowledge (Brinkmann & Kvale, 2008:263; Creswell, 2007:15; De Vos et al.,2011:13).

Social work is a social science that also embraces qualitative social research and its prominent theoretical orientations as other disciplines in the social science home. In the afore-mentioned information on the orientations there has been mention of disciplines such as sociology and psychology. The next topic will focus specifically on the application of social constructionism in social work research.

4.3 SOCIAL CONSTRUCTIONISM AND SOCIAL WORK RESEARCH

The researcher is of the opinion that, in order to comprehend the relationship between social constructionism and social work research, it is important to start by briefly explaining the place of social work in the social sciences, as social constructionism is a framework used mainly in the social sciences. This will be followed by a discussion of social work and social work research, concluding with the application of social constructionism in social work research.

Sciences which participate in research as part of their practice are primarily classified as natural sciences (e.g. chemistry), formal sciences (e.g. mathematics), humanities (e.g. linguistics) and social sciences (e.g. sociology). Social sciences study human thought and behaviour directly, mostly in the present rather than in the past. Their subject matter, particularly social science research, is to understand practices within societies and the values that inform those practices. The social sciences are a large group of interrelated disciplines, and social work is a member of this group (De Vos et al., 2011:4; Walliman, 2006:22, 25).

4.3.1 Social work and social work research

Social work, like the other social sciences, is a science that is concerned with the social life of human beings. In order to be relevant and keep up with the changing needs of society, it needs to engage in research. Research in social work has to be in line with what the discipline is about. In order to understand what this means, a definition of social work is necessary.

Social work, in its effort to adapt to the present times, has been subjected to a shift in focus internationally. It has transited to a preoccupation with social change, problem solving in human relations and empowerment (De Vos et al., 2011:23). This stance has thus necessitated a revised definition of social work which is stated as by the *International Association of Schools of Social Work* (2014:1) as:

> Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance well-being.

The researcher's view is that the definition confirms the crux of what the discipline is about and reiterates the fact that it is practice-based and concerned with empowering service users, social change and social justice that is people-centred, with both the social worker and clients working together in partnership. Furthermore, social work has the task of changing lives as espoused in the definition. This cannot be done by thumb suck, but by engaging in research. The purpose of research should be to investigate the needs of the service users so as not to impose programmes on them, to evaluate the effectiveness of programmes. Social work is not a neutral activity, its knowledge base grows the discipline so that it stays relevant to its mandate (McLaughlin, 2006:9).

Social workers are encouraged to enhance their practice by embracing research as a form of quality control and/or management. In the pursuit of good social work practice, certain guidelines are recommended (Dominelli, 2005:230 in McLaughlin, 2006:12; McLaughlin, 2006:10-11) and these are:

- a participatory or developmental model of intervention or investigation;
- application of anti-oppressive values;
- genuine and egalitarian partnerships between the social work researcher and the researched;
- a change orientation;
- accountability to the research participants/clients for the product of their work; and
- a holistic engagement with the different aspects of the problem under investigation.

The guidelines, according to the researcher, seem to suggest that exploitation of research participants in social work research should be avoided at all costs. Social work research should centre on benefiting the clients, the best interests of the clients have to come first. The subjective view of the research participants/clients should be accepted as being part of the research process and the researcher should also keep in mind that he/she cannot be detached from the process and also brings his/her personal views and beliefs to the process. What becomes important is mutual understanding, not whose view supersedes the other (McLaughlin, 2006:11; Walliman, 2006:26).

The social work profession therefore need to be "research-minded" to be able to fulfil its mandate to the clients of empowerment, social change and justice. This way of thinking challenges social work researchers to work in an inter-disciplinary way and collaborate with related social sciences to keep abreast with developments in the social research arena for the benefit of social work practice and service beneficiaries (McLaughlin, 2006:139). It is assumed that, through the collaboration, social work research will be exposed to social science research methods and therefore able to adapt and adopt some of the approaches, theoretical frameworks and methodologies that are applicable and relevant to social work. The researcher is of the opinion that social constructionism is one of the frameworks that can be adapted to social work research. The next topic explains this assumption further.

4.3.2 Application of social constructionism to social work research

Social constructionism is presented in literature as being incubated in sociology. Sociology as a discipline seems to have been unable to claim its exclusive use and it has spread to other social and behavioural sciences because of its versatility. The use of concepts such as social construction and socially constructed reality in the framework, created interest and eventually adoption of the framework by social scientists who used it where they found the framework applicable. Presumably, social work research is not an exception to this practice (Best, 2008:43, 52).

Social work concerns itself with the welfare of people in society. Social constructionism is also concerned about people in society but, specifically how they interpret and understand the social world around them. An assumption could be made that it is more interested in what people in society perceive as welfare. Another view is that the synergy between social work and social constructionism is cemented by the common belief in respect for the human condition, attention to language and communication, non-judgmental interactions and acceptance of differing worldviews of service users. Social constructionism is also credited with providing social work research with a mechanism for yielding rigorous information that enhances the profession's ability to be effective and maintain high service delivery standards (O'Connor, 2015:3-4).

Evidence of this value-added complementary relationship between social constructionism and social work/social work research is further demonstrated through Table 4.2, adapted from O'Connor (2015:5) as follows:

Table 4.2 Comparison between social work and social constructionism

	Social work	Social constructionism
IDEOLOGY	- Pragmatic - Client self-determination - Interdependence - Social responsibility	- Pragmatic - Interdependence - Social construction of societal standards
PURPOSE	- Empowerment - Change - Problem solving	- Empowerment - Informed choice - Change
KNOWLEDGE	- Nomothetic and idiographic	- Nomothetic
METHODS	- Responsible use of self in relationships - Systematic observation and assessment - Inductive data analysis	- Competent use of self - Systematic and persistent observation - Inductive data analysis

The researcher's view is that, with regards to ideology, both social work and social constructionism speak the same language of being practical, having a belief in the interdependence of people in society and at the same time respecting individual self-determination that is influenced by the society that individual finds herself or himself. The purpose of both is similar with social constructionism taking it a step further by using techniques that make it possible to ascertain from individuals that the choices that they are making about social reality are informed choices (O'Connor, 2015:5).

Whilst social work's knowledge is derived from perspectives of both the individual (idiographic) and sources of generalisable knowledge (nomothetic), constructionism is idiographic as it seeks to understand social interactions and processes in a given society without the intention to generalise the knowledge to other societies. The methods are similar in the sense that, once data has been gathered through verbal interaction and

observation of social behaviour, it is inductively analysed and in the case of social work, theory guides this analysis (Gergen, 2001b:237; Rodwell, 2015:7).

The researcher concludes that social work, as a profession and a discipline that uses research in its practise, seems to have found social constructionism's focus on the social context of realities and its liberal approach to research, enabling it to get to the crux of social problems of service users and facilitating change where necessary without assuming the role of an expert. The framework therefore is in support of what the social work and social work research stand for. As the value added by social constructionism in social work research has been clarified, the next focus is on its contribution to the research study.

4.4 APPLICATION OF SOCIAL CONSTRUCTIONISM TO THE STUDY

The study aims to understand how the research participants construct the reality of their work environment, home-based care, and the related challenges and stresses they may be experiencing. Social constructionism proposes that realities are maintained and organised through stories (Freedman & Combs, 1996:29). In striving to make sense of life, people arrange their experiences of events in sequences across time in such a way as to arrive at a coherent account of themselves and the world around them. The process may involve deconstructing and reconstructing reality as the possibilities are endless. The success of this "storying" of experience provides them with a sense of meaning in their lives (Freedman & Combs, 1996:29-30; O'Leary, 2007:251).

Using the social constructionism framework, the researcher is of the opinion that the research participants are given the opportunity to "tell their story" without the researcher giving her own views of what they may be articulating. The approach thus provides a platform from which participants are able to express their subjective perceptions of their world of work, with the researcher respecting the context boundedness of their reality. The framework also prompts the researcher to ensure that, in her pursuit of gathering information (data) from the research participants, her approach is interactive, using good communication and empathetic skills. The mentioned skills should be demonstrated in a

language (verbal and/or non-verbal) that is familiar and understood by the participants, given the fact that in social constructionism, language plays a pivotal role in the construction of knowledge (Burr, 2003:4; O'Connor, 2015:8).

Furthermore, a distinction is made between two ways in which social constructionism can be applied in research. This is clarified in Table 4.3 adapted from Cunliffe (2008:126) as follows:

Table 4.3 Choices within social constructionism-based research

	Choice 1	Choice 2
Nature of social reality	- Subjective reality with individuals negotiating meaning within social situations - Objectification of social reality, focus on social facts, institutional practices and symbolic products	- Intersubjective reality with people working together spontaneously to create meaning and realities - Emerging social realities, focus on processes of meaning-making, no one person in control
Process of socially constructed reality	- Focus on language and reasoning processes - Social reality is a discursive product	- Focus is on responsive dialogues and conversation between people - Social reality is experienced in interaction with others
Epistemological interest	- Theoretical generalisations about linguistic practices and systems. - Search for patterns	- Context-related interpretative insights - Meaning created in on-going moments

The researcher's view is that she is more inclined to take the second research approach (social constructionism) as outlined in Table 4.3. The reasons for the choice are that firstly, although through the phases of the study (intervention research), data was gathered mainly through individual interviews and self-administered questionnaires, the individual research participants were part of a group of HIV and AIDS home-based care workers. They were recruited within an organisation that they worked for and what happens in the organisation does have an influence on how they perceive reality. They gave individual perspectives, but the social setting that they found themselves in played an important role in meaning making. Their individual responses were therefore seen in light of co-constructed social reality with their colleagues.

Secondly, the purpose of the study was not to generalise the findings to similar settings, but to compile a stress management programme that would address the needs of the research participants. As the research process unfolded, it was important that the research stayed focused on "context-related interpretative insights" so that it captured, as part of data collection, what the real felt needs were and did not compare them with those who were not part of the study. Again as the stress management programme was piloted, there researcher continued to treat the input from the participants in a similar manner.

To conclude, the social constructionism framework can be seen as enabling the researcher to approach the study in an open-minded way, cognisant that there is no single reality out there. For the purposes of the study reality is as constructed by the research participants and this is not static. An emphatic understanding of the reality of participants is paramount with an egalitarian stance with regards to the relationship between the researcher and the researched. The next focus is on a summary of all that has been deliberated on, on social constructionism in this chapter.

4.5 SUMMARY

The chapter has attempted to familiarise the reader with what social constructionism is, without going in too much detail, but giving enough information to promote insight and understanding of what the framework is about. The basic tenets and assumptions of the

framework were also considered on with the aim of demonstrating what is meant by the label that social constructionism is a "broad church." The framework was not just discussed on its own, but extended the discussion by clarifying the differences between social constructionism and constructivism, two orientations that are sometimes confused as being synonymous.

Finally, attention was given to social constructionism and social work research and the chapter concluded with explaining its relevance and application to the study. Its guidelines and methodology encouraged the researcher to carry out the study in a professional manner, adhering to the principles of both social work and social research that are centred on the client/research participant.

Research methods, which are guided by the theoretical framework, are the focus of the next chapter.

CHAPTER 5

RESEARCH METHODS

5.1 INTRODUCTION

The chapter focuses on the research methods that were used to achieve the goal and objectives of the study. The methods are divided into a number of topics, which collectively give an overview of the research plan and its implementation. The chapter therefore discusses the following: the research question, the research approach, the type of research, research designs, sampling methods, data collection methods, data analysis, the pilot study, ethical considerations, and the limitations of the study. Finally, the chapter concludes with a summary.

5.2. RESEARCH QUESTION

The research questions gave context to the goal and objectives of the study and assisted with providing a point of reference with regards to the reasons for undertaking the research project. The research questions also assisted with ensuring that the research process focused on the actual problem under investigation that needs resolution (Bryman, 2012:5; Marshall & Rossman, 2011:70). The research questions that have been formulated for the study, based on the research topic, were:

- What are the workplace support needs of HIV and AIDS home-based care practitioners in Tshwane that could be addressed through a stress management programme?

- What are the main themes to be covered in the stress management programme for HIV and AIDS home-based care practitioners in Tshwane?

- To what extent does the newly developed stress management programme succeed in mitigating the impact of work stress experienced by home-based care practitioners in Tshwane?

Research methods have been adopted and implemented to ensure that the research process is carried out in a manner that answers these research questions accurately. The first topic discussed is the research approach.

5.3 RESEARCH APPROACH

The researcher adopted the mixed methods approach. The mixed methods approach combines the qualitative and quantitative approaches to the research methodology of a single study or multi-phased study and draws from the strengths of one approach in order to minimise the weaknesses of the other (Delport & Fouché, 2011:434; Johnson & Onwuegbuzie, 2004:14-15). Simply put, the qualitative approach involves data in the form of words, pictures and narratives, whilst quantitative approach is about the measurement of phenomena under study using numbers and counts (Monette, Sullivan & DeJong, 2008: 38). The advantages of the mixed methods approach are that it provides improved exploration of the concepts under study, leading to better understanding and deeper and comprehensive research findings and results that inform credible conclusions (Johnson, Onwuegbuzie & Turner, 2007:122; Malina, Norreklit & Selto, 2011:61).

As the researcher was designing and evaluating an intervention programme, that is, the stress management programme for HIV and AIDS home-based care practitioners, it was necessary to ensure that data were gathered using both approaches, in order to reduce the chances of the programme not being able to identify and address the workplace support needs of the home-based care practitioners in Tshwane. The qualitative and quantitative approaches were used to gather and analyse data from the participants in **phases one** and **four** of the **intervention research (IR) process**, namely: problem analysis and project planning (Phase One) and early development and pilot testing (Phase Four). By using both approaches, the researcher ensured that the strengths of

both approaches were capitalised on to produce comprehensive and valid results and findings, and any gap left by one of the approaches was covered by the other.

Furthermore, as explained in Chapter 4, social constructionism was adopted as the framework for the study. The framework/research paradigm therefore enabled the researcher, particularly with the qualitative research approach, to ensure that the participants were afforded the opportunity to "author" the proposed stress management programme, through free expression of the subjective reality of their world of work, the challenges they faced and what could be done to help them cope. This is in line with the framework's assertion that, in striving to make sense of life, people arrange their experiences of events in sequences across time in such a way as to arrive at a coherent account of themselves and the world around them (Freedman & Combs, 1996:29-30). Through social constructionism, research participants were given the opportunity to "tell their story" without the researcher giving her own interpretation of what they might be articulating.

As the research approach is clarified, a discussion on the type of research the study engaged in follows.

5.4 TYPE OF RESEARCH

The research type was applied research, specifically intervention research, as it enabled the researcher to design and evaluate an intervention programme. Intervention research is used for studies carried out for the purpose of conceiving, creating and testing innovative human services approaches to prevent or ameliorate problems or maintaining quality of life (De Vos & Strydom, 2011:475). Thomas and Rothman (1994:4), pioneers in the field, distinguish between three types of intervention research: (i) Knowledge Development, (ii) Knowledge Utilisation and (iii) Design and Development. **Design and Development** was the most suited for the research study because it allowed the researcher to start with a need assessment, then design an innovative programme, and pilot and evaluate it for possible use in similar settings.

Furthermore, Design and Development consists of an integrated model of six main phases of intervention (Thomas & Rothman, 1994:9). The first four phases were applied in this research study as described below. (Take note: details regarding the methodology, and the argumentative deliberations related to this, follow later in this chapter).

1. **Problem analysis and project planning:** The research study, based on the literature consulted, assumed that the HIV and AIDS home-based care practitioners in Tshwane were experiencing problems resulting from obstacles within their work environment, namely, stressful working conditions and difficulty in coping due to the lack of and/or limited support from the workplace. Therefore, through problem analysis, the study shed more light on the challenges experienced by these home-based care practitioners, specifically those working in the greater Tshwane metropole.

   With regard to project planning, the researcher, through the phases of intervention research, undertook a needs assessment to establish the support needs of the HIV and AIDS home-based care practitioners with regards to stress, to compile an intervention programme in the form of a stress management programme, and to refine it through piloting to ensure that it could be used in various home-based care settings within the HIV and AIDS field in the greater Tshwane metropole.

   Fawcett, Saurez-Balcazar, Balcazar, White, Paine, Blanchard and Embree (1994:27-31) cite the following steps as being critical in this phase of problem analysis and project planning:

   - **Identifying and involving clients:** The researcher had to select a population whose issues and problems were of current or emerging interest to the clients themselves, researchers and society. The researcher was of the opinion that the target group identified, that is, the HIV and AIDS home-based care practitioners in Tshwane, met this criterion.

   - **Gaining entry and co-operation from settings:** Conversations with key informants help researchers understand what they have to offer and how to

articulate the benefits for potential participants and members of the organisations. The researcher made contact with key informants in the relevant organisations during the formulation of the research topic stage and later when recruiting and selecting both primary (home-based care practitioners [HBCs]) and secondary (the managers/supervisors of HBCs) research participants.

- **Identifying concerns of the population:** Intervention researchers must not impose their own views concerning the problem and its solution. Rather, they need to strive to understand the issues of importance to the population. Through data collection methods founded on social constructionism, the researcher ensured that the home-based care practitioners' "voices" and concerns were heard and not misinterpreted. The proposed solutions were also noted and incorporated into the prototype intervention programme, i.e. stress management programme.

- **Analysing identified problems:** The researcher had to analyse those conditions that people label as problems, including the negative consequences of those problems. What seemed to be the problem has been briefly stated in the topic "Rationale and problem statement" (see Chapter 1: section 1.3). The research project, as it unfolded, provided additional data on the dynamics surrounding the problem area, based on empirical findings and results.

- **Setting goals and objectives:** Stating broad goals and specific objectives allowed the researcher to clarify the proposed ends and means of the research project. The goal and objectives of the research project were discussed under the topic "Goal and objectives of the study" (see Chapter 1: section 1.4).

2. **Information gathering and synthesis:** When planning an intervention research project, it is important to search and discover what others have done to understand and address the problem. The information gathered from the search, may assist the researcher with functional elements that may be included in the design of the intervention (Fawcett et al., 1994:31-33).

The key aspects of this phase are identified below.

- **Using existing information sources:** In conducting a literature review, the intervention researcher must ensure that the problem area is approached from the basis of a number of disciplines, not only the social sciences or those closely linked with the social sciences. The research must contribute to both "scholarship of discovery" and in establishing new linkages between concepts and methods of various disciplines (Boyler, 1991 in Fawcett et al., 1994:32). The preceding chapters (Chapters 2, 3 & 4) have provided a sound foundation for the establishment of linkages between the concepts and methods of various disciplines, with views from public health, social work, employee wellness, sociology and psychology. A comprehensive deliberation on HIV and AIDS home-based care, stress management and the theoretical framework underpinning the study offered to provide context for the study.

- **Studying natural examples:** Interviews with people who have experienced the problem and those with knowledge about it can provide insights into which interventions may or may not succeed and the variables that may affect success. Although for the purposes of this study, the HIV and AIDS home-based care practitioners were the primary participants, the researcher also consulted senior staff, in the respective organisations, that worked directly with them and/or supervised them as secondary sources of information (see Chapter 6: section 6.3). When negotiating entry into the organisations, the senior staff were familiarised with what the study was about and its presumed feasibility and there was acknowledgement that the study would benefit the home-based care practitioners. Some of the organisations had similar programmes but had had to stop due to financial constraints.

- **Identifying functional elements of successful models:** In addition to gathering information, the researcher needs to familiarise herself with programmes and practices that have previously addressed the problem of interest. The researcher therefore, in addition to the sources of information mentioned, consulted existing stress management programmes, specifically in healthcare settings, that have been found to be effective in addressing typical concerns of healthcare workers.

The purpose was to include what worked in the envisioned programme (see Chapter 3: section 3.4).

3. **Design:** This phase is closely interrelated to the phase of early development and pilot testing (Fawcett et al., 1994:33-36). There are two important operations during this phase, as identified below.

- **Designing an observational system:** Researchers are expected to design a way of observing events related to the phenomenon under study naturalistically. In this study, data was gathered from the participants mainly through verbal communication and a written format. The data collection was carried out at their respective places of employment, environments with which they were familiar.

- **Specifying procedural elements of the intervention:** The procedural elements of the intervention should be clearly explained to allow replication by other typically trained researchers or change agents. Information gathered from the participants, relevant literature consulted and similar existing stress management programmes were used to ensure the clarity of procedural elements and replicability of the programme (see Chapter 8: section 8.2).

4. **Early development and pilot testing:** During this phase, a primitive design is evolved to a form that can be evaluated under field conditions (Fawcett et al., 1994:36-37). This involves the operations set out below.

- **Developing a prototype or preliminary intervention:** At this stage, the researcher must select and specify the preliminary intervention procedures and also establish the mode of delivery. The stress management programme for HIV and AIDS home-based care practitioners was designed using the relevant sources of information, as discussed in the previous phases (see Chapter 8: section 8.2).

- **Pilot testing:** Pilot testing is designed to determine whether the intervention will work. It is normally implemented in settings that are somewhat similar to the ones in which the intervention will be used. For the purposes of this study, the prototype intervention programme was piloted and evaluated using the comparison group pre-test - post-test design (Fouche, Delport & De Vos, 2011:150). Two groups of participants were used, with one group being the experimental group (consisting of twelve participants) and the other the comparison group (consisting of seven participants). Both qualitative and quantitative data were collected, analysed and triangulated to ensure holistic evaluation of the programme. The data assisted in identifying areas in the stress management programme that needed refinement and adjustment.

- **Applying design criteria to the preliminary intervention concept:** This applies to answering questions such as "Is the intervention effective?" and "Is it practical?" (Fawcett et al., 1994:37). The researcher ensured that all relevant input given by the participants, including other secondary sources of information, regarding modification of the programme design were incorporated in the refinement and adjustment process of the programme.

The purpose of the study was mainly programme development and evaluation, therefore, phases five and six of the intervention process were not relevant to the study (this is envisaged for post-doctoral work) and will be just briefly discussed below.

5. **Evaluation and advanced development:** Using pilot tests and field replications to test and refine the intervention is what sets intervention research apart from mere programme evaluation. It also identifies whether modifications need to be made to the content or format of the programme or both (Fawcett et al., 1994:37-39; Fraser, Ritchman, Galinsky & Day, 2009:79). To achieve this, the phase engages in four major aspects which are: selecting an experimental design; collecting and analysing data; replicating the intervention under field conditions; and refining the intervention.

6. **Dissemination:** Once the community intervention has been field tested and evaluated, it is ready to be disseminated to community organisations and other target audiences (Fawcett et al., 1994:39). This phase of the intervention process involves preparing the product for dissemination, identifying potential markets for the intervention, creating a demand for the intervention, encouraging appropriate adaptation and providing technical support for the adopters.

To summarise, the researcher engaged in applied research using the intervention research method, a sub-type of Design and Development. An overview of what each phase of the design and development intervention entailed has been given. The next topic presents an elaborate discussion of the research designs that were used in the study.

5.5 RESEARCH DESIGNS

Mixed methods was the approach that was adopted. Most authors identify four main (basic) types of mixed methods research designs (Ivankova et al., 2007:264-270 in Delport & Fouché, 2011:440-443; Creswell, 2014:219-223), namely; the exploratory, explanatory, the embedded and the convergent parallel (triangulation) mixed method designs. The convergent parallel mixed method design appeared to be the most appropriate design because it allowed data gathering from both approaches concurrently and through merging and comparing both sets of data, the researcher ensured that bias inherent in one method would be neutralised by the other, resulting in collection of trustworthy data (Creswell, 2014: 219-223; Creswell, Klassen, Plano Clark & Smith, 2011:8). In a nutshell, qualitative research designs were used in phase one of the intervention research process with both primary (HBC practitioners) and secondary (HBC practitioners' supervisors/managers) participants. The additional quantitative design was only used with the primary participants (HBC practitioners). In phase four, both qualitative and quantitative designs were used with the experimental group participants, whilst only the quantitative design was used with the comparison group. Both groups consisted of HBC practitioners.

The convergent parallel mixed methods research design and how it was implemented in the study is presented graphically as follows:

	PHASE ONE: PROBLEM ANALYSIS AND PROJECT PLANNING

	Quantitative approach	**Qualitative approach**
Research design	- non-experimental cross- sectional survey	- instrumental case study
Sampling	- 35 HBC practitioners (primary participants) selected through non-probability sampling: purposive sampling	- 35 HBC practitioners selected through non-probability sampling: purposive sampling - 5 HBC practitioners' supervisors/managers (secondary participants) selected through key informant sampling
Data collection	- Self-administered non-standardised questionnaire with ten statements (measuring job satisfaction and dissatisfaction)	- Semi-structured interviews with a schedule of ten open-ended questions for HBC practitioners - Semi-structured interviews with the supervisors/managers with a schedule of six open-ended questions
Data analysis and interpretation	- Descriptive stats, Shapiro-Wilk, Levene test for homogeneity of variances, ANOVA, Pearson correlation co-efficient, Bonferroni test	- Thematic analysis

DATA INTERGRATION

	PHASE 3: DESIGN (PROTOTYPE INTERVENTION PROGRAMME

	Quantitative approach	**Qualitative approach**
Research design	- Quasi-experimental comparison group pre-test post-test.	- Instrumental case study.
Sampling: non-probability	- Volunteer sampling. - 12 participants (HBC practitioners) recruited for the experimental group from one organisation. - 7 participants (HBC practitioners) recruited for the comparison group (no intervention) from another organisation.	- Volunteer sampling. - 12 participants (HBC practitioners who formed the experimental group) were recruited.
Data collection	- Oldenburg Burnout Inventory (OLBI), a standardised questionnaire, with 16 statements measuring work disengagement and exhaustion, administered to both groups at pre and post-test.	- Semi-structured interviews with twelve open-ended questions administered at pre-test level. - Semi-structured interviews with nine open-ended questions administered at post-test level.
Data analysis & interpretation	- Descriptive statistics, *t*-test for independent groups, ANOVA	- Thematic analysis

PHASE 4: EARLY DEVELOPMENT AND PILOT TESTING (THE PROTOTYPE INTERVENTION)

DATA INTERGRATION

RECOMMENDATIONS ON REFINEMENT AND ADJUSTMENT OF THE INTERVENTION PROGRAMME

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Figure 5.1 Convergent parallel mixed methods in IR

A detailed discussion of the implementation process as illustrated in Figure 5.1 follows.

5.5.1 Quantitative research design

The intervention research process that the researcher adopted consists of four phases. Among these phases, the quantitative research designs are applicable in phases one and four of the IR process as follows:

- **Problem analysis and project planning (phase one):** In order to gather all the relevant data from the participants to facilitate problem analysis, the researcher used the non-experimental design, specifically a **cross-sectional survey**. The cross-sectional survey is regarded as being useful for determining whether a particular problem exists within a group of participants and what the level of the problem is. Furthermore, it is perceived as scientific by social scientists as it outlines a process that can be followed, documented and replicated. It is therefore widely used for needs assessments by community development workers, and social workers as it also has the advantage of a higher response rate than mailed surveys (Babbie, 2016: 267; Fouché et al., 2011:156; Lavrakas, 2008: 860).The main limitations of the survey are that it can be time-consuming which could pose a problem with some participants and the fact that the privacy of the participant cannot be assured (Brick & Williams, 2013:39). In spite of its limitations, it was deemed relevant to the study in that it provided the opportunity to use the non-directive approach, measure the variables at the same time and be able to clarify questions to the participants in cases of misunderstanding so that it would lead to comprehensive data collection (Babbie, 2016: 267; Weinbach & Grinnell, 2015:24). The survey was therefore conducted with the HIV and AIDS home-based care practitioners (n = 35).

- **Early development and pilot testing (phase four):** For pilot testing the prototype intervention (stress management programme) and evaluation, the appropriate design chosen for this phase of the intervention research process was the quasi-

experimental design, in particular the **comparison group pre-test – post-test design.** The choice of the design was based on the premise that it allowed for clear identification of the benefits and shortcomings of the prototype intervention by comparing the pre-test and post-test results of both the experimental and comparison groups which is the main objective of this phase of IR. Application of the design involved an experimental group and a comparison group, where measurements of the variables were effected at pre-test and post-test levels with the comparison group not exposed to the intervention programme (prototype stress management programme). The value of the design lies in that it allows direct estimation of the amount of changes that occur within the individual participant and the group at post-test level and provides better control for internal validity factors. Its limitation is that, because membership to both groups is not through random selection, the groups tend to be inequivalent (Fouché et al., 2011:150; Morris, 2008:365,384). Implementation of the design consisted of the measurement of workplace stress, the dependent variable 0 (1), where no independent variable X (prototype stress management programme) was present. Subsequently an independent variable was introduced (with the experimental group only), followed by repeated measurement of the dependent variable 0 (2) for both the experimental and comparison groups. Measures of the dependent variables 0 (1) and 0 (2) were then compared in order to evaluate the two different states of the independent variable within the same group. The comparison group received both the pre-test O (1) and the post-test O (2) at the same time as the experimental group, but did not receive the treatment (Fouché et al., 2011:150). The design is summarised in Figure 5.2 as follows:

EXPERIMENTAL GROUP (n = 12)	COMPARISON GROUP (n = 7)
Step1: Pre-test measurement of variable 0 (1), workplace stress (dependent variable).	Step 1: Pre-test measurement of variable 0 (1), workplace stress (dependent variable)
Step 2: Exposure to the prototype intervention (independent variable).	Step 2: No exposure to any intervention
Step 3: Post-test measurement of variable 0 (2), workplace stress (dependent variable).	Step 3: Post-test measurement of variable 0 (2), workplace stress (dependent variable)

DATA COLLATION, COMPARISON AND INTEGRATION

Figure 5.2 Comparison group pre-test – post-test design

The researcher therefore (after data analysis), compared data from both groups, to establish whether the intervention programme had been successful in meeting the participants' support needs in terms of stress management. In the case of the comparison group, the researcher's focus was on identifying, from the pre- and post-test data gathered, if there had been any changes in their ability to cope, despite the fact that they were not exposed to the intervention programme.

5.5.2 Qualitative research design

The research project is based on social constructionism as theoretical framework, therefore, the researcher adopted the qualitative design of the instrumental case study, as the most appropriate for the study.

These research designs were implemented in the IR process as follows:

- **Problem analysis and project planning (phase one):** During this phase, the researcher gained understanding of the problem situation using the instrumental case study. The case study is defined as "an in-depth description

and analysis of a bounded system" (Merriam & Tisdell, 2016:37). The case study differs from other qualitative designs in that it is defined by the unit/s of analysis and not by the topic or problem under investigation. It thus allowed the researcher to immerse herself in the world of the unit or units being studied and to obtain intimate details about their social world and the context thereof. There are three types of case studies: the descriptive case study, the collective case study and the instrumental case study (Fouché & Schurink, 2011:320, 322; Merriam & Tisdell, 2016:37). Utilisation of the instrumental case study provided the researcher with an opportunity to learn from the HIV and AIDS home-based care practitioners and their supervisors/managers as they articulated experiences, stories, and perceptions about the problem situation. This enabled the researcher to gain the necessary insight into their world, particularly the work world and the associated workplace stress.

- **Early developments and pilot testing (phase four):** Pilot testing the intervention programme was meant to allow the researcher to refine and adjust the prototype intervention programme so that the end result would be a product that could be used in similar settings. The researcher used the instrumental case study design, again with two groups of participants, the experimental and the comparison group. The instrumental case study made it possible for the researcher to familiarise herself with how the participants experienced the prototype intervention, thus gaining the needed inputs and perspectives about the intervention (Fouché & Schurink, 2011:320, 322; Merriam & Tisdell, 2016: 37). In-depth knowledge about the merits and demerits of the prototype intervention needed to be gathered to ensure that the programme addressed the needs of the target group. Data were gathered before and after exposure to the prototype intervention programme. No qualitative data were gathered from the comparison group due to limitations experienced in gathering meaningful data from the group that had not been exposed to the prototype intervention programme.

An explanation of the implementation of the mixed methods research designs in the intervention research process was discussed above. Study population and sampling methods are discussed next.

5.6 STUDY POPULATION AND SAMPLING

The study population is defined as the population "of interest" to the proposed investigation (Davis & Scott, 2007:157). For the purposes of this study, the population was all HIV and AIDS home-based care practitioners in Tshwane metropole working for non-governmental and community-based organisations. The National Norms and Minimum Standards for Home and Community Based Care and Support Programme (Department of Social Development, 2007:14-15) states that all non-governmental and community based organisations rendering HIV and AIDS home-based care must have a minimum of ten home-based care workers and one manager.

The *Gauteng HIV-related Services Directory* (2012:77-122) cites approximately 30 non-governmental and community-based organisations rendering HIV and AIDS home-based care, distributed in six regions of the Tshwane municipality. The HIV and AIDS home-based care services of regions three and four are managed by the Department of Health, whilst region five does not have a home-based service provider as it is mainly a farming area (City of Tshwane Maps and GIS, 2010). The population was therefore estimated at approximately 300 HIV and AIDS home-based care practitioners. One home-based care organisation was purposively selected in each region of the four regions of Tshwane and recruited to participate in the research project. Purposive selection (sampling) of the organisation was based on the following criteria: it had to have been in operation for at least two years in the HIV and AIDS home-based care field; be registered with the Department of Social Development as a not-for profit organisation; have a functioning Board of Management; and have a minimum of eight home-based care practitioners. The four organisations that participated in the study met these criteria.

The second population was the managers/supervisors of the home-based care practitioners. The size of this population was estimated at 30, based on the earlier cited

minimum standards of the Department of Social Development. Three organisations that participated in the study had one supervisor/manager for the HBC practitioners and only one organisation had two supervisors/managers. All five managers/supervisors were recruited and they made themselves available to participate in the study.

Non-probability sampling was selected as being the most appropriate method for the study as it fitted in well with the mixed method approach and the target group of the study. Strydom (2011a:231) clarifies that non-probability sampling is based on the absence of randomisation and is applicable to both quantitative and qualitative approaches especially when the population is small and therefore does not present enough subjects to select randomly from. It is a selection method where the researcher uses subjective judgement and the chances of being selected among the possible research participants are unknown. The researcher selects participants from those who are available. Its main disadvantages are that it is prone to selection bias and the findings cannot be generalised to the population (Acharya, Prakash, Saxena & Nigam, 2013: 332,333; Gorard, 2013:84; Strydom 2011a:231). The researcher therefore used this sampling technique to recruit participants for the study.

Non-probability sampling techniques were used in the two phases of intervention research as follows:

- **Problem analysis and project planning (phase one): Purposive sampling** is a deliberate process of selecting participants based on their ability to provide the needed information and inputs that are in line with the elements and purpose of the study (Babbie, 2016:187; Padgett, 2008:53). The researcher utilised this sampling method as the population was small and it facilitated choosing research participants who presumably had the knowledge and experience that would enrich the study. The sampling method was used to recruit one non-governmental or community-based organisation from each of the mentioned regions in Tshwane to participate in the study. Four non-governmental organisations, one in each region of the Tshwane municipality, were successfully recruited and participated in the study. Furthermore, **purposive sampling** was again used to recruit a total of thirty-five HIV and AIDS home-based care practitioners from four organisations

who participated in this phase (organisation 1:12 participants, organisation 2: 9 participants, organisations 3 & 4: 7 participants each). In recruiting prospective participants (primary participants), the researcher targeted those who had worked as HIV and AIDS home-based care practitioners for at least one year, irrespective of age and gender. The researcher assumed that one year experience as an HIV and AIDS home-based care practitioner provided reasonable exposure to the challenges and stresses of the job. One to two managers/supervisors of the HIV and AIDS home-based care practitioners (secondary participants) were also recruited per Tshwane region using **key informant sampling.** In this type of sampling, participants are selected on the basis that they are identified and assumed to be experts in the social phenomena under study. The selected participants are usually willing and knowledgeable about the subject matter and/or the group they are commenting on. The disadvantage of this sampling technique is that the researcher does not always have the full assurance that the participants are truly the experts they claim to be (Babbie, 2016: 189; Strydom & Delport, 2011:394). Five supervisors/managers participated in the study as key informants.

- **Early development and pilot testing (phase four): Volunteer sampling** was used to recruit two groups of ten participants (an experimental and a comparison group), with whom the prototype intervention programme was tested and evaluated. This form of sampling meant that individuals offered to participate in the study voluntarily and they appeared motivated and eager to contribute towards the study. With volunteer sampling, the researcher had to be cognisant of possible group-think, especially during data collection as participants were colleagues already (Strydom & Delport, 2011:394).The reason for choosing the sampling method was based on the fact that committed participants were necessary as the pilot-testing process was not a once-off engagement, it included pre- and post-test and for the experimental group, additional time for participation in the prototype intervention. A group of five to eight members, in group work, is regarded as having enough participants to generate the required discussion and information. The researcher increased the number to ten to compensate for

potential participant drop-outs (Lindsay & Orton, 2012:26; Toseland & Rivas, 2009:167). The participants in the mentioned groups were recruited from the HIV and AIDS home-based care practitioners who participated in phase one. The participants were, therefore, recruited from two organisations that were purposely selected among the organisations that participated in phase one of the study. The experimental group, consisting of twelve participants, was recruited from one organisation and the comparison group consisting of seven participants, from the other.

During the sampling process, data saturation also needed to be considered as it pertained to the qualitative data. Data saturation is explained as being a point in data collection where no new additional data are found or themes to further develop and gain insight into the problem under study. It is cited that it is an essential guide in qualitative studies where the sample size is linked to the purpose of the study and the complexity of the experiences and views of the research participants (Francis, Johnson, Robertson, Glidewell, Entwistle, Eccles & Grimshaw, 2010:1230). The literature (from reviews of several studies that included saturation) was consulted regarding benchmarks on how many interviews are enough to reach data saturation which in turn informs sample size. Information obtained was that in determining data saturation, it should be noted that some of the realities that researchers had to contend with were time constraints (especially those in funded studies), energy to work with increasing number of participants (as interviews can be exhausting), and availability of participants (Francis et al., 2010:1242; Guest, Bunce & Johnson, 2006; Mason, 2010:6).

Consensus in the studies was that the benchmarks were a minimum of twelve interviews (12 participants) for a study where the aim was to understand common perceptions and experiences among relatively homogeneous participants and a maximum of just under sixty interviews (60 participants) (Francis et al., 2010:1242; Guest, Bunce & Johnson, 2006; Mason, 2010:13). In phase one of the study, as earlier mentioned, the sample size of thirty-five participants was well within the cited minimum and maximum data saturation benchmarks. Phase four utilised groups (experimental and comparison) and number of group members per group was also within the benchmarks of group work practice as the

membership ranged from seven to twelve which is less than the recommended maximum of 15 members (Lindsay & Orton, 2012:26; Toseland & Rivas, 2009:167).

After the sampling process had been completed and data saturation determined, the next step was data collection.

5.7 DATA COLLECTION

The mixed methods research involves collecting both quantitative and qualitative data. Researchers using this approach are therefore encouraged to choose creative qualitative data collection methods and careful selection of quantitative instruments that do not extend beyond those needed to answer the research questions (Creswell & Plano Clark, 2011:179). The quantitative and qualitative data gathering methods are discussed separately as set out below.

5.7.1 Quantitative data collection methods

For the quantitative part of the study, a non-standardised self-administered questionnaire and a standardised questionnaire, the Oldenburg Burnout Inventory (Demerouti & Bakker, 2007) (Appendices C & F), were used to gather data from the participants on the problem under investigation.

The non-standardised questionnaire (Appendix C) was administered individually to participants during **phase one** of the intervention research process (problem analysis and project planning) only. It consisted of ten statements focusing on the incidence and their experience of workplace stress (burnout included) and support available. The first five statements measured job satisfaction whilst the remaining five statements measured job dissatisfaction. The responses to the statements were ranked similarly to a Likert scale, which is a scale that typically has five to seven points that the respondents use to rate their degree or intensity of agreeing or disagreeing with a statement (Hampson, 2014:3; Sullivan & Artino, Jr, 2013:541). The questionnaire ranking ranged from one to four, with strongly disagree as one, disagree as two, agree as three and strongly agree as four.

With **phase four** (early development and pilot testing), the Oldenburg Burnout Inventory questionnaire (Appendix F) was group administered, to the experimental group before and after exposure to the programme. The Inventory was also administered to the comparison group, although they were not exposed to the stress management programme. The Oldenburg Burnout Inventory is a questionnaire with 16 items that measure disengagement and exhaustion in the workplace. Demerouti and Bakker (2007:2) explain that the instrument was developed for, among others, people who work in healthcare and those who do white collar work. The instrument is in the public domain and no permission is required for use. The use of the Professional Quality of Life Scale (Stamm, 2005:3), Malsach Burnout Inventory - Human Service Survey (Demerouti & Bakker, 2007:3) and Utrecht Work Engagement Scale (Schaufeli, Bakker & Salanova, 2006:702) were considered but they were found inappropriate for the present study. The ProQol (Professional Quality of Life Scale) has an additional scale, namely Compassion Satisfaction, which is not applicable to this study (Stamm, 2005:5). Utrecht WES, on the other hand, focuses on work engagement, the opposite of burnout, and does not have a scale for work stress (Schaufeli et al., 2006:702). Lastly, the Malsach Burnout Inventory is the predecessor of the Oldenburg Burnout Inventory and needed revision as it had measurement limitations arising from the one-directionality of the wording (either positive or negative) of the items on the scale (Demerouti & Bakker, 2007:3).

The Oldenburg Burnout Inventory, although originally constructed in German, was translated into English and a study to test its reliability and validity of the translated version was conducted in the USA with a wide variety of professionals (healthcare workers included). Results obtained validated the reliability, factorial validity and construct validity for the instrument. The questionnaire was further successfully implemented in South Africa, specifically the construction industry (Demerouti & Bakker, 2007:4; Demerouti, Mostert & Bakker, 2010:219; Halbesleben & Demerouti, 2005:217-218). The value of the Oldenburg Burnout Inventory instrument is that it was developed specifically to assess workplace stress (including burnout) among human service professions. HIV and AIDS home-based care practitioners are in the same field of work. Secondly, it is an improved version of the Malsach Burnout Inventory that has been extensively used previously in

measuring stress (including burnout) in the workplace, including, among others, human service professions.

In this study, the Oldenburg Burnout Inventory was implemented as a group administered questionnaire, where the participants completed the questionnaires on their own with the researcher being available for clarification should it be necessary. In so doing, the researcher limited the possibility of bias, especially with the group, as they were not able to discuss responses (Delport & Roestenburg, 2011:188-189, Hampson, 2014:6). The researcher adhered to this recommendation and was only available to clarify instructions and misunderstood questions.

5.7.2 Qualitative data collection methods

For this part of the study, the researcher used the semi-structured interviews with interview schedules. Greeff (2011:351) explains that researchers normally use this type of interviewing to gain a detailed picture of the participants' beliefs about, or perceptions or accounts of, a particular topic. With the semi-structured interview schedule, the interview was guided rather than dictated by the schedule, thus giving the researcher the flexibility of gaining better understanding of the participants' responses. Some of disadvantages of interviewing are cited as: interruptions; competing distractions; teaching, preaching and counselling by the researcher; revealing own response (researcher); superficial interviews; and the use of translators (Gary, 2015:138; Greeff, 2011:346-7). The researcher managed these challenges by preparing the participants prior to the interview about the process to clarify what was expected of them and this was also be covered during the consent process. An effort was also be made to ensure that the setting where the interviews would take place is private and not subject to interruptions. No translators were used and the researcher fully assumed the role of social researcher and de-roled from other professional roles.

Furthermore, the researcher used interviewing techniques to ensure that the interviews were conducted in a professional manner, the shortcomings of interviewing are contained and to elicit as much information as possible from the participants. Specific techniques

used included putting the participant at ease at the start of the interview by beginning with biographical questions, not infringing on the participant's privacy by avoiding personal questions, maintaining eye contact, using appropriate probes to get clarification and more information, when summarising always checking with the participant that what he/she said had been captured correctly especially that the researcher was interviewing in mother tongue and translating into English, monitoring the duration of each interview to ensure that it did not exceed the recommended forty-five minutes (managing interviewee fatigue) and terminating each session on a positive note through expressing appreciation for their time and assistance (Gary, 2015:137,139; Jarbandhan & Schutte, 2006:677-678; Leeuw, 2008:317-318)

The data collection process was implemented in the phases of intervention research as follows:

- **Problem analysis and project planning (phase one):** A separate interview schedule (Appendix D) was used with ten questions for the primary participants, the HIV and AIDS home-based care practitioners. The semi-structured interview schedule consisted of Section A that addressed biographical data about the participants and Section B that had ten open-ended questions ranging from what attracted the home-based care practitioners to the work, the challenges they faced, the highs and lows of the work, stress, coping mechanisms and their suggestions for support.

  Another shorter interview schedule (Appendix E), consisting of only six open-ended questions,   was used for the managers/supervisors. This short interview schedule focused mainly on the managers/supervisors' perceptions of what challenges the primary participants faced and what workplace support systems were available, as well as their effectiveness where applicable.

- **Early development and pilot testing (phase four):** Another semi-structured interview schedule was developed for data collection with the experimental group before and after exposure to the programme for pilot testing the stress management programme. The aim of the pre-test interview schedule (Appendix G) was to gather information mainly on the workplace challenges the participants

faced, including stress, coping mechanism used, if they were coping in the first place, and what their expectations were regarding the intervention programme. The post-test interview schedule (Appendix H) looked at the workplace challenges and coping mechanisms, the only difference was that it asked participants if their pre-test expectations had been met and requested suggestions for improvements of the programme. The pre-test interview schedule consisted of twelve open-ended questions, whilst the post-test schedule consisted of nine open-ended questions. In addition to the interviews, the participants completed session evaluation forms after each session. The purpose was to capture an evaluation of individual sessions including the facilitation process as the programme unfolded from session to session.

Through the data collection instruments mentioned, the researcher was able to establish whether the programme met the support needs of the participants. To achieve this, the data had to be analysed.

5.8 DATA ANALYSIS

Two types of data sets had to be analysed, namely quantitative and qualitative data, in line with the mixed methods approach of the study.

5.8.1 Quantitative data analysis

In quantitative research, the researcher analyses the data based on the type of questions and used the appropriate statistical tests to answer the research questions. The choice of statistical test was based on the type of questions asked, the number of independent and dependent variables, the type of scales used to measure those variables, and whether the variable scores are normally or non-normally distributed (Creswell & Plano Clark, 2011:207).

The researcher, with the assistance of a statistician from the Department of Statistics (University of Pretoria), analysed data from the survey questionnaire and the Oldenburg

Burnout Inventory using the Statistical Package for the Social Sciences (SPSS), Version 24.

More specifically, the quantitative data was analysed in phases one and four of the intervention process as follows:

- **Problem analysis and project planning (phase one):** Descriptive and association statistical methods, that is procedures that describe numerical data so that it can be organised, summarised and interpreted (Monette et al., 2008:414, in Fouché & Bartley, 2011:251), were used to analyse the coded data gathered from the non-standardised survey questionnaire. Although the workplace support needs of the HIV and AIDS home-based care practitioners was the main variable measured, this was operationalised in the compilation of the questionnaire as job satisfaction and dissatisfaction. The self-administered non-standardised questionnaire (Appendix C) as earlier mentioned, consisted of ten statements. The first five statements (1-5) measured job satisfaction, whilst the last five statements (6-10) measured job dissatisfaction in HIV and AIDS home-based care. Job satisfaction is simply explained as how content you are with your job whilst job dissatisfaction is the opposite, meaning, how discontent you are with your job (Costen, 2012:292; Singh & Jain, 2013:105). Responses to the statements were either strongly disagree, disagree, agree or strongly agree. Furthermore, they were coded for statistical analysis with 1 (strongly disagree) up to 4 (strongly agree). To guide the participants in the completion of the questionnaire, they were instructed as follows; "indicate your level of agreement with the following statements." The participant then circled the response that closely represented his/her opinion. Once all the participants had completed their questionnaires, their responses were coded. The process of coding the data was done through descriptive statistical methods which is a method of transforming numerical data so that it can be organised, summarised and interpreted (Monette et al., 2008:414, in Fouché & Bartley, 2011:251).

  Univariate analysis, which provides analytical information for one variable, was computed for the biographical data of the participants that was extracted from the

questionnaire, specifically age, highest qualification level and years of experience as home-based care worker. This was implemented through frequency distributions using tables, graphs and measures of central tendency (Monette, Sullivan & DeJong, 2008:373; Singh, 2007:125). Bivariate analysis was regarded as the most appropriate method of analysing the questionnaire data because, in order to extract valuable and workable data from the questionnaire responses, it was essential to compare the data with significant biographical data, that is; age, highest qualification level and years of work experience (Fouché & Bartley, 2011:266; Singh, 2007: 126). Such findings were considered to be significant in the compilation of the proposed stress management programme as they shed light into which specific target group should be the main focus of the programme.

The statistical tests used to analyse the data were descriptive statistics which presented the mean, median and standard deviation of the scores obtained, the Shapiro-Wilk test used to calculate whether the scores displayed a normal distribution and the Levene's test tested for homogeneity of variances. The one-way analysis of variance (ANOVA) was also computed after it was confirmed that the scores had a normal distribution and variances were homogenous. The ANOVA evaluated whether the means in each group differed significantly. The Bonferroni test, a post-hoc multiple comparison test, was used to authenticate the significant ANOVA by introducing various comparisons of job satisfaction and age groups (Marsh & Elliott, 2008:187; Privitera, 2016:289,302). A further test, the Pearson correlation-coefficient (r) was also introduced to measure the strength and linear direction of the relationship between age and job satisfaction and dissatisfaction scores of the participants after a significant effect of age group on job satisfaction was found (Moore, 2010:105,107; Salkind, 2017:127-129). The level of significance, a criterion of judgement upon which a decision is made regarding the value stated in the null hypothesis, was established at 0.05, which is a commonly used value in the social and behavioural sciences. Such a level of significance basically means that results from the mentioned comparisons of variables are only meaningful if their p-value is below 0.05, that is, $p<0.05$ (Marsh & Elliot, 2008:151; Privitera, 2016:182).

- **Early development and pilot testing (phase four):** Association statistical methods, specifically bivariate analysis, were utilised to analyse the measurements from the Oldenburg Burnout Inventory (Appendix F), that is, disengagement and exhaustion for both the experimental and comparison groups (Rubin & Babbie, 2008:493, in Fouché & Bartley, 2011:266). Furthermore, measurements of both groups at the pre-test and post-test levels on disengagement and exhaustion were compared. The research results obtained from the two groups of participants were firstly analysed through descriptive statistics (mean, standard deviation and median). Additional statistical tests, suitable for analysing data from two individual groups, had to be chosen to analyse the data further. To make a decision about which test to use, the Shapiro-Wilk test was computed to calculate the normality of distribution of scores and the Levene's test to test for homogeneity of variances. The tests confirmed normality of distribution and homogeneity of variances. Based on the confirmation of the mentioned tests, the *t*-test for independent groups and analysis of variance (ANOVA), were then chosen as the statistical tests to identify the differences in scores between the experimental group who attended the prototype intervention programme and the comparison group who did not attend intervention programme. The *t*-test mainly compares the differences between the means of the two groups and assists the researcher to understand how the two groups differ. The level of significance was again established at 0.05 ($p = 0.05$) (Pietersen & Maree, 2007:233; Privitera, 2016:182,240,289).

5.8.2 Qualitative data analysis

Creswell and Plano Clark (2011:208) mention that qualitative data analysis involves coding the data, dividing the text into small units, assigning a label to each unit, and then grouping the codes into themes. The researcher used thematic analysis to analyse the data gathered through semi-structured interview schedules with HIV and AIDS home-based care practitioners and their managers/supervisors.

Babbie and Mouton (2011:492, 412) postulate that, according to Roller, Mathes and Eckert (1995:167), thematic analysis is "on the most general level, any technique for making inferences by objectively and systematically identifying specified characteristics of messages." In thematic analysis, the coding process is inherent in data collection or observation.

After completion of data gathering in each of the specified phases of intervention research process (phases one and four), the data was organised into themes and sub-themes so that the process of data analysis could occur simultaneously with the research process. In order to achieve this, the researcher followed the data analysis process as described by Schurink, Fouché and De Vos (2011:403-419), adopted from Creswell (2007:150-155) and Marshall and Rossman (1999:152-159).

Data were therefore analysed using the steps described below.

- **Step one: Preparing and organising the data.** The main activities in this stage were planning for recording the data, data collection and preliminary analyses, managing the data, reading and re-reading the data and writing memos to ensure intimate familiarity with the data (Clarke & Braun, 2013: 121; Schurink et al., 2011:403-405) The researcher recorded the data by taking notes as she interviewed the participants (primary and secondary participants) and made an audio recording to ensure that she captured all that the participants were communicating. This was followed by putting memos to the notes to identify patterns and common concepts that facilitated the coding process. This was an on-going process that the researcher engaged in, as she gathered data from the participants at each phase (phases one and four) of the intervention research process.

- **Step two: Reducing the data.** This stage involves generating categories and coding the data, testing emergent understandings, searching for alternative explanations, interpreting and developing typologies, capturing semantics and other important concepts emanating from the data. Clarke and Braun (2013:121) recommended two additional steps in the data reduction process, namely, reviewing themes, where the researcher checks whether the themes portray a

convincing and compelling story about the data, and defining and naming themes which involves identification of the essence of the themes and how they fit in the overall story of the data (Clarke & Braun, 2013:121; Schurink et al., 2011:410-418). The researcher first coded the data (through open coding), assigning coloured labels to similar words/meanings in responses, recurrent ideas, patterns of ideas, phrases and any other concepts/ideas that were identified as the researcher worked on reducing the data. Once the data had been coded, it was categorised into themes and sub-themes. The audio-recorded data was used to assist the researcher in checking the accuracy of the notes taken on the participants' responses. The researcher used the process of coding and categorising to identify emergent understandings, gaps in data gathered and any alternative explanations of the data. With regards to the interpretation of the data, the researcher used the two typologies, namely the emic approach which is interpreting data as narrated by the participants (from the participants' point of view), in line with the theoretical framework of social constructionism. The etic approach, was also used to validate participants' narratives about the problem under investigation through the literature and findings from similar studies (Schurink et al., 2011:417).

- **Step three: Visualising, representing and displaying the data.** Biographical data of the participants, the data categories and accompanying themes and sub-themes are presented visually in tables and graphs at each phase of the intervention research process (phases one and four) (Schurink et al., 2011:418).

When analysing qualitative data, the researcher had to check objectively whether the data presented truly represents the views and opinions of the research participants. For that purpose, it had to be subjected to rigorous examination for quality assurance. The next topic elaborates on the process.

5.8.2.1 Data quality

When conducting research, the highest possible quality and standard of reporting is sought to capture accurately and reflect what transpired during investigation of the

problem situation (Cope, 2014:89). In line with the mixed methods approach, data quality assurance is discussed in both qualitative and quantitative approaches. From the quantitative approach validity and reliability are discussed, whilst from the qualitative approach data trustworthiness is considered.

5.8.2.1.1 Validity of quantitative data

Validity is defined as the extent to which a concept is accurately measured by an instrument in quantitative research (Heale & Twycross, 2015:66). To establish validity for the survey questionnaire (Phase One), content validity was used. Content validity examines whether the instrument measures all the content that should be covered regarding the variable under investigation (Calnan, 2007:180; Heale & Twycross, 2015:66). Guided by information gathered from the literature review of questionnaires on workplace stress and burnout in healthcare, the researcher formulated the statements on the questionnaire in such a way that they reflected the variables under study. The researcher also enlisted the assistance of an experienced researcher and colleagues with the content validity of the statements. The only change recommended was the use of terminology that was very simple and easy to follow, given that some of the participants did not have a Grade 12 qualification and English is their second language. The necessary changes were effected. The validity of the Oldenburg Burnout Inventory (Phase Four) had previously been established as it is a standardised questionnaire in the public domain (Demeorouti & Bakker, 2007:16).

5.8.2.1.2 Reliability of quantitative data

Reliability refers to the instrument's ability to measure consistently what it claims to measure. With regard to reliability of the survey questionnaire (Phase One), internal consistency reliability was used through the Cronbach Alpha to establish whether the questionnaire was able to illicit the same responses after repeated use. The Cronbach Alpha is cited as the frequently used test for internal consistency reliability. The Cronbach Alpha was calculated for both job satisfaction and dissatisfaction and the values obtained for job satisfaction was 0.75, whilst for job dissatisfaction it was 0.72. The alpha correlation values fall within the acceptable range of reliability which is that the value has to be 0.7 and higher (Alwin, 2007:10; Heale & Twycross, 2015:66-67). With regards to

the Oldenburg Burnout Inventory, the internal consistency reliability for healthcare workers was confirmed with a Cronbach Alpha of .84 (Demerouti & Bakker, 2007:16). The Oldenburg Burnout Inventory Cronbach Alpha was not re-calculated as the sample size in Phase Four was below 25 participants.

5.8.2.1.3 Trustworthiness

For a research study to be meaningful and significant in the generation of knowledge, it had to be trustworthy. This implies that it has to be carried out in a fair and ethical manner and its findings should represent as closely as possible the experiences of the participants. It has to maximise objectivity and minimise bias (Rubin & Babbie, 2010:231; Steinmetz, 1991, in Padgett, 2008:184-186). The researcher has to demonstrate, through data analysis and interpretation, that the findings reflect the thoughts, feelings and the opinions of the research participants. The researcher has to ensure that his/her reactivity and bias does not contaminate the data (Lietz, Langer & Furman, 2006:444).

To ensure trustworthiness the researcher focused mainly on establishing the credibility of the study through the strategies of triangulation, peer debriefing, and member checking (Babbie & Mouton, 2011:277). With **triangulation** the researcher used the mixed methods approach. Both qualitative and quantitative approaches were used in the study resulting in both quantitative and qualitative data collection. This process of using multiple sources of data ensured that any bias or loopholes that were identified in one method, were neutralised by the other, resulting in clearly articulated and comprehensive presentation of the data gathered (Cope, 2014:90).

With **peer debriefing**, a qualitative researcher is required to enlist the support of peers and/or other professionals to improve the quality of the research findings (Anney, 2014:276). The researcher engaged a fellow doctoral researcher to peer review analyses, views and interpretations of the data. The reviewer was firstly familiarised with the study and its procedures to ensure that the review would be objective. She was provided with the relevant research report material. This was followed by a consultation session that involved a discussion of the study materials. The process assisted with accurate capture of the views of the participants in light of the fact that some of the inputs had to be translated to English.

Finally, through **member checking**, the researcher ensured that the voices and meanings of the participants were reflected as expressed. The researcher engaged the participants in checking whether the themes that emerged from data analysis reflected accurate interpretation of what they expressed during data collection (Anney, 2014:277; Cope 2014:90). The researcher verified data that were unclear with the respective participants to ensure that their views had been accurately captured. Member checking involved face to face interactions and telephone discussions. The audio recorder was also useful in this regard, as the research was able to play the recorded interviews several times to ensure accurate capturing of inputs.

5.9 PILOT STUDY

A pilot study can be viewed as the dress rehearsal of the main investigation (Strydom, 2011b:237). It is similar to the researcher's planned investigation, though on a smaller scale. The intervention research process dictates that the researcher pilot tests the data gathering instruments and the prototype intervention programme at phase four of the process (Fawcett et al., 1994:36-37). This had been discussed already under the heading "data collection." The qualitative and quantitative data collections instruments were therefore pilot tested in phase four of the intervention research process.

In the case of phase one, the researcher pilot tested the survey questionnaire and semi-structured interview schedule with four HIV and AIDS home-based care practitioners. The semi-structured interview schedule of the supervisors/managers was piloted in a similar way, with one supervisor. These participants were not part of the main intervention research study. Feedback from the pilot study was that some of the terminology from the questionnaire was not simple enough for an individual without a Grade 12 qualification and English as a second language. The specified statements in the questionnaire were amended as recommended. The interview schedules, on the other hand, were left as they were and no changes or modifications suggested.

In phase four, there was no need to pilot test the Oldenburg Burnout Inventory as it is a standardised questionnaire. The pre-test and post-test interview schedules were peer

reviewed by a psychometrist who suggested modification of the sequence and numbering of the open-ended questions. Again the suggested amendments were effected. The piloting process adequately assisted with identification of the shortcomings of the data collection instruments, and the necessary changes and amendments were made.

5.10 ETHICAL CONSIDERATIONS

Babbie and Mouton (2011:520-527) summarise as follows the most important ethical agreements that prevail in social research, which were also applicable to this study:

- **Voluntary participation:** when recruiting prospective participants for phase one and phase four of IR, the researcher emphasised the voluntary nature of participation in the study and that they were allowed to "drop out" at any stage of the research process should the need to do so arise. This voluntary participation was also included in the research consent forms to ensure that there were no misunderstandings (Babbie & Mouton, 2011:521).

- **No harm to the participants:** the researcher was cognisant of the fact that through this study, particularly during needs assessment (phase one), she was asking participants to share confidential information about their work life and experiences thereof. Some emotional harm was expected in light of the fact that they might have re-lived some of the trauma they experienced in their work. The researcher made herself available for debriefing the participants. None of the participants came forth to request the service either directly to the researcher or through their supervisors/managers in both phase one and four (of IR). The researcher's colleague (a social worker), Ms Tshikalange, was also on stand-by should the participants have requested any further counselling and support (Babbie & Mouton, 2011:522).

- **Violation of privacy and confidentiality:** In both phase one and phase four of the study, the researcher protected the privacy of the participants by asking them not to write their full names on questionnaires and interview schedules. Each questionnaire and interview schedule was numbered for administrative purposes.

Furthermore, the researcher assured participants of confidentiality in both phase one and four by clarifying and explaining some of the professional ethics that the researcher, as a social worker, has to abide by. All completed questionnaires and interview schedules are securely stored by the researcher and she has sole access to the storage (Babbie & Mouton, 2011:523).

- **Deceiving subjects:** the researcher fully disclosed all the information that the participants needed to know to make an informed decision about participation in the study. The researcher is bound by research and professional ethics to treat clients, in this case participants, with dignity and respect. The purpose of the study, including details of the research process from start to finish was clearly explained to all the research participants during recruitment (Babbie & Mouton, 2011:525).

- **Analysis and reporting:** on completion of the research report, the researcher will make it available to the participants electronically through a soft copy and also publishing the study in reputable academic journals. The aim is for the participants to have access to the research product as they contributed in its creation (Babbie & Mouton, 2011:526).

Strydom (2011c:117, 122-123) added the following ethics that the researcher found relevant:

- **Informed consent:** the researcher had a briefing session, which formed part of the recruitment drive, informing the prospective participants (home-based care practitioners and their managers/supervisors) what the research was about to enable them to make informed decisions. This information was also included in the consent form. The home-based care practitioners and their managers/supervisors had different informed consent forms (Appendices J & K). All questions regarding their participation and the study were answered to ensure that all concerns were addressed and clarified. Use of the audio recorder was also explained to the prospective participants and their consent sought. The informed consent forms therefore had a cover page giving background information about the study, followed by what the prospective participants were

consenting to by participating in the study, including the fact that the research records are archived for 15 years in line with University policy. Another informed consent form was developed and used for the pilot testing phase of the stress management programme with the experimental and comparison groups, respectively (Appendices L & M) (Strydom, 2011c:117).

- **Actions and competence of the researcher:** the prospective participants were assured of the researcher's competence as she explained that she is a registered social worker with the South African Association of Social Service Professions (SACSSP), a statutory body, and had extensive experience as a social worker in the healthcare field and presently working in the employee well-being services field. Furthermore, the researcher provided a letter to the participating organisations detailing her qualifications, registration with the university and the supervisor's contact numbers before starting with the recruitment of participants. Her association with Hivsa, a reputable training organisation in the HIV and AIDS field also added to her credibility (Strydom, 2011c:123).

- **Obtain authorisation to conduct the study:** the researcher approached directors of non-governmental and community based organisations in each of the four regions of Tshwane municipality. Background information on the study was provided, including the benefits of participating in the study through a written motivation letter. This was followed up by telephonic contacts and meetings. Four permission letters were then issued by the respective organisations (Appendix B). An ethical clearance letter (Appendix A), reference GW20150515HS, was also issued by the Research Ethics Committee granting the researcher permission to proceed with the study.

5.11 LIMITATIONS OF THE STUDY

The following limitations of the study were identified:

- The sample in phase one (problem analysis and project planning) was small and, therefore, the research findings and results could not be generalised to the population.

The main reason for the small sample was that in 2015 the Gauteng Department of Health started a process of absorbing the home-based care workers and other lay community health workers who worked in non-governmental organisation partners, into the public health service. This reduced the number of Tshwane regions that participated in the study from six to four. The other reason was that, among the non-governmental organisations that participated in the study, funding challenges for the home-based care programmes were experienced. The participants struggled with transport fare to be available for research purposes and therefore the expected maximum number of participants per organisation was not possible. The majority of the home-based care workers worked in communities that were far and on the outskirts of towns. They were mainly based in the communities they serviced and only reported to the organisations' office once a week. With the drying up of funding, some resorted to casual work to make ends meet and therefore were not available to participate in the study even when transport money would be provided.

- The time allocated per session for the implementation of the stress management programme was limited. The sessions were conducted on the home-based care practitioners' office day as the other days they did fieldwork. The researcher had constraints in terms of extending the session allocated time as she had to ensure that such extensions did not compromise the work programme of the home-care practitioners.

- An important point is the validity of the Oldenburg Burnout Inventory among HIV and AIDS home-based care practitioners who use English as a second/third language. The results obtained from the measurements obtained from the OLBI in Phase Four raised concerns as to whether the pilot study participants understood the statements of the questionnaire given that there was no clear confirmation from the results as to whether the prototype intervention programme was effective or not.

- The physical setting of the training room for pilot testing was not conducive to optimal participation by the participants and it was the only room that could be used. The room was not well lit and ventilated. The implementation of the intervention programme was carried out in the summer months and the heat affected concentration and participation, in spite of short breaks.

5.12 SUMMARY

Through the various topics of this chapter, a detailed explanation has been given on the step by step plan for the study, guided by the research questions. The mixed methods approach and the intervention research process provided the researcher with procedures and guidelines that made it possible to gather as much data as possible from the HIV and AIDS home-based care practitioners in Tshwane. The compilation of the proposed stress management programme, therefore, will not only rely on input from experts in the field and existing studies and literature, but also on input from those who are experiencing the stress and burnout on the ground.

In carrying out the research, the ethical considerations remain important in ensuring that, like any other social work intervention, participants' rights are protected, respected and the research process is empowering rather than disabling. The limitations of the study are also stated to highlight the constraints experienced in the execution of the study.

The next chapter then focuses on how the qualitative data gathered in phase one of the intervention research were analysed and interpreted.

CHAPTER 6

QUALITATIVE RESEARCH FINDINGS: PROBLEM ANALYSIS AND PROJECT PLANNING (PHASE 1)

6.1 INTRODUCTION

In order to establish what the workplace support needs of the HIV and AIDS home-based care practitioners were, they had to be consulted. The consultation process in this research process involved using both qualitative and quantitative data collection methods as explained in the previous chapter.

The focus of this chapter is to present and discuss the qualitative data gathered from the primary participants, the HIV and AIDS home-based care practitioners, and their managers/supervisors. A semi-structured interview schedule (Appendix D), consisting of ten open-ended questions, was used to collect data from the HBCs. The questions posed ranged from what attracted the home-based care practitioners to the work, the challenges they face, coping mechanisms and their suggestions for support. Furthermore, data were also gathered from the managers/supervisors of home-based care practitioners, using a similar instrument, a semi-structured interview schedule (Appendix E). The latter schedule consisted of six open-ended questions that focused mainly on the managers/supervisors' perceptions of challenges faced by the primary participants and available workplace support systems.

The semi-structured interviews for both the primary and secondary participants were conducted in the participants' vernacular and then translated to English. In some cases the translation was done in the presence of the participants to ensure that their responses had been correctly captured. An audio recorder was also used which the participants had consented to when they signed the informed consent form. The recorder served as back-up to compare and contrast the translated interview responses of the participants. This

process played a significant role in ensuring that the voices of the participants were accurately heard and captured.

In each section, the biographical data of the participants are outlined, followed by a discussion of the emerging themes and sub-themes from the data. Triangulation of both sets of data is then discussed, mainly to highlight patterns of differences and similarities. The process assisted the researcher in identifying the felt workplace support needs of the home-based care practitioners that the proposed stress management programme had to address.

6.2 SECTION A: HIV AND AIDS HOME-BASED CARE PRACTITIONERS

Altogether thirty-five primary research participants were interviewed from the different regions of Tshwane. Their biographical profiles and themes and sub-themes from the data gathered are discussed below.

6.2.1 Biographical profile of the home-based care workers

The following biographical data are discussed: gender, age, population group, educational qualifications, marital status and lastly, years of experience as an HIV and AIDS home-based care worker.

6.2.1.1 Gender

The participants consisted of 32 females and only 3 males. Dominance of females in home-based care work was also found by Lehmann and Sanders (2007:7) in their investigation of several studies related to home-based care. It appears that such trends are largely influenced by societal practices and beliefs regarding gender roles (Lehmann & Sanders, 2007:6), namely that females are supposed to be carers of the ill and dying.

6.2.1.2 Age

The age of the participants ranged from 24 years to 65 and it is presented as follows:
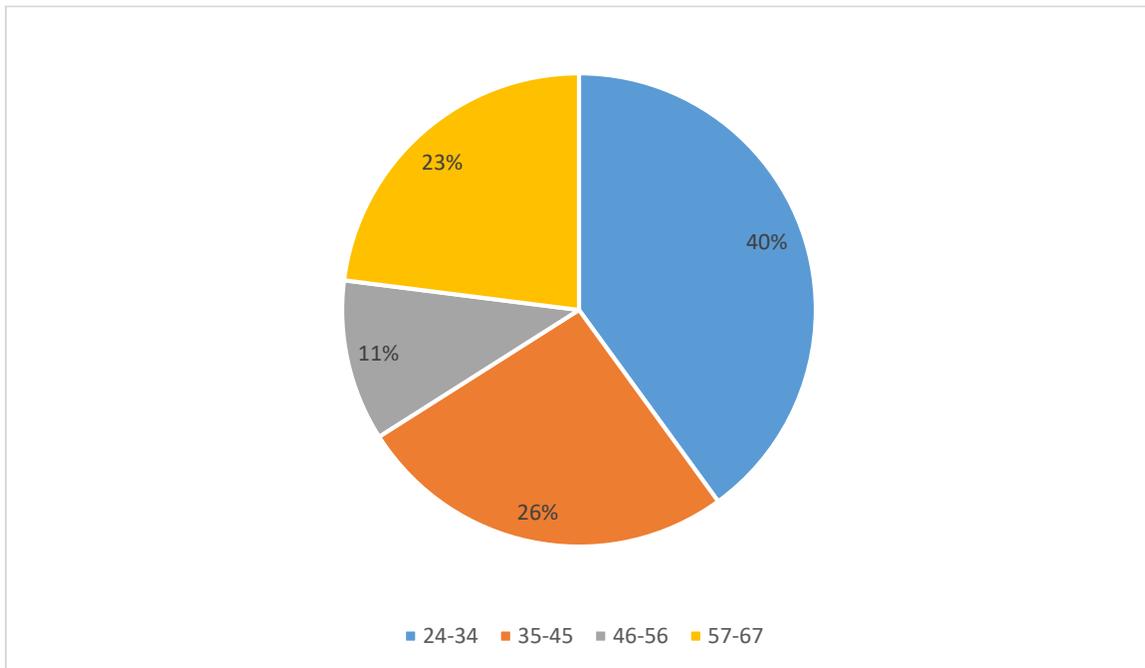
Figure 6.1: Age of the home-based care workers

Figure 6.1 shows that the majority of the participants fell within the 24-34 years group, confirming the assertion that home-based care workers are mostly young adult women who still have the capacity and energy to do physically demanding work (Ntobeng, 2016:14).

6.2.1.3 Population group

The group consists of 34 Africans and 1 Coloured person. The participants work in predominantly African communities as home-based care workers are supposed to be from the communities they serve. The data confirm that the national guidelines were adhered to in the selection process (Department of Health & Department of Social Development, 2009:45).

6.2.1.4 Educational qualifications

Among the participants, their education qualifications ranged from those with no formal school education to those with a post-matriculation certificates. The data are presented in **Table 6.1**.

Table 6.1 Educational qualifications of the home-based care workers

EDUCATIONAL QUALIFICATION	NUMBER OF PARTICIPANTS (n)
No formal schooling	1
Grade 1-7	2
Grade 8-11	17
Grade 12	12
Post grade qualifications	3

The majority of the participants are those with Grade 8 to 11. The National Department of Health and the National Department of Social Development (2009:46) stipulate that the minimum qualification for home-based care workers is a Grade 12 certificate. Those without a matric go through Adult Basic Education and Training which the employer organisations have to provide in collaboration with the Department of Health and the Department of Social Development (Department of Health & Department of Social Development, 2009:46; Department of Social Development, 2007:15). The lack of a Grade 12 certificate should therefore not be used to prevent those willing to become home-based care workers to join the programme.

6.2.1.5 Marital status

The marital status of the participants varies (see Table 6.2).

Table 6.2 Marital status of the home-based care workers

MARITAL STATUS	NUMBER OF PARTICIPANTS (n)
Married	6
Widowed	2
Single	26
Other	1

As indicated in Table 6.2, a large proportion of the participants were single. There is a possibility that this is linked to the fact that most of the participants were within the age group of 24-34. The data then puts the participants in early adulthood, according to the psychosocial theory of human development of Erickson, which is from 20 to 39 years of age. It is further proposed that it is a developmental stage where the individual is preoccupied with establishing intimate relationships with other adults and at the same time retaining a sense of self. Common personality traits during this stage are said to include agreeableness, well-organised, reliable, hardworking, driven and responsible and openness to experience (Gardiner & Kosmitzki, 2011:198; Walker & Crawford, 2014:120). It can be assumed then that it is a stage where the individual is pursuing finding a life partner to share and experience intimacy and commitment in a relationship.

6.2.1.6 Years of experience as home-based care worker

The minimum requirement for participation in the study was at least one year experience as a home-based care worker. Although this was specified during the recruitment process, there were participants who did not have one year experience but on average, between six months and one year. These participants were included in the study to obtain a holistic picture. The data are presented as follows:

Table 6.3 Years of experience as a home-based care worker

YEARS OF EXPERIENCE	NUMBER OF PARTICIPANTS (n)
Less than 1 year	6
1 to 5 years	21
6 to 11 years	6
More than 11 years	2

The data suggest that the majority of the participants fell within the 1 to 5 years of experience as home-based care workers. The researcher's view is that it is a reasonable amount of time for an individual to be exposed to the realities of home-care work and be able be to "tell a story" about his/her experiences.

The biographical data presented familiarised the reader with who the participants were and what experiences and knowledge they brought to the research project. The focus now shifts to the themes and sub-themes extracted from the information they shared with the researcher.

6.2.2 Themes and sub-themes from the home-based care workers

Data gathered from the home-based care practitioners using the semi-structured interview schedule were thematically analysed, and in the process, data were also coded (Babbie & Mouton, 2011:412,492; Roller, Mathes & Eckert, 1995:167 in Babbie & Mouton, 2011:492). From the coding, phrases were identified which eventually led to themes and sub-themes. The whole process of data analysis was guided by the social constructionism theoretical framework to ensure that the themes and sub-themes, although translated, reflected the voices of the participants as experts of their own social reality. Each theme together with its accompanying sub-theme/s are discussed separately, supported both by verbatim quotations of the participants, and possible explanations from both the theoretical framework (social constructionism) underpinning this study and literature. These are tabulated as follows:

Table 6.4 Themes and sub-themes from the primary participants

THEMES	SUB-THEMES
1. Appeal of home-based care: What sparked the interest in home-based care?	1.1 Altruism: passion to help others in need 1.2 Home-based care as an employment opportunity
2. Work routine of home-based care	
3. What home-based care workers perceived as challenges in execution of their duties	3.1 Experience of the work as emotionally challenging 3.2 Lack of material resources that affect the ability to meet patients' needs. 3.3 Challenges emanating from patient care.
4. Motivators in home-based care work	4.1 Personal appreciation 4.2 Patient recovery 4.3 Non-specific motivators
5. Home-based care workers' suggestions for improvement of workplace support	
6. Home-based care worker qualities that promote resilience	6.1 Work attitude 6.2 Conduct 6.3 Values

Theme 1: Appeal of home-based care: What sparked the interest in home-based care?

The theme "appeal of home-based care" explored, from data gathered, what attracted the participants to this kind of work, in light of the inherent challenges of healthcare work, particularly in the field of HIV and AIDS. Two sub-themes, altruism and employment opportunity, were extracted, highlighting the different reasons participants were doing this kind of work.

Sub-theme 1.1: Altruism: passion to help those in need

Altruism is briefly defined as "for the other", basically caring for the other (Haski-Leventhal, 2009:271). This is simply put as a desire to help those in need. The majority of participants stated that they were in the HIV and AIDS home-based care field because they wanted to help others in need, meaning the ill, neglected and less privileged. This sentiment is best captured in the following responses:

*"I like to look after those who need care because their children cannot look after them,…
and those who have no one to care for, and also take them to the clinic for check-ups.
When they are ill and just need to see the Doctor then I am able to help."*

*"My sister-in-law told me about home-based care as she was already working as a carer and
I became interested. I wanted to be a nurse as young girl and home-based care provided me
with the opportunity to fulfil my childhood dream."*

Some participants were even more specific, stating that they had always had a desire to work in healthcare. A participant expressed it as follows:

*"I liked nursing when I was younger but my family did not have money to pay for the training
fees…..finances were a problem. I decided to stay in the healthcare field and do home-based
care. At the moment I will be writing by final subject in matric and planning to study for a higher
certificate in home-based care. I have come to like home-based care very much… "*

Community healthcare workers, which includes the home-based care workers, are acknowledged as being among concerned community members who do not sit on the side lines but take action to service humanity. What drives them is not necessarily financial reward, but the moral and religious conviction of being altruistic and caring for their neighbour. It is further cited that such qualities tend to make them trustworthy and thus easily accepted by those in need of their services (Standing & Chowdhury, 2008:2098; Schneider et al., 2008:85).

The home-based care workers basically volunteer to be of service to others. During the recruitment process it should be emphasised that prospective workers should not to be nominated but volunteer to participate in the community healthcare worker programmes. This is after they are familiarised with the nature of the work, including the expectations and risks involved (Department of Health & Department of Social Development, 2009: 47; Schneider et al., 2008:182). In spite of this, the researcher found that among these participants, such conditions did not seem to discourage them from reaching out to those in need.

Furthermore, social constructionism posits that generally, how individuals behave and their frame of references are largely influenced by the society in which they live (Mead, 1970:6-7,189,228). An assumption can then be made that it is probable that the

participants' altruistic behaviour was informed by the society in which they live. A need for HIV and AIDS home-based care workers was expressed by the community and they made themselves available as they might have perceived this as socially-acceptable behaviour. Unemployment is another driver that contributed to the participants finding themselves in home-based care.

Sub-theme 1.2: Home-based care as an employment opportunity

The Expanded Public Works Programme (EPWP) was instituted, amongst others, to enable adults affected by poverty and unemployment to find a way to meet their basic needs. The EPWP Social Sector Plan, mainly targets unemployed women and recruits them as home and community-based care workers to service the social and healthcare needs of their communities. In the process, they received training, work experience and income that they desperately needed (EPWP Social Sector Plan, 2004:7-8). The participants said the following about their situation:

> *"A friend of mine shared with me what being a home-based care worker involves and I saw it as a worthwhile skill to have. I was unemployed and decided to give it a chance. I am now enjoying the work."*

> *"I was widowed and unemployed….. I was advised by my cousin to go to the organisation to ask for food for myself and my family…. I was hesitant in the beginning to ask for food…. seeing my desperate situation, my cousin offered to accompany me…..When we got to the office of the organisation, the administrator took my details…….. and told me that I should come on Mondays and Thursdays to collect food parcels. She then surprisingly recruited me to be a home-based care worker. I responded by saying that I cannot as I thought that you needed some qualification to be a home-based care worker…. She reassured me that they will teach me and even give me a colleague to support me as I learn the work. I then accepted and have been working as a home-based care worker ever since."*

The most recent national unemployment statistics from Statistics South Africa indicate that unemployment among those aged 15-34 (youth) is at 37.1%, which is 10.6% above the national average. The majority of the participants fell in this age group that is regarded as vulnerable to unemployment, particularly those with a Grade 12 or less educational qualification (Statistics South Africa Quarterly Labour Force Survey, Quarter 4, 2016:1).

National job creation programmes like the EPWP, of which the home-based care work is a part, continue to play a substantial role in curbing unemployment. Besides providing the home-based care workers with a stipend to meet their basic needs, it is also an avenue for fulfilling the dream of acquiring skills that enable them to compete for better jobs in the open labour market (Akintola, 2011:60; HIV & AIDS & STI National Strategic Plan 2007-2011:45; Thabethe, 2011:790).

One of social constructionism's tenets is the acceptance of differing perceptions of reality and therefore the framework does not subscribe to one single final view of reality. Basically what this means is that, although a small proportion of the participants saw home-based care as an employment opportunity, it does not mean their view should be disregarded in favour of the majority view. It is their perception of reality and should be accepted as such (Gergen, 2001b:228).

The data so far, seem to highlight that the majority of the participants, although unemployed, participated in the home-based care programme, mainly to make themselves available to those who most needed their services and in the process, benefit from the incentive of a stipend. A study in Tanzania on the sources of community health worker motivation, and another study on the assessment of quality of home-based care in the Eastern Cape, revealed that, firstly, when home-based care workers were rewarded for their altruistic efforts, through either financial and/or non-financial incentives, there were positive spin-offs for the patients, such as being served by committed and empathetic caregivers. Secondly, the workers felt supported by the employer and this nurtured dedication and work excellence (Greenspan, McMahon, Chebet, Mpunga, Urassa & Winch, 2013:10; Morton, 2012:112). The second theme, work routine of home-based care, is the focus of the next topic.

Theme 2: Work routine of home-based care

One way of understanding the world of the HIV and AIDS home-based care workers and their daily challenges, roles and responsibilities, is to ask them what their typical day looks like. No sub-themes were extracted from this theme as it appeared that they had similar

job descriptions with few variations. Typical responses from the participants were summarised by the following statements:

> *"On entering the patient's house, I start with greetings and checking how they are doing then assess the patient's needs for the day… I sweep the house if need be, check if he/she has taken his/her medication, if not, I make soft porridge quickly so that they can eat before taking medication. If they have not bathed, I boil water for them and prepare the tub so that they can bath. If the patient is a woman and she needs help with bathing, I do assist….the problem is that we do not have protective gloves……"*

> *"I start by assessing the needs in the home. Sometimes I find that the patient is alone. Activities include cleaning the house, cooking for the patient, bathing and checking that they take their medication as advised by the clinic…. Sometimes I also help with homework supervision for the children."*

> *"…. I look after patients. I clean for them and help with many things that they need help with…. If they need to be bathed, I do help. With medication, I check first how the patient is supposed to take the medication and then give him/her the medication. When I find a patient that has not accepted his/her HIV status, I counsel him/her and encourage him/her to eat healthy food and take his/her medication regularly………"*

The participants' statements were supported by an example of home-based care worker activities are outlined in Table 6.5, adapted from Du Preez and Niehof (2008:96) as follows:

Table 6.5 Home-based care worker activities

CARE CATEGORY	ACTIVITY
1. Monitoring patient condition	- Regular assessment of the patient - When necessary arrange for clinic/hospital visit and accompany patient if need be
2. Basic nursing	- Treating minor symptoms and pain relief
3. Physical care	- Feeding, bathing - Turning and lifting the patient etc.
4. Treatment	- Supervise or assist with taking treatment - Prepare traditional remedies where necessary
5. Rehabilitation care	- Assist patient with doing exercises - Massaging to prevent/reduce stiffness and pain
6. Psychosocial and spiritual support	- Talking to the patient and keeping him/her company - Spiritual guidance
7. Household assistance	- Assisting with domestic work such as cleaning and cooking.

Furthermore, it is cited that although home-based care differed from one programme to another, the basic roles and responsibilities were the same. The home-based care workers were expected, depending on the client's needs, to engage in lay counselling, teach family members on how to care for the patient, do simple nursing tasks like dressing of wounds, monitor medication compliance, the provision of food parcels, do ordinary household chores and render palliative care to those who needed it. In addition, link the patients with comprehensive social and health support services that were available to the community (Lund & Budlender, 2009:9; Orner, 2006:239; Wringe, Cataldo, Stevenson & Fakoya, 2010:327).

With regards to lay counselling, a participant mentioned that:

> *"Once I am in the patient's home, I start with greetings and asking the patient how they are feeling, where they are at and then allow them to talk about what they are unhappy about……"*

The researcher's view is that the data seem to suggest that the scope of the work is quite broad as both patient care and household chores were done at each home-visit. There is consensus then on what literature cites as the daily routine of home-based care workers and what the study revealed through the participants. This consensus appears to be in line with the social constructionism view that meaning and understanding of social phenomena, in this case the routine work of home-based care workers, is shaped within social transections among people and it is communally shared. In this instance, although a job description has been pre-determined, both home-based care workers and their patients share, and interact on how the home-based care has to be customised to meet their needs (Burr, 2003:4; Freedman & Combs, 1996:23; Gergen, 2001a:2; Lock & Strong, 2010:7; Touminen & Savolainen, 1997:83). The next discussion is on how the participants experienced the various challenges in going about their daily work routine.

Theme 3: What home-based care workers perceived as challenges in execution of their duties

In Chapter 2, home-based care and the HIV and AIDS pandemic, an elaborate discussion of the challenges of healthcare workers in the HIV and AIDS field, was given including a specific mention of the home-based care workers. It was highlighted that the psychological support and healthcare needs of people living with HIV and AIDS seem to be more demanding as compared to patients with other diagnoses also requiring home-based care. As a result, servicing people living with HIV and AIDS was reported to be time consuming and stressful (Moetlo et al., 2011:138).

The theme is about what the participants themselves were saying about what they perceived as work challenges. The idea was to not only rely on what has been learnt in literature, but also cite the input of those on the ground. Three sub-themes were identified and they are: experience of the work as emotional challenging; lack of material resources that affects the ability to meet patients' needs; and challenges emanating from patient care. Experience of the work as emotional challenging is discussed first.

Sub-theme 3.1: Experience of the work as emotional challenging

Home-based care workers, as care givers for people living with HIV and AIDS, are expected to relieve suffering through practical tasks and also being empathetic and compassionate to what the patients are going through. Depending on how needy the patient is, this can be emotionally draining (Horsfield, 2007:5). This sub-theme focuses on negative emotional and/or psychological impact of working as a home-based care worker. The following statements shed light on what most of the participants thought:

> *"The problem for me is that some patients decide to stop taking treatment so that they can continue getting the grant….it then feels like all my efforts to get them better are fruitless… I think the main problem is unemployment…. Sometimes I work with patients who do not want to do anything for themselves and rely fully on food parcels and other handouts. This can be very demotivating as it appears as if you are not making any progress with the patient……I am also drained by having to deal with anger from patients who do not want to accept their HIV positive status…."*

> *"I do not mind walking from house to house but now recently I find having to visit patients in their homes unpleasant…..maybe it is because I have been a home-based care worker for many years…..having to work with patients who have serious health problems is emotionally disturbing as sometimes you do not know what to do….. sometimes the patient would say that they slept on an empty stomach whilst you had supper and you start feeling sorry for the patient and guilty at the same time…the dirt in some of the homes that you end up tidying up can be unbearable……."*

> *"What is distressing about my work is that sometimes you visit a patient today… you bathe her and dress her in clean clothes, put on new disposable napkin and make sure that she has a meal…. her adult children are just there at home and not helping. When you visit again the following day you find that the last meal she had was the one you prepared and she is still wearing the same napkin that you left her with and it is soiled…… I sometimes find myself thinking about such patients when I am at home and in some situations I even struggle to sleep because of excessive worry and concern………how can the children neglect their parent/family member like that….?"*

The participants were not alone in feeling emotionally drained. Findings from research studies in both Zambia and South Africa on the emotional challenges of volunteer caregiving work, confirm that lay healthcare workers in the HIV and AIDS field sometimes experience their work as being emotionally draining and as a result they were at high risk

of emotional exhaustion and stress. Contributing factors were: having to constantly deal with illness; fear and death; and sometimes feeling frustrated by the inability to alleviate the pain and suffering of patients. Another factor was emotional involvement with patients, resulting in difficulty in dealing with both their own emotional reactions to the situation and that of patients. In some situations, lay healthcare workers were so emotionally affected that they even considered resigning from the work (Akintola, 2008:361; Dageid et al., 2007:11; Dieleman et al., 2007:145; Visser & Mabota, 2015:173).

Both the literature and the participants responses attest to the emotional strain that home-based care were sometimes exposed to. This would appear to suggest that, although the participants and other home-based care workers work in different contexts, their reality in terms of this work challenge is similar (Gergen, 2001b:231). The next focus now is on lack of resources.

Sub-theme 3.2: Lack of resources that affect the ability to meet the patients' needs

Cited literature has confirmed that recruitment of home-based care workers targeted mainly the unemployed community members. Home-based care workers are therefore mainly people who are disadvantaged financially and prefer to use their time constructively, instead of just idling (Akintola, 2011:58). An assumption can then be made that, although they volunteered their time, they did not have the financial resources to assist their patients with material needs.

Providers of home-based care programmes accordingly need to provide the necessary material support to enable the home-based care workers to do their work. Given that such programmes were normally run by non-governmental organisations with state and donor funding, that sometimes pose a problem, particularly that the programme tended to be expensive (Amaron et al., 2012:5; Akintola, 2011:55). The participants' concerns and experience relating to lack of material support were captured as follows:

> *"I am hopeful that the situation will improve but at the moment I find walking from house to house tiring….our patients live far apart and without transport you even do not manage to see all your patients for the day…….the problem is that the organisation's car is available but there is no money for petrol….. Sometimes I wake up early to make up for the walking time, it can be a challenge but commitment to my patients urge me to wake up and go.*

…..there was an instance where when I arrived at a patient's home, I found that they looked hungry and there was nothing to eat. I had a sandwich that I was supposed to have for breakfast and ended giving it to the family to share. …When I got to the next home, there was a little child who also needed something to eat….I felt so helpless……...this has tendency to stay with me for a while, especially when I am at home cooking…thinking that some of my patients probably do not have any food for supper."

"The thing is that there was an instance when I had to work with a patient who was so ill that she could not do anything for herself. I had to start with bathing her using my bare hands because I did not have hand gloves and any other protective gear……Thereafter I realised that I had to prepare a meal for her, only to find that there was no food in the house. I did not have money either and there were no food parcels from the organisation……I think if at least I was receiving a stipend, I would have used some of the money to help the patient……..we have raised these concerns with the supervisor and the response was that there were no funds….. such challenges are a source of stress for me…."

Wringe et al. (2010:332,334) explain that in their review of lessons learnt from delivery of comprehensive HIV and AIDS home-based care programmes in low and middle income countries, home-based care organisations highlighted that one of the most difficult matters to deal with was undetermined costs and sources of finance for the programme. It was further mentioned that such organisations prefer engaging volunteers for home-based work as they could not afford to run the programme with paid staff. It appeared the problem in some instances was bigger than that, it was also about limited resources to provide work supplies like kits for home-based care workers, food parcels for the patients in need, and for transportation for home visits and for taking patients to health facilities (Chimwaza & Watkins, 2004:803; Moetlo et al.,2011:141 Shaibu, 2006:91; Thabethe, 2011:789). There were also instances where the home-based care workers themselves used their own money (from limited financial resources) to buy food and other basic necessities for patients for survival (Naidu & Sliep, 2011:434). Furthermore, a few participants added that not having transport to visits or bus/taxi fare exposed them not only to the hot sun and/or rain but also to the risk of crime. A participant expressed her sentiment as follows:

"*Walking from house to house to patients' homes that are far apart can be dangerous…sometimes we walk in deserted areas and we are therefore exposed to criminal activity….*"

Safety concern is an indirect consequence of financial challenges, especially in communities with high crime rates (Lund & Budlender, 2009:16). It appears then that the government has to face the reality that poverty-stricken communities where most of the home-based care services are rendered, are in no position to provide financial resources to keep the programme going. It thus has to explore, in partnership with the private sector and donor community, how the home-based care programmes could be made constructively sustainable (Kok et al., 2010:60; Mohammad & Gikonyo, 2005:20; Ogunmefun et al., 2011:7).

Social constructionism proposes critical evaluation of the social world as and when it is necessary. What is not serving the best interest of the society needs to be challenged and replaced by something just. Deducing from the participants' views, it appears the situation in which they find themselves requires some critical evaluation as it seems it is not working for all the main parties involved; patients, home-based care workers and the organisations. An assumption can then be made that the home-based care workers and their organisations need to express themselves loudly, if need be through social action, to both donors and government about their funding needs so as to ensure that they run sustainable programmes that meet the patients' felt needs (Burr, 2003:3; Lock & Strong, 2010: 8-9).

Lack of material resources due to financial constraints is not the only challenge that the home-based care workers had to contend with, there were also those that emanated from overall patient care. These challenges are discussed next.

Sub-theme 3.3: Challenges emanating from patient care

As mentioned before, home-based care services differed from programme to programme and therefore sometimes there was no consensus on what the job description of a home-based care worker really entailed (Kok et al., 2015:1214; Lund & Budlender, 2009:9). The participants, without being specific about the home-based care programme they were part

of, highlighted concerns around patient care, which they had to deal with when working with the patients at their homes, as follows:

> *"Hhhmm sometimes the client is in denial and then he/she refuses treatment. It is draining to work with a patient like that. Then through patience and support, the client eventually discloses and then the tension dissolves….. In other situations the patient would complain that the family is not as supportive as he would like them to be and I get caught up in the middle."*

> *"I find the care needs of bed-ridden patients particularly demanding. I remember a patient I cared for who was diabetic and had wounds that over time got worse and became septic despite all my efforts to help. The smell of the wounds was unbearable."*

> *"One of the challenges I experience in my work is that I sometimes find patients who refuse to take ARV's because their friends or neighbours have told them that if they take treatment they will die….. some do not want to disclose their HIV status to the family because they scared how the family will react……some believe that ARV's have unbearable side effects so they are better off not taking them. I have to find a way to convince the patient that that is not the case, ….sometimes it just takes too long…….in the meantime I worry that the patient's condition may deteriorate before he starts treatment."*

Such experiences seem to be common in HIV and AIDS home-based care work. Similar studies on the challenges of caring for people living with HIV and AIDS in South Africa, Appalachia (United States of America) and Democratic Republic of Congo have alluded to the fact that some participants complained that sometimes patients did not only resist help, but they also had unrealistic expectations of the carer. Furthermore, depending on the condition of the patient, it may be required of the home-based care worker to over-extend himself/herself in terms of the time and human energy required to address the patient's needs. Sometimes they also had to deal with negative reactions from the patients' family and/or friends and neighbours (Du Preez & Niehof, 2008:88,102: Held & Brann, 2007:213; Kipp, Nkosi, Laing & Jhangri, 2006:695-696).

The physical care of the patient sometimes left the home-based care worker physically drained and exhausted. There was also mention of the fact that in cases where it was suspected that the home-based worker was paid, the family just left all the care to him/her. This sometimes went to the extent of the worker being called after hours and weekends

to attend to the patient when his/her condition seem to deteriorate. A participant expressed her experience as follows:

> *"One of my patient's health condition deteriorated to the point where she needed to be taken to hospital. The family called me very late at night, (it was almost midnight) to let me know and even ask that I organise transport to take her to the hospital. I had to leave my family and attend to the patient….I even used my own money to pay for the transport to the hospital…."*

In rare occasions, this misconception resulted in conflict between the home-based worker and the family at the expense of the patient (Chimwaza & Watkins, 2004:801; Hlophe, 2006:204).

The work challenges expressed by the participants paint a holistic picture of what they had to deal with almost on a daily basis. The emotional challenges ranked highest, followed by lack of material resources and finally patient care. Social constructionism stipulates that all individual perceptions of reality are important as there is no single right view of social reality, but a variety of possibilities. This is evidenced in the participants' different opinions of what they perceive as challenges of working as home-based care workers. The researcher's stance is that of a non-judgmental listener and observer of the participants' world as they explain and unfold it through language (Gergen, 2001b:228; O'Connor, 2015:3). In spite of all the challenges, the participants seemed not discouraged and fully committed to help their fellow community members. The next theme's focus is on motivators that kept them going in spite of the work-related challenges.

Theme 4: Motivators in home-based care work

The above-mentioned information seems to suggest that a great deal is expected of the HIV and AIDS home-based carers. During the interviews, some of the participants made mention of the fact that they did not always have their partners available even though they were supposed to work in pairs. What then kept them going in light of the almost never changing workload? Most of the participants shared what motivated them to keep going. Motivation is explained as an individual's "enthusiasm for doing something." (*Cambridge English Dictionary,* 2017:1) It is said to be influenced by the interplay of individual,

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organisational and cultural factors (Mathauer & Imhoff, 2006:3). There is intrinsic motivation, meaning motivation from enjoying a particular activity and extrinsic motivation which is motivation driven by an external reward (Millette & Gagne, 2008:12).

Three sub-themes emerged from the participants' responses, namely personal appreciation, patient recovery and non-specific motivators.

Sub-theme 4.1: Personal appreciation

Studies on motivation and support for lay healthcare workers of people living with HIV and AIDS revealed that in spite of the obstacles they faced in execution of their work, they tended to show admirable dedication and commitment. It was stated that one of the contributing factors to such drive is recognition of work done either by the organisation and/or community (Campbell et al., 2008:512; Willis-Shattuck, Bidwell, Thomas, Wyness, Blaauw & Ditlopo, 2008:6). Participants' views about personal appreciation was reflected in the following statements:

> *"I feel good when I leave the patient's home clean and smelling wonderful. I like it when the patient even thank me for it."*

> *"I am encouraged by a patient that shows that she appreciates the work I do and the help I give…..seeing a patient's health improving is also a form of acknowledgement of my efforts."*

The statements seem to suggest that the participants, although aware of what is expected from them, treasured being acknowledged for work done exceptional. Studies in South Africa, Tanzania and Uganda on understanding motivation among community health workers discovered that home-based care workers, like other lay healthcare workers, found encouragement and moral support in positive feedback and recognition from both the community and the organisation on their good work performance. They were inspired when their skills and contribution to the betterment of others were not ignored but celebrated. It is thus recommended that organisations "employing" home-based care workers make an effort to increase feedback on individual work performance and overall organisational effectiveness. Such feedback has a way of demonstrating the impact that both the individual worker and the organisation has on the people it is serving (Akintola,

2011:55; Greenspan et al., 2013:6; Millette & Gagne, 2008:20; Vareilles, Marchal, Kane, Petric, Picket & Pommier, 2015:11-12).

There was a participant who specifically cited recognition by manager as meaningful. She said the following:

> *"I was particularly touched when my manager called me and commended me for the good work I was doing with the patients. It made me very happy…."*

The rest of the participants valued appreciation by the patients and the community more. Deducing from the data, it can be assumed that although they were expected to do much with limited skills and material support, the positive feedback of their patients was rewarding, reassuring and reinforcing their commitment to the work (Campbell et al., 2008:511). Studies cite additional forms of recognition valued by lay healthcare workers as enhancement of social status and acknowledgement of the noble work they do (Glenton, Scheel, Pradhan, Lewin, Hodgins & Shrestha, 2010:1922; Gopalan, Mohanty & Das, 2012:7). From a social constructionism view it can be assumed that the regular interaction between the participants and their patients, did not only lead to knowledge and experiences that were challenging. There were positive outcomes too, in this instance, participants being acknowledged for their valuable contribution to the society (Burr, 2003:4; Young & Collin, 2004:376). Another motivator, patient recovery, is discussed next.

Sub-theme 4.2: Patient recovery

The HIV and AIDS pandemic seemingly was among the main contributing factors to increased demand for healthcare services. The role of the home-based care workers was mainly to provide basic curative services to patients in their home and communities in addition to other patient support services as part of the continuum of care (Lehmann & Sanders, 2007:6). Among the participants interviewed, some indicated that patient recovery or improvement in health status motivated them to stay on the job in spite of its demands. This was captured in the following statements:

> *"I had a patient who was very resistant to treatment. Through my persistence and patience, I managed to convince him to take treatment. He is now compliant and does not need any support from us anymore. He is independent."*

> *"I had a seriously ill patient that I had to attend to. I was not confident that through home-based care he/she could recover………with the support of the team I work with and patience, I managed to nurse him back to health….he recovered…… It was a highlight for me."*

> *"I remember a male patient that I was allocated to….on my first visit he could not do anything for himself….I stepped in and helped out which included cleaning the house and even ensuring that he took his medication as prescribed…..over time he improved and fully recovered…now he is able to care for himself…….he does not need home-based care anymore…."*

Additional studies on motivation among community health workers and volunteers (home-based care workers included) confirmed that patient recovery or just improvement of the patients' health gave the home-based care workers a self-confidence boost and energy to want to do more. It was stated that visible positive results from patients, prevention of common health tragedies, facilitating progressive community health and using their knowledge to help communities with their health needs gave the workers the assurance that they were doing valued and prestigious work (Campbell & Scott, 2011:10; Glenton, Scheel, Pradhan, Lewin, Hodgins & Shrestha, 2010:1922; Gopalan et al., 2012:7; Greenspan et al.,2013:9; Jaskiewicz & Tulendo, 2012:7; Vareilles et al., 2015:10).

The data from the participants seemed to indicate that although they had limited healthcare expertise, that is, they were without prior formal training in community health, they were committed to do more where possible (Gopalan et al., 2012:2). This appears to be an un-intended outcome of home-based care as one of its main aims, especially in the HIV and AIDS sector, was palliative care (Lehmann & Sanders, 2007:13; Lund & Budlender, 2009:9). Social constructionism states that human beings have unlimited potential and this seem to be evident in some of the achievements of the participants (O'Connor, 2015:6). It can also be assumed that patient recovery did not only show the potential of the participants only, but also that of the patient and his/her family. The last sub-theme, non-specific motivators is discussed next.

Sub-theme 4.3: Non-specific motivators

Among the participants' responses, there were several motivators mentioned where a sub-theme could not be extracted. The researcher's view is that even though the majority

of the participants indicated that they became home-based care workers mainly out of altruistic reasons, the reasons for continuing doing the work are varied. The non-specific motivators range from being motivated by the knowledge and skills gained, the opportunity to spread their wings and work with children to getting a self-esteem boost through being effective in their work. The following statements recorded what some of the participants said:

> "I have learned a lot from the in service training I received and the topics that were covered during the training…..and the opportunity to practise what I had learnt. This was something new… I did not know anything about home-based care before."

> "Some of my patients are now taking their medication as expected…. Some managed to gain the confidence to disclose their HIV status to their families. Others I managed to assist them with applying for disability grants."

> "I have successfully managed to care for and nurse a very ill patient back to health. This gave me a huge confidence boost."

There is evidence to support the opinions of the participants. The literature shows that there were a variety of non-financial incentives that kept the home-based care workers committed to helping the community. These included empowerment through acquisition of knowledge and skills on community health which created professional and career pathways, job satisfaction, pride in helping their communities and improving self-esteem and a sense of self-worth. There was also mention of social rewards such as elevation of status in the community and being called upon to lead important community initiatives. The branded uniform or badges also made them visible agents of a respected health system/organisation (Akintola, 2010:55; Gopalan et al., 2012:7; Greenspan et al., 2013:9; Kok, Dieleman, Taegtmeyer, Broerse, Kane, Ormel, Tijm & Koning, 2015:1214,1216; Strachan, Kallander, ten Asbroek, Kirkwood, Meek, Benton, Conteh, Tibenderana & Hill, 2012:113-114).

Furthermore, mention was made of the fact that personal growth and development and career-related benefits seemed to be major non-financial motivators for lay community health workers. Such motivators were seen as promoting job satisfaction and laying a foundation for job prospects in the healthcare field. It was also mentioned that, although the care workers regarded such benefits as very important, they were reluctant to be

outspoken about them for fear of being labelled as opportunists and not sensitive to the plight of the sick (Akintola, 2010:57; Bhattacharyya, Winch, LeBan & Tien, 2001:21; Kok et al.,2015:1214; Strachan, 2012:113).

Assisting patients with application for social grants was another area that a few participants regarded as fulfilling. From the data gathered, it appeared this was not their primary role. It seems though, that, should a need for such a service be identified, they were expected to help. What seemed to be motivating about this task is that it was practical and the results are almost immediate (Lund & Budlender, 2009:9). Social constructionism posits that social relationships play an important part in shaping people's description and explanation of the social environment in which they find themselves. With regards to the participants, the relationships they had established with their patients presumably shaped and guided their perception of what they regarded as motivating about home-based care (Gergen, 2001b:48).

In summary, although a variety of motivators have been mentioned by participants, patient recovery rated high as a motivator, followed by non-financial recognition/appreciation by both the community and the organisation. The data demonstrated what kept the participants committed to their patients and the community service. The next theme's focus is on what supervision support they required from the organisation to keep them going.

Theme 5: Home-based care workers' suggestions for improvement of workplace

       support

It was recommended that in the design management of home-based care programmes, workers must benefit from regular supervision and support. It was acknowledged that, in spite of the awareness of the importance of supervision in this area of work, it is usually the most neglected (Bhutta, Lassi, Pariyo & Huicho, 2010:8,45; Halpern, 2009:226; Jaskiewicz & Tulenko, 2012:6; Kok et al., 2015:1217; Lehmann & Sanders, 2007:20).

Supervision is basically described as being a positive relationship between the supervisor and supervisee, wherein the supervisor oversees and helps the supervisee to sustain morale, provides a shoulder to lean on with work discouragements and discontents, and also giving him/her (supervisee) a sense of worth, belonging and security in the work that he/she does (Halpern, 2009:226; Kadushin & Harkness, 2014:9,11).

This theme focuses on presenting data that explain what the participants shared about their experience of supervision and what they would like to be put in place. Among the participants, only a small proportion indicated that they were not receiving any form of supervision. The rest of the participants were receiving supervision and support, but they were of the opinion that more could be done to meet their support needs. The recommendations put forward by the participants are presented in Table 6.6.

Table 6.6 Suggestions for support as voiced by home-based care workers

Suggestions	What the participants said
1. Debriefing	- *"I prefer that we have debriefing once a week as a group. Some form of a stress management programme that is done regularly could also help."* - *"I wish we could have the group debriefing back…it has not happened in the last three years because of lack of funds. I suggest that we have the sessions twice a year and that they should be facilitated by a psychologist."*
2. Structured group supervision	- *"It would be nice to have once a month team meetings that allow for sharing of work experiences and challenges."* - *"I suggest that we have fortnightly meetings to share experiences, new information and support one another…"*
3. Training	- *"I need supervision support as we do not receive any supervision. I also wish we could have information and knowledge of what to expect in the field as we do home-based care."* - *"I wish we could have regular in-service training…that is the only thing that we lack support with."*
4. Individual counselling	- *"Sometimes when I come back from home visits I wish I could have a counselling session because of some of the disturbing things I sometimes experience when working with patients….I need to offload so that I do not go home stressed….every Friday would work as it is not every day when the stress is unbearable."* - *"I think counselling would help a lot…"*
5. Onsite support for home-visits by supervisor	- *"I wish that the supervisor could accompany me to one or two home-visits weekly mainly for support."*

The participants provided a broad spectrum of suggestions for workplace support with psychosocial support appearing to be the greatest need as compared to training and group supervision. In support of this view, a participant said:

> *"We are heavy laden by the emotional stress of the job…….. you arrive at home after work and you still feel heavy. I wish we could have access to debriefing sessions so that the load could be made lighter. …. Yes the load of emotional stress and the demanding job."*

The situation the participants found themselves in terms of inadequate supervision support appear not to be unique. A longitudinal study found out that, even after about twenty years, middle and low class countries (of which South Africa is one) still experienced, amongst others, poor selection of HIV and AIDS home-based care workers, deficiencies in training, support and supervision (Wringe et al., 2010:334). In order to remedy such challenges that eventually impacted on the quality of services rendered by the home-based care workers, suggestions included employing an adequate number of nurses to do the supervision as this would cover upskilling and also psychosocial support. Another suggestion was that an experienced and better qualified home-based care worker could be promoted to supervise colleagues. This could be motivational, and pave a way for career advancement and the supervisees would benefit from a supervisor who has walked in their shoes (Jaskiewicz & Tulenko, 2012:6; Rosenburg, Mabude, Hartwig, Rooholamini, Oracca-Tetteh & Merson, 2005:33).

The voices of the participants were heard in terms of the workplace support they would like to have. The suggestions given by the participants, appear not only focused on what they needed as individual home-based care workers, but what would also be to the benefit of their colleagues. This way of thinking is supported by the social constructionism view that as interactions are relational, those who find themselves in the same social context, would have a shared view or construction of experience. The participants exist in relation to their colleagues and their inputs are part of authoring the experiences of home-based care workers (in their social environment), not just for themselves (Burr, 2003:4; Cunliffe, 2008:129; Young & Collin, 2004:376). The next theme's focus is on the qualities and attitudes that an individual needs to have to make a good home-based care worker that is able to survive the demanding expectations of the work.

Theme 6: Home-based care worker qualities that promote resilience

The researcher understands resilience to mean achieving your goals despite adversities. The most appropriate conceptualisation seems to be that it is the ability to maintain personal and professional wellbeing in the face of ongoing work stress and adversity (McCann, Beddoe, McCormick, Huggard, Kedge, Adamson & Huggard, 2013:61). From the data presented in this chapter so far, it seems evident that home-based care work is not a job that could be undertaken mechanically without any emotion. It seems that the job functioning engages almost all the senses of workers and from time to time the individual finds himself/herself having to deal with the stress and adversity mentioned. The previous theme (theme 5) gave testimony to the supervision support the home-based carers needed in light of what they have to endure daily.

Three sub-themes were extracted from this theme, namely work attitude, conduct and values. The actual statements of the participants in terms of what they regarded as good qualities of a home-based care worker are presented first. Thereafter, the statements are summarised and presented as sub-themes in Table 6.7. The participants' responses were captured as follows:

> *"A home-based care worker must have the heart to do this kind of work…..perseverance is very important as sometimes we work for up to nine months without a stipend…..must be able to keep the patient's secrets……I say so because sometimes you find a patient having messed himself/herself…an embarrassing situation… and you cannot share that with anyone……."*

> *"One must have a good work ethic. …must also be respectful because it is through respect that others will respect you too…..patients can sometimes be difficult because of the pain they are experiencing…. you should not allow that to get to you and just be empathetic….the work has a lot of challenges…..it is important to always remember that the patient comes first…"*

> *"You need to accept the patients as they are, do not be judgmental….make an effort to keep their private matters confidential…. A smile is very important……put the needs of the patient first."*

> *"Speak to the patient honestly in a non-judgmental way, have patience and bring joy to the patient…"*

The data further revealed that in addition to non-judgmental attitude and confidentiality and respect, patience was mentioned by most of the participants as being a very important attribute to have in home-based care. It seems, because of the self-giving and caring nature of the work, without patience, the work could become unbearable and unfulfilling (McAllister & McKinnon, 2009:371). Additional inputs from the participants were categorised as sub-themes and are presented in a table format (Table 6.7). This was done to ensure that the most of the valuable inputs of the participants were reflected and also because resilience sometimes does not fit into a clear cut definition, but better described in terms of qualities, traits and characteristics (Jackson, Firtko & Edenborough, 2007:3).

Table 6. 7 Resilience enablers among home-based care workers

WORK ATTITUDE	CONDUCT	VALUES
- patience - perseverance - work with passion and love - be open towards patients - be calm and caring - work from the heart - show selflessness	- take your work seriously - be hard working - be kind to patients - show compassion in your work - be a team player - smile - put the needs of patients first - bring joy to patients - be strong willed and not fearful and anxious - behave in an emotionally mature manner - encourage self-reliance in patients	- respect for patients, colleagues and seniors - non-judgmental attitude towards patients - honesty - trustworthiness - controlled emotional involvement with patients - positive regard towards patients

The literature cited additional attributes that healthcare workers (home-based care workers included) needed to have to manage the inherent stress of the job. These

included sense of hope, self-efficacy, internal locus of control, optimism, humour, spirituality, maturity, prosocial behaviour, empathy, the ability to organise daily activities and being adaptable to change (McAllister & McKinnon, 2009:373; McCann et al.,2013:63,65). These attributes seem to resonate with what the participants mentioned already. For example, the participants' input with regard to the combined sub-themes of work attitude, conduct and values encompass prosocial behaviour, hopefulness, emotional maturity and optimism.

Recognition needs to be given to the fact that social constructionism highlights that the researcher should, during both data gathering and analysis, assume the role of a "student" to be able to gain an understanding of the participants' constructions of their social reality. Respect for the views of the participants is important as they are experts in how they are experiencing their particular social reality and context. Multiple meanings and points of views may be expressed and they all need to be given the same importance (Gergen, 2001b:228; O'Connor, 2015:9).This translates to the fact that what the participants have identified as being important attributes of a good home-based care worker be respected and accepted as is, more so that there is theoretical justification of their views.

Discussion of the six themes and the accompanying sub-theme extracted from the data has given an insider's view of what HIV and AIDS home-based care work is about. The participants expressed genuine concerns and, in spite of these concerns, they carry on and try to do their best. They have, through language, communicated their experiences of home-based care work in such a way that a coherent picture of themselves and the world around them was painted. Sharing of the home-based care experience by the participants has significantly contributed towards "storying" what they face in their daily routine (Freedman & Combs, 1996:29-30; O'Leary, 2007:251).

The researcher's view is that it is evident from the data and the literature cited that for any home-based care programme to be successful and keep the care workers motivated and fulfilled, adequate funding for the programmes that covers operational costs, psychosocial support and the on-going training needs of the care workers have to be sought for the sake of both the care workers and patients and their families. A discussion of the

workplace support needs of the participants which have been identified, as extracted from the themes and sub-themes follows.

6.2.3 Identified workplace support needs

The previous section presented a detailed discussion of what the participants perceived as challenges in their work environment, what helped them cope, and what could be done to improve job satisfaction, resilience and the quality of the services they rendered. The workplace support needs were identified using the analysed data from the participants and are summarised below. They are:

- relief from emotional stress;
- coping with patient care demands;
- lack of material resources: transport to home visits and for patients to healthcare facilities, food parcels and some form of financial incentives;
- need for structured debriefing sessions; and
- need for on-going professional development and training.

With the exception of lack of resources, the participants put forward recommendations and suggestions as to how the identified support needs could be met. They proposed structured and regular debriefing (weekly, fortnightly or monthly), structured individual supervision, monthly group supervision, individual trauma counselling, structured on-going training and onsite support by the supervisor.

These support needs and the participants' intervention proposals subsequently made a meaningful contribution to the compilation of the stress management programme. To ensure that the proposed stress management programme was not only based on the views of the home-based care workers, their supervisors were also interviewed as secondary sources of information. The next section focuses on the data gathered from the supervisors/managers.

6.3 SECTION B: HIV AND AIDS HOME-BASED CARE PRACTITIONERS' SUPERVISORS/MANAGERS

Five supervisors/managers of the home-based care practitioners were interviewed, using a semi-structured interview schedule. The aim was to source additional information on the challenges of home-based care work from the people who are in the first line of report. This is in line with the social constructionism's assertion that there is no one true explanation of reality. There has to be a critical but collaborative exploration of meaning of the social world, by interested parties in a spirit of inclusivity and thus entertaining all points of view (Gergen, 2001b:228). In this case, it was allowing both the home-based care workers and their supervisors/managers to give a collaborative exploration of their experiences of home-based care. Firstly, their biographical information is presented, followed by the themes and sub-themes extracted from the data.

6.3.1 Biographical information on the supervisors/managers

The biographical data are discussed with reference to gender, age, educational qualifications and years of experience as a supervisor/manager.

6.3.1.1 Gender

Among the five participants, four were female, whilst one was male. As is the case with the home-based care workers, this is a female dominated field with low representation of males (Fine, 2011:58; Orner, 2006:237).

6.3.1.2 Age

The age of the supervisors/managers is presented in Figure 6.2 as follows:
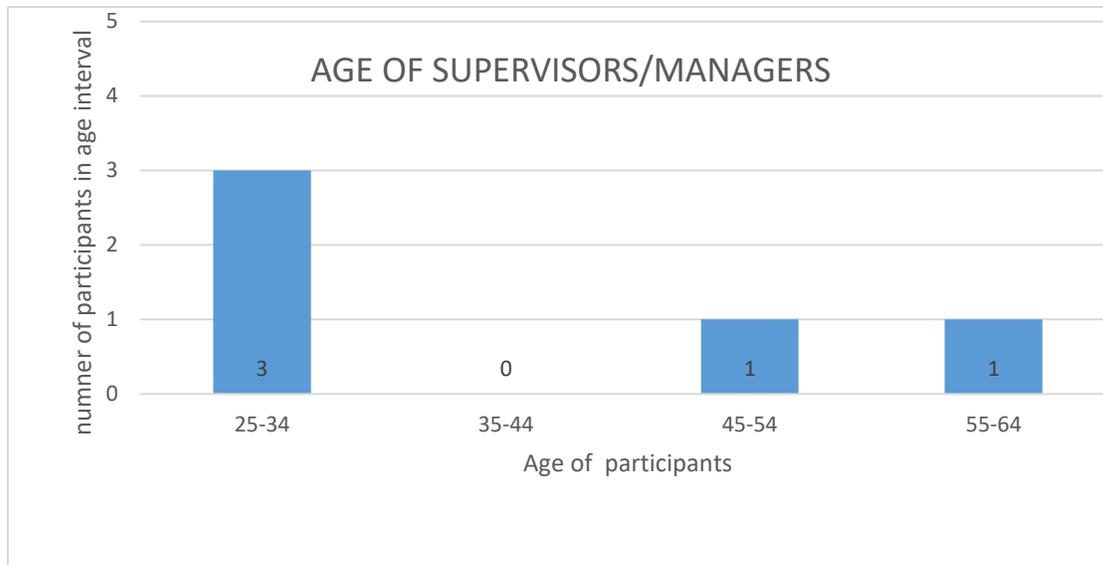
Figure 6.2 Age of the supervisors/managers

The age of the supervisors/managers seemed to indicate that the majority were in early adulthood, a similar trend with the primary participants.

6.3.1.3 Educational qualifications

The qualifications are presented in Table 6.8 as follows:

Table 6. 8 Supervisors/managers educational qualifications

QUALIFICATION	NUMBER OF PARTICIPANTS (n)
Grade 8 - 11	2
Grade 12	0
Post-grade 12 qualifications (specify)	3 (2 x Certificate in social auxiliary work, 1x Nursing diploma

The two supervisors without any formal qualifications indicated that they received on the job training, whilst the other three had professional qualifications that enabled them to supervise and mentor the home-based care workers.

6.3.1.4 Years in the position of supervisor/manager

Table 6.9 below gives a presentation of years of experience as follows:

Table 6.9 Years in the position of supervisor/manager

YEARS IN POSITION	NUMBER OF PARTICIPANTS (n)
2 – 4 years	3
5 – 7 years	2

The minimum number of years as supervisor/manager was two years whilst the maximum was seven years. The researcher's view was that a minimum of two years gave a supervisor reasonable time to become accustomed to the work and be able to know the needs of the supervisees.

The profile of the supervisors/managers presented an overview of the secondary participants and probably also their credibility as sources of information on the topic under investigation. The next focus is on the themes and sub-themes extracted from the data.

6.3.2   Themes and sub-themes from the supervisors/managers

Data gathered from the supervisors/managers were analysed using thematic analysis, following the same procedure as was used with the analysis of data from the primary participants. One of social constructionism's viewpoints is that realities are maintained and organised through stories (Freedman & Combs, 1996:29). The data therefore reflect the "storying" by the secondary participants of how they perceived and experienced the world of the home-based care workers. Four themes emerged from the data analysis and only two themes have sub-themes. These are first presented in tabular form (Table 6.10) and are then discussed in detail.

Table 6.10 Themes and sub-themes from the supervisors/managers

THEME	SUB-THEME
1. Stress and burnout among home-based care workers	1.1 Understanding of stress and burnout 1.2 Observation of symptoms of stress and burnout
2. Perception of workplace challenges of home-based care workers	2.1 Emotional challenges of home-based care work 2.2 Lack of material resources to do the work 2.3 Challenges emanating from patient care
3. Available workplace support services	
4. Suggestions for improvement of workplace support	

Theme 1: Stress and burnout among home-based care workers

The concepts stress and burnout were explained in Chapter 2 (home-based care and the HIV and AIDS pandemic). It was emphasised that both stress and burnout are often associated with work in the helping/caring professions such as healthcare, religion and education (Arman et al., 2011:295). The participants gave their views on this matter. Two sub-themes were identified from their responses and these were understanding of stress and burnout and observation of symptoms of stress and burnout.

Theme 1.1: Understanding of stress and burnout

Understanding of stress and burnout by supervisors and managers was important as they needed to identify it and provide the necessary support to affected home-based care workers. The participants' views were:

"Stress is caused by high workload and having unresolved problems."

"It is when a person is not coping with work or personal challenges and they fear to reach out for help."

With regards to burnout, responses received included the following:

> *"It is when you are experiencing stress for a long time and it comes out in anger, poor interpersonal relationships…….always quarrelling with colleagues and sometimes with patients…. and not coping with the work."*

> *"I think one is burned out when he/she has totally lost the drive and interest in the job because of stress."*

The quoted responses from the participants seem to highlight that they had a clear understanding of what stress and burnout were. Theoretical explanation of the concepts confirmed what the participants mentioned. Briefly explained, stress is experienced when an individual is faced with the high and/or contradictory demands of the job and struggling to cope. Burnout, on the other hand, is persistent and prolonged unresolved stress that is characterised by exhaustion and reduced effectiveness in the work environment (Engelbrecht et al., 2008:s16; Glasberg et al., 2006:393). A discussion of what the participants viewed as the symptoms of stress and burnout follows.

Theme 1.2: Observation of symptoms of stress and burnout

In addition to understanding stress and burnout, the participants gave their views of what they observed among the home-based care workers as symptoms of stress and burnout. The purpose was to establish further whether the participants were aware when the "red flags" for stress and burnout started showing in the home-based care workers who report to them. The participants shared the following comments about what they observed:

> *"I observed signs of fatigue, demotivation and a lack of energy and drive in some of the home-based care workers."*

> *"I remember a specific incident with one of the carers. She was displaying a lot of anger…..she would behave in an unbecoming manner by submitting reports late, lack of commitment in her work….. when I needed to follow up with her telephonically on work matters she would just ignore my calls. Sometimes when she was in the office she would isolate herself from her colleagues…"*

The symptoms of stress and burnout identified by the participants were supported by an assertion of Cogan et al. (2005:2) that symptoms of stress and burnout may be physical (e.g. fatigue), emotional (e.g. anger) or behavioural (e.g. social withdrawal). The data

suggest that the participants knew what to look out for among the home-based care workers in instances where these workers seemed to be struggling to cope with work. This was important as supervisors/managers play a critical role in the identification and intervention of workplace stress and burnout (Colligan & Higgins, 2006:95). The next theme's focus is on the discussion of the participants' perception of the challenges facing the home-based care workers in the workplace.

Theme 2: Perception of workplace challenges of home-based care workers

It is assumed that the participants, as direct supervisors/managers of the home-based care workers, would have first-hand information concerning the challenges experienced by home-based carers while carrying their daily activities. Each participant gave his/her view, and three sub-themes emerged from their input, namely: emotional challenges of home-based care work; lack of material resources to do the work; and challenges emanating from patient care. The home-based care workers' emotional challenges are discussed first.

Theme 2.1: Emotional challenges of home-based care work

The participants gave an impressive account of what they viewed as the emotional impact of home-based care work on their supervisees. They voiced their opinions as follows:

> *"They are stigmatised because of working with HIV and AIDS patients. Sometimes even the family of the patient reject their services because they also fear the stigma."*

> *"In some instances they get threats from patients, especially when they do not get their way with unrealistic demands. They then come to me for support and to also talk about their concerns about not feeling safe at some of the patients' homes…"*

> *"One of the challenges is the difficulty to cope with the demands of the job. A typical example is that after visiting a patient, a carer would come and one finds their mood low and they appear drained."*

> *"Sometimes the home-based care workers gets emotionally over-involved with patients,… sometimes they treat them like their family members… especially those that are over-reliant on the carer because they live alone."*

The cited responses capture the crux of what the participants shared about what they perceived being the emotional challenges that the home-based care workers experience. The researcher's view is that these tally with the primary participants' inputs. The home-based carers also highlighted the emotional drain due to their work. The next focus is on the lack of material resources which are needed by the home-based carers to render their services.

Sub-theme 2.2: Lack of material resources to do the work

The difficulties associated with maintaining a successful home-based care programme without the necessary human, material and financial resources have already been referred to in the previous section (Section A). The supervisors/managers concurred that the lack of material resources did impact on the home-based care workers' ability to be effective in their work.

They made the following statements regarding the lack of material resources:

> *"The home-based care workers have to walk long distances with scarce public transport because the patients' houses are sometimes far apart and the organisation cannot provide transport ……this exposes them to the hot sun and rain."*

> *"I sometimes get complaints that they are overworked and underpaid… I know of a situation where carers would, instead of visiting the patient, check on patients telephonically… "*

Most of the participants identified the lack of transport for the home-based care workers to do home visits as a main issue of concern. It appears this affected the number of patients they could reach for service delivery per day and they also got tired from the walking. A discussion of the last sub-theme, challenges emanating from patient care, follows.

Sub-theme 2.3: Challenges emanating from patient care

The participants, from their responses, seemed aware of the fact that the home-based care workers needed support with care of the patients in light of the fact that the majority of those doing this work were lay people. They shared the following concerns with regards to what the challenges facing the carers.

"…….because they do not have formal training, they sometimes use general knowledge to do the work……it is passion to help others in need that motivates them to be creative and find alternative ways of assisting the patients."

"Some of the carers work with patients who do not have another adult in the family to look after him/her when the carer leaves…….they are left alone until the carer comes again the following day…."

From the input of the participants, it appears that, although the home-based care workers did encounter difficulties in this area of work, it seems this was not the greatest need as compared to the other two sub-themes. The next focus is on support services that have been put in place to assist the home-based care workers to cope with the above-mentioned work-related challenges.

Theme 3: Available workplace support services

Home-based care in the HIV and AIDS field requires genuine care for patients and their families. Supervisors and managers have a responsibility to ensure that the home-based care workers stay motivated by implementing support services that are conducive to effective coping (Benevides-Pereira & Das Neves Alves, 2007:569-570; Colligan & Higgins, 2006:95). The participants mentioned the following about available workplace support services in their organisations:

"We provide individual counselling for the home-based care worker if she needs immediate debriefing. The service is rendered through our sister organisation that has a social worker…… such counselling is provided on a need basis. We also meet every Friday as a group for an informal debriefing…I facilitate the sessions."

"We have a trustee, a nurse by profession, who does counselling for the home-based care workers as and when it is necessary………So far I think it works as I have seen an improvement in the affected home-based care workers after such sessions."

"We normally have a once a year debriefing session early in the year…. It is facilitated either by the manager or an external volunteer…."

These were the only two workplace support services mentioned. The participants added that they have not found these strategies effective in assisting the home-based care

workers cope and more needs to be done, depending on the availability of funding. Some participants further mentioned that, when funding was available, the support services were regular and structured and an external professional facilitated the group debriefings. This was expressed by a participant as follows:

> *"A few years ago we used to have one debriefing group session per quarter……….this had to be stopped as there were no funds to pay for the facilitator…."*

In light of the highlighted gap left by funding cut-backs and resultant financial constraints, the participants were requested to make suggestions on what they would regard as a reasonable workplace support service for the home-based care workers. The discussion of their suggestions is covered in the next topic.

Theme 4: Suggestions for improvement of workplace support

According to the *National Norms and Minimum Standards for Home and Community based care and support programme* (Department of Social Development, 2007:16), all community caregivers, which included the home-based care workers, had to undergo at least two hours of debriefing on a monthly basis. The document does not specify who is supposed to facilitate this nor mention any other additional workplace support services, besides training. In order to improve the existing ineffective workplace support, the participants put forward the following suggestions:

> *"I prefer that we go back to the quarterly debriefing groups…. that is times a year. Reducing the workload of the carers to a manageable level could also help."*

> *"I suggest that we have quarterly group debriefing sessions by an external facilitator and six-monthly team building.."*

> *"What could work for us is to have a dedicated counsellor who is available to us when there is a need for individual counselling and also to facilitate debriefing sessions every fortnight."*

The suggestions for the improvement of workplace support are summarised as:

- structured group debriefing sessions for the team preferably by a professional;
- a suggestion for team-building sessions each semester; and

- manageable workload for home-based care workers.

It appears then that debriefing played an important role in the psychosocial support of the home-based care workers. In addition to these suggestions, *The Community Care Worker Management Policy Framework* (Department of Health & Department of Social Development, 2009:79) stipulated that home-based care organisations need to have quality support programmes that ensured that the wellbeing of home-based care workers was nurtured and they were empowered to sustain their ability to provide a caring and affective service to their patients. It could be assumed that, if all the suggestions mentioned were implemented, the general wellbeing of the home-based care workers would improve. The next focus is on the presentation of workplace support needs as identified by the participants.

6.3.3 Identified workplace support needs

In the previous section the supervisors/managers' input in terms of what they perceived as the workplace support needs of the HIV and AIDS home-based care workers was discussed. They also presented suggestions on how these needs could be addressed. From the data gathered, the following needs were identified:

- relief from emotional stress;
- coping with patient care demands;
- lack of material resources: particularly transport to home visits; and
- a structured workplace support programme, preferably facilitated by an external professional with specific focus on group debriefing and team building.

The researcher's impression is that the identified needs do not differ much with what the primary participants highlighted. The main difference seems to be what each group of participants emphasised as a need. Relief from the emotional stress of home-based care work seemed to be a priority for both groups.

One of the main goals of social constructionism is an understanding of social reality which is achieved through employing techniques (facilitated by language and social processes)

that eventually leads to generation of knowledge. It is through this knowledge that individuals are capacitated to make informed decisions (Burr, 2003:3; Lock & Strong, 2010: 8-9; O'Connor, 2015:7). By gathering data from both the primary (home-based care workers) and secondary participants (managers/supervisors), the aim was to gain a better understanding of the world of the home-based care worker in Tshwane. Another advantage of this process was that as it unfolded through the interaction between the participants and the researcher, the participants began to have a clearer understanding of their situation through reflective and critical analysis. They were capacitated to put suggestions as to how they wanted their work environment to change for their own benefit and that of their patients.

The next section focuses on comparing the two sets of data (i.e., data triangulation) in an effort to triangulate the findings.

6.4 SECTION C: DATA TRIANGULATION OF RESEARCH FINDINGS

The purpose of gathering data from both the primary and secondary participants was to ensure that all the relevant data with regards to the workplace support needs of the home-based care workers were captured and that the perceived quality of the data is of an acceptable research standard. This was achieved through a process of triangulation whereby the combined data were used to compensate for omissions or oversight by one of the groups (Cooper & Schindler, 2014:166-167). Basically, it was the subjective views of those experiencing the assumed workplace stress and those whose responsibility was to support and guide them. In the analysis of both sets of data, patterns of similarities and differences were observed in terms of what was regarded as workplace support needs by both the primary and secondary participants.

In terms of **similarities**, the following were identified:

- Relief from emotional stress: both the primary and secondary participants expressed how emotionally draining the work could be. The primary participants were vocal about how draining the work was and how they struggled to cope, to the extent that some were not able to de-role once they

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were back home. The secondary participants also commented on the helplessness that they sometimes observed among their supervisees.

- Coping with patient care demands: both groups of participants expressed that although the primary participants received training, in most instances they were unprepared for what they had to deal with in reality with regards to patient care. More was seemingly expected, especially by the patients and their families.

- There was a need for debriefing sessions to assist them to cope with the demands of the work, especially when they experienced trauma during home-visits.

- Lack of material resources: the primary and secondary participants voiced their opinions and concerns with regards to how the lack of material resources such as food parcels, transport, regular stipend, home-based care kits, etc. compromised the home-based care workers' ability to render effective and quality service. The lack of adequate and consistent funding was highlighted as a major contributing factor.

With regards to the lack of material resources, the primary participants expressed their greatest need as transport to visit patients' homes, take patients to healthcare facilities, and to distribute food parcels. For the secondary participants, emphasis was more transport for home-based care workers to carry out home visits. The opinions of both groups were further supported by similar studies on community and home-based care workers' circumstances in South Africa (Limpopo and Gauteng) where HIV and AIDS home-based care workers indicated that structural problems such as the lack of resources, lack of transport for the carers and also for taking the patients to and from healthcare facilities left them emotionally overwhelmed and barely coping (Moetlo et al., 2011:140-141; Ntobeng, 2016:53). Generally, there was consensus between both groups of participants in terms of the workplace support needs, with emotional support being a priority.

Even though there were numerous similarities, both groups differed in their view of the need for additional workplace support services. The **main difference** was that the primary participants had identified a need for on-going professional development and training,

whilst the secondary participants had highlighted a need for an external professional to conduct the debriefing sessions.

The workplace support needs identified by both the home-based care workers and their supervisors/managers, were then incorporated into the prototype stress management programme with the exception of lack of resources and on-going professional development and training. The researcher's view was that the latter were needs best addressed by the organisations' management or were beyond the ambit of a programme focused on psychosocial stress-centred issues.

6.5 SUMMARY

Data gathered from both primary and secondary participants have been analysed with the aim of understanding their world, specifically the difficult challenges that they faced as carers of those who are ill at home. Sometimes they were the only link the patients had with public health resources and other community resources they needed. The data have shown that the main challenges that the HIV and AIDS home-based care workers faced was the emotional stress/drain, the lack of material resources that made their work much more difficult, challenges of caring for ill people who also came with emotional baggage (adds to the emotional stress), and the lack of proper psychosocial support structures from the organisations. Difficulty with funding was highlighted as one of the main contributing factors to the situation which was probably out of the hands of both the home-based care workers and their supervisors/managers.

The qualitative data therefore yielded information on what the workplace support needs of the participants were and recommendations were made by both the home-based care workers and supervisors/managers concerning what possible action could be taken to partly remedy the situation. Additional quantitative data have also been gathered to ensure that no stone is left unturned with regards to the workplace needs of the home-based care workers. The next chapter presents and analyses the quantitative data.

CHAPTER 7

QUANTITATIVE RESEARCH RESULTS: PROBLEM ANALYSIS AND PROJECT PLANNING (PHASE 1) & DATA TRIANGULATION

7.1 INTRODUCTION

In addition to the qualitative data that were discussed in the previous chapter (Chapter 6), quantitative data were also gathered from the thirty-five primary participants. The quantitative data were gathered using a non-standardised questionnaire with ten statements, which focused mainly on the participants' perceptions of job satisfaction and dissatisfaction.

The chapter is divided into two sections. Section A focuses on a discussion and interpretation of both the biographical data of the participants and their inputs on the questionnaire. The biographical data, although already discussed in the previous chapter (Chapter 6), is presented again but with specific focus on the participants' age, highest qualification level and years of work experience. A comparison is provided to investigate a possible association between each of these variables (participants' age, highest qualification level and years of work experience) and job satisfaction and dissatisfaction, as expressed by the participants. Section B on the other hand, focuses on the triangulation of both the qualitative (Chapter 6) and quantitative research findings. The aim again has been to cover any loopholes or/and gaps that each of the research approaches may have had, that would impact on the quality of the findings reached and concomitant conclusions.

7.2 SECTION A: RESEARCH RESULTS AND INTERPRETATION

Before presentation of data analysis and interpretation, firstly the measuring instrument and the statistical procedures used to analyse the data are briefly explained. The self-administered non-standardised questionnaire (Appendix C) as earlier mentioned,

consisted of ten statements. The first five statements measured job satisfaction whilst the last five statements measured job dissatisfaction among HIV and AIDS home-based carers. Responses to the Likert scale statements were coded as 1 = strongly disagree; 2 = disagree; 3 = agree and 4 = strongly agree. Each participant completed the questionnaire individually, with the researcher present for clarifications or questions that the participant might have had. The researcher's input was kept to the absolute minimum so as not to influence the participants' responses (Delport & Roestenburg, 2011:188). The participants' responses were initially analysed using descriptive statistics. Furthermore, bivariate statistical analysis was used to compare the data measuring job satisfaction and dissatisfaction with biographical data, that is: age, highest qualification level and years of work experience (Fouché & Bartley, 2011:266).

In totality descriptive statistics (means, frequencies and percentages), the Shapiro-Wilk test, Levene's test for homogeneity of variances, one-way analysis of variance (ANOVA), the Bonferroni test and the Pearson correlation-coefficient (r) are the statistical tests that were used to analyse the data. When comparing the age groups of the participants and job satisfaction and dissatisfaction, two additional statistical tests were implemented: the Bonferroni test to authenticate the findings of the ANOVA and the Pearson correlation-coefficient to measure the strength and direction of the linear relationship between the age groups of the participants and job satisfaction and dissatisfaction (Marsh & Elliott, 2008:187; Moore, 2010:105,107; Salkind, 2017:127-129; Privitera, 2016:289,302).

The next discussion focuses briefly on the biographical data which are presented in tables.

7.2.1 Biographical information of the HIV and AIDS home-based care workers

The quantitative data analysis focused only on the age, highest qualification level and years of experience as home-based care worker, of the participants. The reason for this was the assumption that these biographical variables might have a bearing on the analysis of the data on job satisfaction and dissatisfaction of the thirty-five participants. The biographical data are presented as follows:

7.2.1.1 Age

The age of the participants is presented in three groups consisting of the youth, 24-35 year olds, adults, 36-58 year olds, and older persons, 60-65 year olds. It is tabulated as follows:

Table 7.1 Age of the home-based care workers

		n	%
	Youth (24-35)	15	42.9
	Adults (36-58)	13	37.1
	Older persons (60-65)	7	20.0
	Total	**35**	**100.0**

The mean age of the participants was 41.34 years ($M = 41.34$, SD = 14.00) at the time of the study. The mean age of participants fell within the adult category, although the frequency column indicated that there were more participants in the 24-35 year age group. Based on the data, it could be assumed that the majority of the participants (42.9%) were in the early adulthood stage according to the psychosocial theory of human development of Erickson, which is from 20 to 39 years of age. It was further proposed that it is a developmental stage where the individual is preoccupied with establishing intimate relationships with other adults and at the same time retaining a sense of self. Common personality traits during this stage include agreeableness, being well-organised, reliable, hardworking, driven and responsible and openness to experience (Gardiner & Kosmitzki, 2011:198; Walker & Crawford, 2014:120).

The cited literature seemed to be consistent with the reasons the participants gave as to why they became home-based care workers (discussed in Chapter 6, Theme 1: Appeal of home-based care). The above-mentioned personality traits could be the driving force behind the participants' interest in employment opportunities that would make meaningful contribution to society through self-giving.

7.2.1.2 Years of experience as home-based care worker

As mentioned in Chapter 5, section on "study population and sampling," the minimum requirement for participation in the study was at least one year's experience as a home-based care worker. However, there were a few participants with less experience who meaningfully contributed to the study, and their data were included in the survey. The years of experience as home-based care workers were categorised as follows to undertake further analysis (see Table 7.2).

Table 7.2 Years of experience of home-based care workers

		n	%
	0 - 3 years	17	48.6
	More than 3 years	18	51.4
	Total	**35**	**100.0**

Table 7.2 highlighted that 51.4% of the participants had more than three years of experience as home-based care workers. It was almost an equal split with those who had less than three years of experience, that is, 48.6%. The mean number of years of experience was established at 3.9 ($M = 3.9$, SD = 3.17). The outcome of the analysed data seemed to suggest that the average number of years of experience of the participants was around four years. A similar study of caregivers across thirteen non-governmental organisations running home-based care programmes in the Eastern Cape also found that the average years of experience among the carers was four years (Morton, 2012: 82,99).

It should be noted that studies highlighted that high staff turnover was common in community and home-based care programmes. This concerning trend was attributed to challenges with respect to sources of funding, community ownership, and in some instances high levels of emotional stress and a lack of training and supervision (Lehmann & Sanders, 2007:14,15; Wringe et al., 2010:5). For the researcher, it meant the

participants reflected some of the realities of staff turnover in their field of work. The next focus is on the highest qualification level of the participants.

7.2.1.3 Highest qualification level

The participants, as part of the biographical data, were expected also to indicate their highest level of qualification. The data are presented as follows (see Table 7.3):

Table 7.3 Highest qualification level of the home-based care workers

		n	%
	Grade 11 and lower	20	57.1
	Grade 12 and higher	15	42.9
	Total	**35**	**100.0**

The data highlighted that the majority of the participants (57.1%) did not have a Grade 12 certificate. This finding was seemingly not unique to this study. Several studies in HIV and AIDS home-based care in India and South Africa also found the same trend, with more than 75% of participants not having obtained a Grade 12 certificate (Gopalan et al., 2012:4; Moetlo et al., 2011:139; Ntobeng, 2016:40). Although the participants were not open about revealing that their interest in home-based care was also sparked by unemployment, Statistics South Africa does emphasise that those who are unskilled and with a qualification below Grade 12 found it very difficult to enter the job market. Those who do, end up struggling to get promotions (Statistics South Africa: National and Provincial Labour Market: Youth, 2015:1). It can therefore be assumed that, although the primary appeal was altruism, limited job options because of their academic background might have played a role in their enrolment in the home-based care programme.

The biographical data as extracted from the non-standardised questionnaire has been deliberated on and gave a picture of trends identified and of who the participants were.

The next focus is on the analysis of data from the participants' responses about their experiences of HIV and AIDS home-based care.

7.2.2. Presentation of data on the participants' experience of HIV and AIDS home-based care

As earlier explained, the participants had to respond to ten statements that could be rated on a Likert scale from strongly disagree to strongly agree. The statements focused specifically on how the participants experienced their work as HIV and AIDS home-based care workers. The purpose was, therefore, to answer the following research question: *"What are the workplace support needs of HIV and AIDS home-based care practitioners in Tshwane that could be addressed through a stress management programme?"*

The analysis of the participants' responses to the non-standardised questionnaire is presented first, followed by a comparison of the results with their ages, years of work experience as home-based care workers and their highest qualification level.

7.2.2.1 Presentation of data from the non-standardised questionnaire

For comprehensive data analysis and presentation of the results, the data are presented in two figures. Figure 7.1 presents participants' responses to statements on job satisfaction (statements one to five), whilst Figure 7.2 is on the responses to statements on job dissatisfaction (which are statements six to ten). Furthermore, the categories of strongly agree and agree were combined into one, and the same was done with the categories of strongly disagree and disagree.

The responses on job satisfaction are presented as follows:
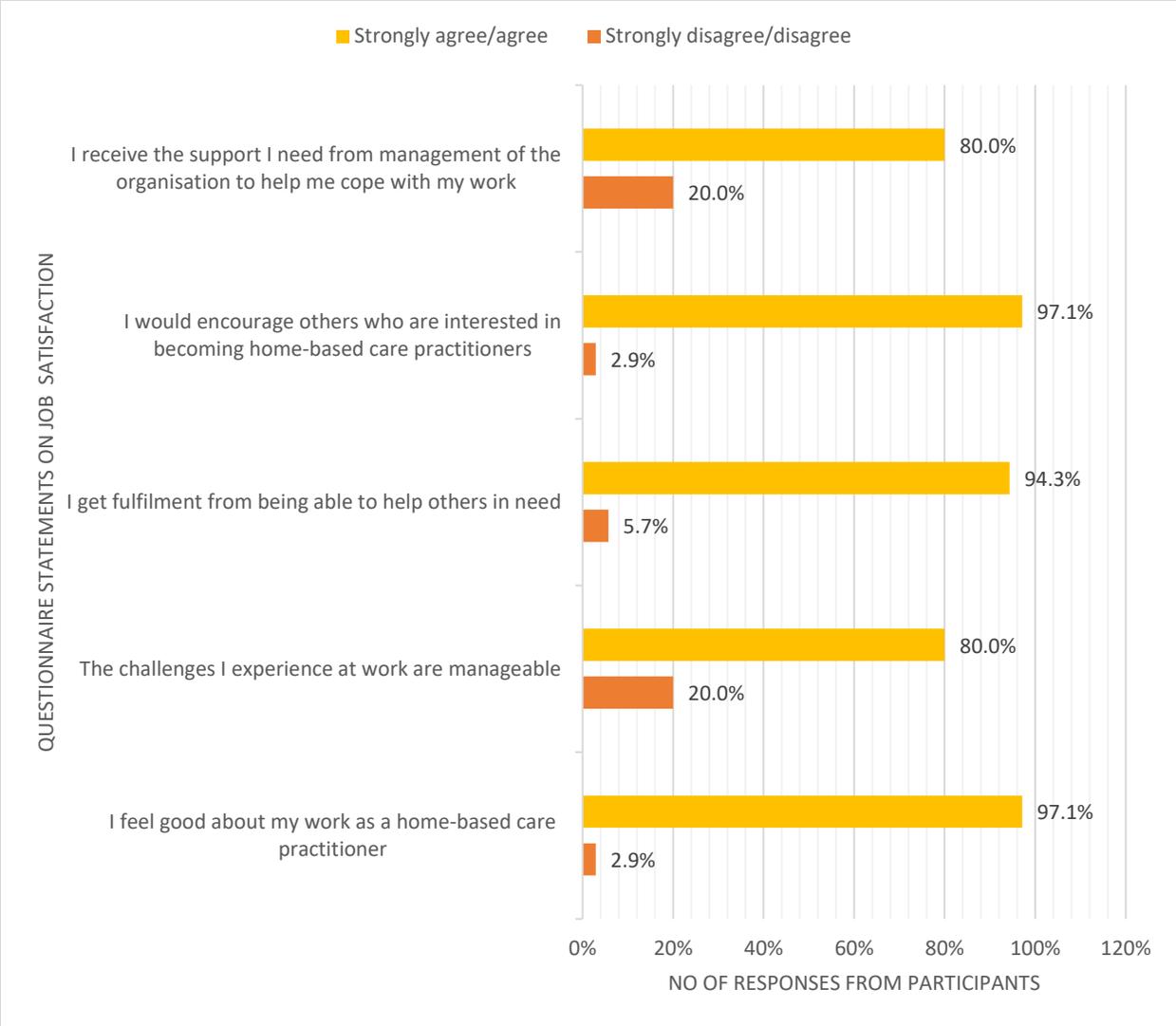
Figure 7.1 Home-based care workers' job satisfaction responses

Analysis of the data as presented in Figure 7.1 seems to suggest that there was an overall high level of job satisfaction among the participants. The levels of strongly agree/agree are notably higher than those of strongly disagree/disagree. The response rates provide evidence in support of this assumption in that the strongly agree/agree response rate ranges from 80% to 97.1%, whilst the strongly disagree/disagree responses ranges between 2.9% to 20%. It needs to be noted, though, that the statements on workload and supervision/management support (*Statement 2 "The challenges I experience at work are manageable" & Statement 5 "I receive the support I need from management of the organisation to help me cope with my work"*) had the overall highest strongly

disagree/disagree response rate, that is, 20%. This finding could indicate that this was a concern for the participants and therefore should not be ignored.

The literature confirmed that job satisfaction encompasses intrinsic and extrinsic features about the work. Extrinsic features include, amongst others, remuneration, organisational management style, job security and physical surroundings, whilst intrinsic features include the work itself (including workload), relationships with colleagues, work equipment and supervision. It was further observed that it was found across cultures that job satisfaction was largely influenced by the work the individual did and his/her personality (Judge, Parker, Colbert, Heller & Ilies, 2015:27,43; Weinberg & Cooper, 2007:16). The participants' responses seemed to imply that their job satisfaction was influenced largely by intrinsic features, that is, factors that had to do with the work itself, as evidenced in responses to statements 1, 3 and 4 (*Statement 1 "I feel good about my work as a home-based care practitioner," Statement 3 "I get fulfilment from being able to help others in need" & Statement 4 "I would encourage others who are interested in becoming home-based care practitioners"*). A similar finding was made in studies in South Africa on job satisfaction among nurses working in public health facilities. They attributed their job satisfaction to the work context, specifically that they found fulfilment in helping to alleviate the suffering of patients and observing improvement in their quality of life (Bester & Engelbrecht, 2009:112-113; Delobelle, Rawlinson, Ntuli, Malatsi, Decock & Depoorter, 2011:380). The participants, being healthcare workers, like the nurses, seemed also to be deriving their job satisfaction from their interaction with patients.

The second part of the questionnaire (statements 6-10) focused on statements that implied job dissatisfaction with home-based care work. The participants' responses are displayed in Figure 7.2 as follows:
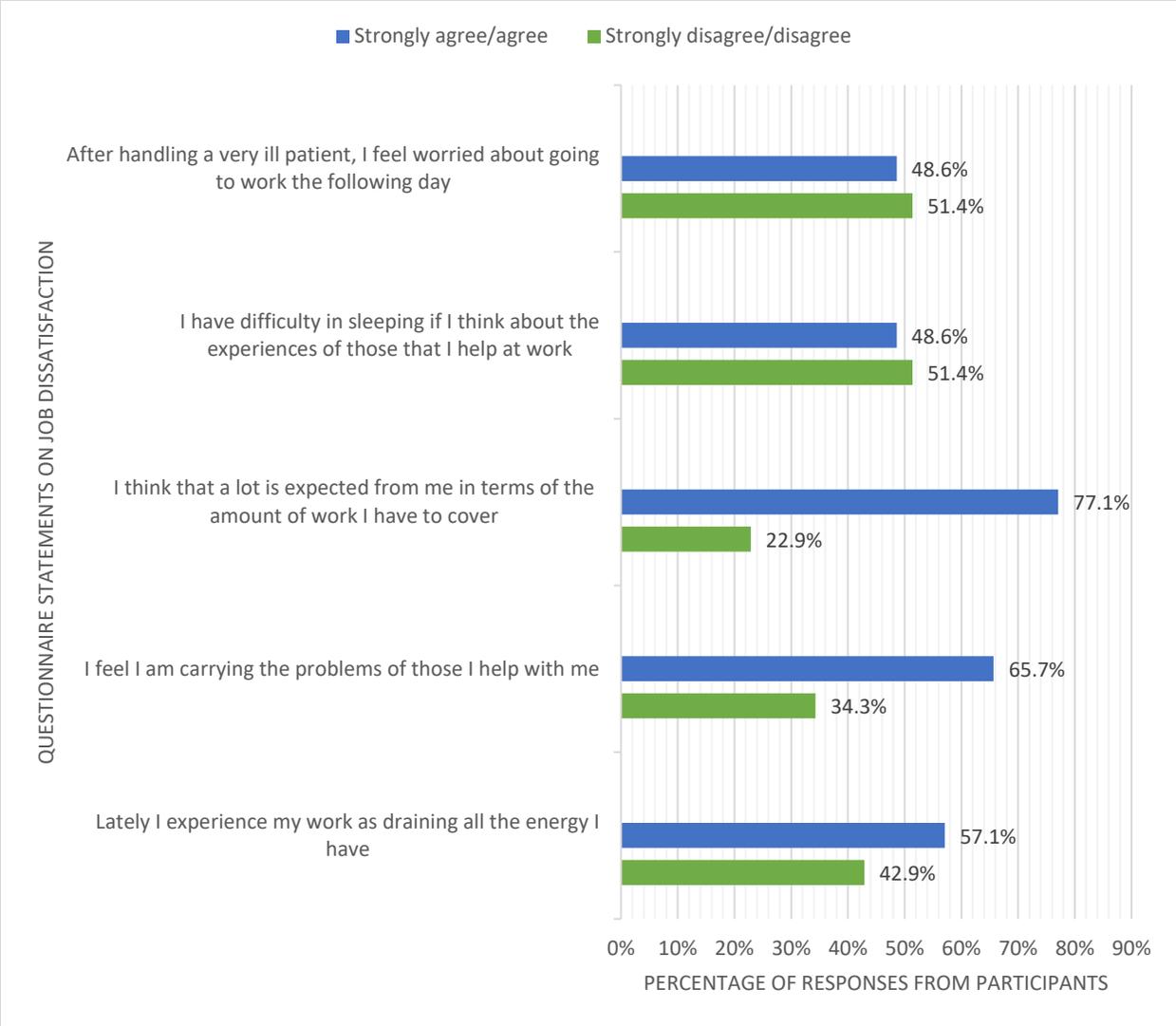
Figure 7.2 Home-based care workers' job dissatisfaction responses

The participants' responses as presented in Figure 7.2 seemed to indicate that, even though they reported that they were satisfied with some of the intrinsic features of home-based care work, there were other aspects of the work environment that they were dissatisfied with. An analysis of responses to statements 6 to 8 (*Statement 6 "Lately I experience my work as draining all the energy I have, Statement 7 "I feel I am carrying the problems of those I help with me" & Statement 8 "I think a lot is expected from me in terms of the amount of work I have to cover"*) seemed to indicate that the participants experienced their work as draining, presumably both physically and emotionally, and that they were overburdened with the workload. The responses to these statements ranged

from 57.1% to 77.1%, with workload ranking the highest. The finding seems to suggest that more than half of the participants found their work dissatisfying, specifically with the observed features of the work. With regards to statements 9 and 10 (*Statement 9 "I have difficulty sleeping if I think about the experiences of those that I help" & Statement 10 "After handling a very ill patient, I feel worried about going to work the following day"*) there was an almost equal split with those who struggled not to think about work whilst at home (48.6%) and those who were able to de-role (51.4%). The difference between the two groups emphasises that almost half of the participants struggled with de-roling. This result seems to support the participants' responses to statement 7 (*Statement 7 "I feel I am carrying the problems of those I help with me"*), where 65.7% agreed that they felt like they were carrying the problems of those they help.

Studies in South Africa on home-based care work highlighted that the practical demands of the caring process, particularly for terminally ill patients, placed a tremendous strain on the carers and impacted them on a range of levels (Morton, 2012:52; Orner, 2006:237). Similar studies that focused on the working conditions of nurses in the South African context, found that most participants cited high workload as a major source of job dissatisfaction. They were frustrated by the pressure they had to work under which made it difficult to give patients the attention they needed (Bester & Engelbrecht, 2009:111; Kekana, Du Rand & Van Wyk, 2007:32). It appears then that the high workload was not unique to nurses, but also applied to the home-based care workers, as they both attend to patients. The only difference was that nurses attended to patients in a formal healthcare facility, whilst the home-based care worker attended to them at home. Such frustrations, sometimes led to disillusionment, demotivation and compromised quality of home-based care work (Ntobeng, 2016:46).

The analysis of both sub-sections of the questionnaire seems to highlight that, although the participants experienced the content of their work as satisfying, particularly helping others in need, they were dissatisfied with the heavy workload that was draining and for some of the participants, also struggled with de-roling and/or disengaging from their work. The next section explores whether job satisfaction and dissatisfaction are associated (or

not) with the participants' age, years of experience as home-based care workers and highest qualification level.

7.2.2.2 Comparison of non-standardised questionnaire responses with the participants' age, years of experience and highest qualification levels

It has been established that, even though the participants found their work fulfilling, there were features of the work that they were dissatisfied with. This topic explores, through bivariate statistics, whether there was any association or relationship between job satisfaction and dissatisfaction and age, years of work experience and highest qualification level of the participants. As mentioned earlier, the overall aim was to gather as much data as possible so that the proposed stress management programme is holistic in addressing the needs of the home-based care workers.

In addition to descriptive statistics, a parametric test, one-way analysis of variance (ANOVA), was also used to conduct the bivariate analysis, as the research sample showed a normal distribution on the scatterplots, and based on the outcome of the Shapiro-Wilk test that obtained a p-value > 0.05 in all instances. The analysis of variance is a general method of testing the difference between the means of more than two groups on one factor or dimension (Moore, 2010:643; Salkind, 2017:289). The level of significance for the test results was established at 0.05, which is a commonly used value in the social sciences (Marsh & Elliot, 2008:151). Such a level of significance basically means that results from the comparisons of variables mentioned are only meaningful if their p-value is below 0.05, that is, p<0.05.

Other tests used as earlier mentioned were the Post Hoc multiple comparison test and the Pearson correlation coefficient, specifically with the comparison between the age groups of the participants and job satisfaction and dissatisfaction. Firstly, both job satisfaction and dissatisfaction were compared with the ages of the participants, secondly, with their years of experience as home-based care workers and thirdly, with their highest qualification level to establish the presence or absence of association.

7.2.2.2.1 Comparison of job satisfaction and dissatisfaction across the age groups of the participants

The participants from the three age groups (Table 7.1), that is youth (24-35), adults (36-58) and older persons (60-65) indicated their perceptions on satisfaction and dissatisfaction about their work as home-based care workers. The raw data gathered did not clarify which age group was more satisfied with their work and which was more dissatisfied with their work. Therefore, the study explored the possible effect of age group on job satisfaction and dissatisfaction, respectively, of the participants. In the interpretation of the tabulated results, it needs to be noted that the participants' responses to the statements on the questionnaire were ranked from 1 to 4, with 1 = strongly disagree, 2 = disagree, 3 = agree and 4 = strongly agree.

The results are presented in tables, with Table 7.4 displaying descriptive statistics for the job satisfaction and dissatisfaction scores across the three age groups and Table 7.5 the results of the one-way analysis of variance (ANOVA).

Table 7.4 Descriptive statistics data results – job satisfaction/dissatisfaction scores across age groups

| | | n | Mean | Std. Deviation | 95% Confidence Interval for Mean | | Minimum | Maximum |
					Lower Bound	Upper Bound		
Job satisfaction:	Youth	15	3.04	.51	2.76	3.32	2.20	4.00
	Adults	13	3.34	.40	3.09	3.58	2.80	4.00
	Older persons	7	3.60	.38	3.25	3.95	3.00	4.00
	Total	35	3.26	.49	3.09	3.43	2.20	4.00
Job dissatisfaction:	Youth	15	2.49	.61	2.16	2.83	1.60	3.60
	Adults	13	2.85	.55	2.51	3.18	2.00	3.80
	Older persons	7	2.77	.56	2.25	3.29	1.80	3.60
	Total	35	2.68	.59	2.48	2.89	1.60	3.80

Table 7.5 Results on analysis of variance (ANOVA) – job satisfaction/dissatisfaction scores across age groups

		Sum of Squares	df	Mean Square	F	Signifi-cance
Job satisfaction:	Between Groups	1.62	2	.81	3.96	.03
	Within Groups	6.52	32	.20		
	Total	**8.14**	**34**			
Job dissatisfaction:	Between Groups	.94	2	.47	1.40	.26
	Within Groups	10.8	32	.34		
	Total	**11.7**	**34**			

Descriptive statistics in Table 7.4 show that the means for all three age groups differed with regards to **job satisfaction**, but not with a high margin. The mean for the youth was 3.04 (M = 3.04, SD = 0.51), the adults 3.34 (M = 3.34, SD = 0.40), whilst the older persons was 3.60 (M = 3.60, SD = 0.38). The results therefore seem to indicate that, although they were all satisfied with their work, the older persons showed a slightly higher level of satisfaction than did the other two groups. With regards to **job dissatisfaction**, the mean for youth was 2.49 (M = 2.49, SD = 0.61), the adults 2.85 (M = 2.85, SD = 0.55) and the older persons 2.77 (M = 2.77, SD = 0.56). It appears then that the level of job dissatisfaction was higher among both the adults and older persons group. In order to verify the accuracy of the results, an analysis of variance (ANOVA) was computed (Table 7.5).

Before the analysis of variance (ANOVA) could be computed, certain assumptions had to be satisfied: the data had to have a normal distribution and the variances had to be homogenous. The Shapiro-Wilk test confirmed that the data had a normal distribution, while Levene's test for homogeneity of variances indicated that the variances were indeed homogeneous. The analysis of variance (ANOVA) tested the null hypothesis that the mean job satisfaction/dissatisfaction scores were all equal across. The ANOVA results in Table 7.5 indicated the p-value for **job satisfaction** scores among the three age groups as 0.03 [F (2,32) = 3.96, p-value = 0.03, effect size ω = 0.3873]. This meant that there was a significant difference across at least two of the age groups of the participants' mean job satisfaction scores as the p-value was lower than the level of significance (α = 0.05).

The effect size was 0.3874, which is a medium to large effect. With regards to **job dissatisfaction**, the p-value is 0.26 [F (2,32) = 1.40, p-value = 0.26]. The results suggested that there was not a significant difference of age group of the participants on their mean job dissatisfaction scores.

Furthermore, a Post Hoc multiple comparison test, specifically the Bonferroni test, was performed on the job satisfaction scores of the participants. In this case the Post Hoc test was used to identify for which age groups the mean job satisfaction scores were statistically different form one another. This meant that it could only be computed after a significant result had been obtained from a statistical test, in this instance, the ANOVA (Marsh & Elliott, 2008:187). The test broadened the scope by calculating various comparisons of job satisfaction in one age group with the other two age groups. The results are presented in Table 7.6 as follows:

Table 7.6 Results from Bonferroni test

Dependent Variable	(I) Age groups	(J) Age groups	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Job satisfaction	Youth	Adults	-.30	.17	.27	-.73	.13
		Older persons	-.56	.21	.03	-1.08	-.03
	Adults	Youth	.30	.17	.27	-.13	.73
		Older persons	-.26	.21	.68	-.80	.27
	Older persons	Youth	.56[*]	.21	.03	.04	1.08
		Adults	.26	.21	.68	-.27	.80

Table 7.6 illustrated that the *p*-value of the comparison between jobs satisfaction among the youth and the older persons was 0.03 (p<0.05), implying that the mean job satisfaction scores differed significantly at the 5% level. The results of the remainder of the job

satisfaction score comparisons with the various combinations of the age groups showed p-values that were greater than 0.05 (p>0.05), meaning they were not statistically significant. The test results then, did not only confirm the ANOVA finding that there was seemingly an association between job satisfaction and age group. It specified that the association lies between the youth and the older persons and this was evidenced by the p-value of 0.03. The Bonferroni test thus seemed to have authenticated the findings of ANOVA on the comparison of job satisfaction and the age groups of the participants.

A further test, specifically the Pearson correlation-coefficient, was introduced to measure the strength and linear direction of the relationship between age and job satisfaction and dissatisfaction scores of the participants in light of the finding of a significant effect of age group on job satisfaction. It should be clarified that a correlation coefficient is always a number between -1 and +1. Values that are near 0 indicate a very weak linear relationship between the variables under study. The strength of the correlation increases as the value (number) moves closer to either -1 or +1. Furthermore, a positive value implies direct/positive correlation, meaning an increase or decrease in the one variable results in an increase or decrease in the other variable. On the other hand, a negative value implies an indirect/negative correlation, where an increase in one variable results in a decrease in the other variable and vise versa (Moore, 2010, 105,107; Salkind, 2017:127-129). The Pearson correlation coefficient results are presented in Table 7.7 as follows:

Table 7.7 Pearson correlation-coefficients with respect to age and job satisfaction/ dissatisfaction scores

		Age (years)	Job satisfaction	Job dissatisfaction
Age (years)	Pearson Correlation	1	.49[**]	.22
	Sig. (2-tailed)		.00	.20
	n	35	35	35
Job satisfaction	Pearson Correlation	.49[**]	1	.43[*]
	Sig. (2-tailed)	.00		.01
	n	35	35	35
Job dissatisfaction	Pearson Correlation	.22	.43[*]	1
	Sig. (2-tailed)	.20	.01	
	n	35	35	35

[**]. Correlation is significant at the 0.01 level (2-tailed).

[*]. Correlation is significant at the 0.05 level (2-tailed).

Table 7.7 shows that the Pearson correlation-coefficient between age and job satisfaction was 0.49; it is positive and closer to 0.50. The p-value (2-tailed) was ≤ 0.001, implying that the correlation coefficient is significantly different from zero at the 1% level of significance. This is a statistically significant correlation which means that there was a linear relationship between age and job satisfaction, confirming the results of the previously discussed tests. The Pearson *r* value obtained was 0.49. The results suggested that there was a direct correlation between age and job satisfaction, meaning an increase or decrease in age will effect an increase or decrease in job satisfaction. With regards to the strength of the correlation, it appears to be weak to moderate, as the value is closer to 0.50 than to 1.

Job dissatisfaction and its relationship to age were also correlated. The p-value (2-tailed) obtained was 0.20, a value that is greater than 0.05, that is, p>0.05. The results implied that the correlation coefficient between age and job dissatisfaction score did not differ significantly from zero. Furthermore, the Pearson correlation coefficient obtained was

0.22, a value that is positive and closer to 0. A conclusion could consequently be made that although the test results indicated a positive correlation between age and job dissatisfaction, the correlation appeared weak.

It appears that although the descriptive statistics seemed to suggest that there is also an association between job dissatisfaction and age group, the statistical analyses did not support that suggestion. However, the results from the ANOVA supported the finding that older persons seem more satisfied with their job as compared to those who are younger. Review studies in human resources that investigated the relationship between job satisfaction and age, amongst others, suggested that older persons were found to be more satisfied with their jobs, probably because they had fewer opportunities to change jobs and thus displayed commitment to their jobs (Kooij, Jansen, Dikkers & De Lange, 2010:1126; Willis-Shattuck et al., 2008:6).

The focus now shifts to a comparison of job satisfaction and dissatisfaction with regards to the participants' years of experience as home-based care workers.

7.2.2.2.2 Comparison of job satisfaction and dissatisfaction across years of job experience

The participants indicated on the questionnaire the number of years they had worked as home-based care workers. During the analysis of the data, these years of experience were divided into two categories, those who had worked for three years and less and those who had worked for more than three years as home-based care workers. Statistical procedures were applied to determine whether there was an association between job satisfaction and dissatisfaction with the categories of years of experience as home-based care workers. The analysed data are displayed in tables, with Table 7.8 showing descriptive statistics for the job satisfaction and dissatisfaction scores across groups of years of work experience and Table 7.9 on the results of the one-way analysis of variance (ANOVA).

Table 7.8 Descriptive statistics data results – years of work experience

		n	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Mini-mum	Max-imum
						Lower Bound	Upper Bound		
Job satisfaction	0 - 3 years	17	3.16	.41	.10	2.95	3.38	2.20	4.00
	More than 3 years	18	3.36	.55	.13	3.08	3.63	2.20	4.00
	Total	**35**	**3.26**	**.49**	**.08**	**3.09**	**3.43**	**2.20**	**4.00**
Job dissatisfaction	0 - 3 years	17	2.52	.46	.11	2.28	2.75	2.00	3.20
	More than 3 years	18	2.83	.66	.16	2.50	3.16	1.60	3.80
	Total	**35**	**2.68**	**.59**	**.010**	**2.48**	**2.88**	**1.60**	**3.80**

Table 7.9 Results on analysis of variance (ANOVA) – years of work experience

		Sum of Squares	df	Mean Square	F	Sig.
Job satisfaction	Between Groups	.32	1	.32	1.34	.26
	Within Groups	7.82	33	.24		
	Total	**8.14**	**34**			
Job dissatisfaction	Between Groups	.87	1	.87	2.66	.11
	Within Groups	10.83	33	.33		
	Total	**11.70**	**34**			

The descriptive statistics in Table 7.8 indicate that the mean for **job satisfaction** of the first group (0 – 3 years of work experience), was 3.16 ($M = 3.16$, SD = 0.41) whilst for the second group (3+ years of work experience) the mean was 3.36 ($M = 3.36$, SD = 0.55). It appears therefore that there was a negligible difference between the two means implying that both groups had the same level of satisfaction. The number of years as a home-based carer seemed not to have had any influence on the level of job satisfaction. With regards to **job dissatisfaction**, the mean for the first group was 2.52 ($M = 2.52$, SD = 0.46), whilst for the second group, it was 2.83 ($M = 2.83$, $SD = 0.66$). Again the difference

between the means is minimal and therefore it could be assumed that years of work experience again did not show any noticeable impact on the level of job dissatisfaction.

Table 7.9 displayed the results of the ANOVA which have been computed to test the null hypothesis that the mean job satisfaction/dissatisfaction scores would all be equal across the two groups of years of work experience as home-based care workers. The p-value for comparison of **job satisfaction** and the two groups of years of work experience was 0.26 [$F(1,33) = 1.34$, p-value = 0.26]. The p-value was greater than 0.05 (p>0.05) which implied that there was not a statistical significant difference of years of work experience on the mean job satisfactions scores. A similar finding existed with the comparison of **job dissatisfaction** and the two groups of years of work experience. The p-value was 0.11 [$F(1,33) = 2.66$, p-value = 0.11] which is greater than 0.05 (p>0.05) and therefore the findings also implied that there was not a statistical significant difference of years of work experience on the mean job dissatisfaction scores. It can be concluded, based on results of both descriptive statistics and the ANOVA, that there was no significant difference between job mean satisfaction/dissatisfaction scores and years of work experience as home-based worker. On the contrary, studies (Spain & USA) on job satisfaction and dissatisfaction in the services industry (private and public sector), found that job satisfaction increased with the years of work experience (Barth, Lloyd, Christ, Chapman & Dickinson, 2008:204; Peiro, Agut & Grau, 2010:682).

Years of work experience was not the only variable explored with regards to its possible relationship with job satisfaction and dissatisfaction, the highest qualification level was also considered and it is discussed next.

7.2.2.2.3 Comparison of job satisfaction and dissatisfaction across highest qualification levels

The minimum educational qualification requirement to work as a home-based worker, as earlier mentioned, was Grade 12. Concessions were made to allow those without Grade 12 to work towards attaining the qualification. From the biographical information obtained from the participants, two categories of highest qualification levels were created. The first

group consisted of those with Grade 11 and below, whilst the second group consisted of those Grade 12 and post-Grade 12 qualification. This section explores a possible association between job satisfaction/dissatisfaction and each category of highest qualification levels. The data are presented using tables, namely: Table 7.10 on descriptive statistics for the job satisfaction and dissatisfaction scores across the two groups of highest qualification level and Table 7.11 on the results of the one-way analysis of variance (ANOVA). These tables are presented as follows:

Table 7.10 Descriptive statistics data results – highest qualification level

		n	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Mini-mum	Maxi-mum
						Lower Bound	Upper Bound		
Job satisfaction	Grade 11 and lower	20	3.40	.50	.11	3.16	3.64	2.20	4.00
	Grade 12 and higher	15	3.08	.42	.11	2.85	3.31	2.20	3.60
	Total	**35**	**3.26**	**.49**	**.08**	**3.09**	**3.43**	**2.20**	**4.00**
Job dissatisfaction	Grade 11 and lower	20	2.75	.55	.12	2.49	3.00	1.80	3.80
	Grade 12 and higher	15	2.59	.64	.17	2.23	2.94	1.60	3.80
	Total	**35**	**2.68**	**.59**	**.01**	**2.48**	**2.88**	**1.60**	**3.80**

Table 7.11 Results on analysis of variance (ANOVA) – highest qualification level

		Sum of Squares	df	Mean Square	F	Sig.
Job satisfaction	Between Groups	.88	1	.88	3.99	.05
	Within Groups	7.26	33	.22		
	Total	**8.14**	**34**			
Job dissatisfaction	Between Groups	.23	1	.23	.66	.42
	Within Groups	11.47	33	.35		
	Total	**11.70**	**34**			

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The descriptive statistics in Table 7.10 illustrated that the **job satisfaction** mean score for the first group (grade 11 and lower) was 3.40 (M = 3.40, SD = 0.50), whilst for the second group (grade 12 and higher), it was 3.08 (M = 3.08, SD = 0.42). The difference was not by a convincing margin and therefore created doubt with regards to assuming that there was no association, or there was an association between job satisfaction and highest qualification level. The situation was different with regards to **job dissatisfaction**. The mean score for the first group was 2.75 (M = 2.75, SD = 0.55), whilst the second group, it was 2.59 (M = 2.59, SD = 0.64). The findings were subjected to further scrutiny using the ANOVA.

Table 7.11 displayed the results of the analysis of data using the ANOVA. The purpose of the analysis was to test whether the mean scores for job satisfaction and dissatisfaction, respectively, were equal between the two groups of highest qualification level of the participants. The results indicated that the p-value was 0.05 [F (1,33) = 3.99, p-value = 0.05, effect size ω = 0.2632]. As p = 0.05, it can then be concluded that the findings indicated that there was not a statistically significant difference of group of highest qualification level on the mean scores for **job satisfaction**. The effect size of ω = 0.2632 is small to medium. With **job dissatisfaction**, the p-value obtained was 0.42 [F (1,33) = 0.66, p = 0.42], meaning p-value >0.05, thus implying that there was not a statistically significant difference of group of highest qualification level on the mean scores for job dissatisfaction. Both statistical tests seemed to suggest that there was no association between job satisfaction/dissatisfaction and group of highest qualification level. A study in Spain on job satisfaction and educational qualifications in the service industry found that highly educated workers were less satisfied with their work as compared to those less qualified. A study in Croatia among nurses, on the other hand, found that it was the less qualified that were less satisfied about their work (Golubic, Milosevic, Knezevic & Mustajbegovic, 2009:2064; Peiro et al., 2010:681). A literature review by Coomber and Barriball (2007:311) on the impact of job satisfaction on staff turnover among nurses, highlighted that there were conflicting research findings on whether educational qualifications impacted on job satisfaction/dissatisfaction or not. As a result, conclusions could not be drawn because a need for further research in this area existed. It does

appear then that the matter is still inconclusive as recent studies cited also provide conflicting conclusions.

With reference to the data analysis and interpretation of the comparisons of job satisfaction and dissatisfaction across the given categories of age groups, years of work experience and highest qualifications level of the participants, the findings seem to indicate that the only association that was evident was that of job satisfaction and the age groups. To be more specific, the older persons seemed more satisfied with their work than the youth. Therefore, it can be concluded that years of work experience and highest level of qualification did not have an effect on how satisfied or dissatisfied the participants were with their job as home-based care workers.

The next topic discusses the triangulation of both qualitative and quantitative research findings with the aim of establishing patterns of similarities and differences as part of the process of quality assurance for the proposed stress management programme.

7.3   SECTION B: DATA TRIANGULATION OF QUALITATIVE AND QUANTITATIVE RESEARCH FINDINGS

Data were gathered, analysed and interpreted using both qualitative and quantitative methods with the aim of ensuring that any valuable and relevant data that might be omitted by one method be captured by the other. The qualitative data analysis and interpretation were discussed in Chapter 6. It is basically engaging in checks and balances and ensuring that the voices and responses of the participants are accurately captured. Through the process of data triangulation, both sets of data were compared and conclusions were drawn. These conclusions played a vital role with regards to the content of the prototype stress management programme as the programme had to reflect what the participants identified as felt needs.

The process of data triangulation unfolds through a discussion of similarities and then differences between both qualitative and quantitative findings, followed by conclusions drawn with regards to the content of the prototype programme.

7.3.1 Similarities and differences between qualitative and quantitative research findings

The qualitative data consisted mainly of the narratives of the participants on a number of aspects of their work, including what they perceived as workplace support needs in accordance with the semi-structured interview schedule used. The quantitative data on the other hand quantified, using a non-standardised questionnaire (with Likert-scale type questions), how satisfied or dissatisfied the participants were with their work as home-based care workers. The comparison of the two sets of findings, using the concepts of job satisfaction and dissatisfaction, yielded patterns of similarities and differences that are presented in Table 7.12 and Table 7.13 respectively as follows:

Table 7.12 Similarities between qualitative and quantitative research findings

	QUALITATIVE FINDINGS	QUANTITATIVE RESULTS
Job satisfaction	The participants were satisfied with their work because: - A huge majority were home-based care workers mainly for altruistic reasons. - What motivated them in their work was: personal appreciation by patients, families, community and the organisation; recovery of patients from illness and a confidence boost from work achievements amongst other motivators.	The participants were satisfied with their work because: - They strongly agreed with statements that referred to the work being fulfilling, feeling good about the work and encouraging others to be home-based care workers. The positive responses ranged from 80% to 97.1% for strongly agree/agree.
Job dissatisfaction	The sources of participants' job dissatisfaction were: - The emotional strain of the job as it was difficult to only empathise and not sympathise with the patients. - The inadequate workplace support services	The sources of the participants' job dissatisfaction were: - Experience of the work as physically and emotionally draining and thus having difficulties to de-role when at home. Responses on strongly agree/agree ranged from 48.6% to 65.7%. - Inadequate supervision and management support (Statement 5 "I receive the support I need from management of the organisation to help me cope with my work). Responses were 20% for strongly agree/agree.

The similarities of both the qualitative and quantitative findings confirmed that the participants were satisfied with the content of the work. It was other features of the work, particularly the working conditions that they were dissatisfied with.

Differences between the two sets of findings were also identified and they are presented in Table 7.13 as follows:

Table 7.13 Differences between qualitative and quantitative research findings

QUALITATVE FINDINGS	QUANTITATIVE RESULTS
1. The participants added the following sources of **job dissatisfaction**: - Difficulty in coping with patient care. - Lack of material resources to do the work.	1. The participants rated high workload as a major source of **job dissatisfaction**. 77.1% of the participants indicated it as a concern.
2. Through the qualitative research method, both the primary and secondary participants were able to make suggestions on how the workplace support needs could be met.	2. The limitation of the quantitative method, as it works with numbers, was the inability to give the participants the opportunity to make suggestions on how the workplace support needs/job dissatisfaction might be addressed.
3. There was no comparison between the interview schedule responses and biographical data to assess the possibility of association.	3. Semi-structured questionnaire responses on job satisfaction and dissatisfaction were compared with the participants' age, years of work experience and educational qualifications to establish a possible association. The only statistical significant finding was that there was an association between job satisfaction and age, with the older persons being more satisfied with their work than the youth.

The findings, both qualitative and quantitative, therefore seem to corroborate the fact that both the emotional strain and inadequate supervisor/management support were the main concerns of the participants. The qualitative findings added difficulty to cope with patient care and lack of material resources to do the work as further concerns. From the

quantitative results, high workload was pointed out as being another main stressor that they struggled to cope with, and there was also an indication of which age groups the prototype programme should target the most, namely youth and adults.

As the research findings have been triangulated, the next focus is on those findings that should be incorporated in the prototype stress management programme.

7.3.2 Triangulated research findings and inputs for the proposed stress management programme

The triangulated research findings seemed to highlight that, although participants enjoyed their work, they were struggling to cope with the demands of the work. The available support structures were also cited as inadequate. The findings therefore confirmed a need for a stress management programme.

The research findings further suggested that the prototype programme had to assist and provide support for the participants in coping with the following:

- The **emotional stress** of the work: all participants claimed that the work was draining and with the qualitative findings, they were more specific on how emotionally and physically draining the work was and how they struggled to cope, to the extent that some were not able to de-role once they were back home.
- Coping with **patient care demands**: participants mentioned unpreparedness for what they had to deal with in reality with regards to patient care, as being another contributing factor to their inability to cope.

Another important suggestion for the prototype programme that was put forward by all participants was an improvement of the workplace support programme, with **regular and structured debriefing** as a priority. Therefore, facilitation procedures for conducting debriefing sessions were included in the programme. It should further be noted, as per the quantitative results, that the programme was **targeted more at the youth and the adults**, without alienating the older persons.

Concerns around **lack of material resources** to do the work, **unmanageable workload** and **inadequate staff development and training** are the responsibilities of the organisations' management and fall outside of the scope of the study. The researcher could only play an advocacy role by making the management of the respective organisations aware of these concerns.

7.4 SUMMARY

The quantitative research findings have been interpreted and discussed, shedding light into what the participants thought about job satisfaction and dissatisfaction with regards to their work as HIV and AIDS home-based care workers. It was evident that, although they enjoyed their work, there were aspects of their work which brought challenges to them, particularly the unmanageable workload. Inadequate workplace support was cited as compounding these challenges that they faced on almost daily basis.

Triangulation of both the qualitative and quantitative research findings presented a clear and full picture of the participants' perceptions of their work environment. There were both similarities and differences with regards to the findings, but there was general consensus that the participants needed improvement in the psychosocial support they received from their organisations to be able to cope with the demands of the work. The next chapter focuses on the compilation of the prototype stress management programme, as informed by the triangulated qualitative and quantitative research findings.

CHAPTER 8

THE STRESS MANAGEMENT PROGRAMME FOR HIV AND AIDS HOME-BASED CARE PRACTITIONERS

8.1 INTRODUCTION

The qualitative and quantitative research findings of Phase One (problem analysis and project planning) of the intervention research process confirmed the need for a stress management programme for HIV and AIDS home-based care practitioners.

This chapter focuses on the Design phase (Phase Three) of the intervention research (IR) process. It is closely interrelated with the early development phase (Phase Four) as together, they are part of a process continuum. The primary focus is on the design of the intervention (the stress management programme), and its observational models (Fawcett et al., 1994:33-36; Fraser et al., 2009:30).

The chapter starts by familiarising the reader with a description of the process that led to the compilation of the stress management programme, followed by a discussion of the theoretical framework that guided the design of the programme. Next is a detailed discussion of the five modules and seven sessions making up the programme. The topics of the modules include an overview of the stress management programme, patient care, understanding stress, stress management techniques and building resilience. Furthermore, a discussion follows of the programme (evaluation) theory, namely the logic model that guided programme implementation and evaluation. The chapter concludes with a summary.

8.2 DESCRIPTION OF THE STRESS MANAGEMENT PROGRAMME

The design of the stress management programme was informed by the implementation of objectives two and three of the intervention research process (Phase One and Phase Two), namely:

2. to assess the stress-related workplace support needs of HIV and AIDS home-based care practitioners in Tshwane; and
3. to consult relevant literature and existing effective stress management programmes in the healthcare field to gather additional data for insightful synthesis of data gathered from the research study participants.

Furthermore, a theoretical framework, to guide and provide theoretical grounding for the study, i.e., social constructionism, was adopted as being appropriate and relevant for the study. The same theoretical framework underpinned the design and compilation of the stress management programme. A discussion of the theoretical background and empirical findings to the compilation of the stress management programme follows.

8.2.1 Background information to the stress management programme

In an effort to gain insight into the research problem, the researcher consulted the existing literature and research studies on HIV and AIDS home-based care (see Chapter 2) and also on stress management programmes in the health care sector (see Chapter 3). The information gathered on home-based care, in brief, revealed that home-based care was part of the Department of Public Works' Expanded Public Works Programme (EPWP) of recruiting unemployed people and providing training and work experience opportunities whilst receiving a stipend. With the Department of Health struggling to contain the HIV and AIDS pandemic, the home-based care workers managed to fill the gap of staff shortages and overcrowding in public health facilities by caring for ill patients living with HIV and AIDS at home under the auspices of accredited non-governmental organisations.

Nursing patients in their homes presumably exposed the home-based care workers to the challenges of providing healthcare services in poorly resourced communities. The

literature and research studies in several African communities clearly explained that they were faced with high workloads, and also emotionally draining and stressful working conditions. These unfavourable working conditions were breeding grounds for distress and burnout (Chimwaza & Watkins, 2004:803; Defilippi, 2003:28; De Wet & Du Plooy, 2012:36; Hlophe, 2006:208; Majaja et al., 2009:16; Thomas, 2006:3179). Most non-governmental organisations, due to limited financial resources, prioritised survival needs to providing psychosocial support for the home-based care workers. Some home-based care practitioners resorted to relying on family and friends for support (Marais, 2005:68). The importance of structured and professional psychosocial support was highly recommended for the benefit of both the home-based care practitioners and their patients (Dageid et al., 2007:21-22; Uys, 2003:28).

In addition to studying the literature, empirical evidence was sought from the home-based care workers themselves. A need assessment was conducted with thirty-five HIV and AIDS home-based care workers, recruited from the regions of the Tshwane metropolitan municipality. They were the primary participants who were interviewed (using an interview schedule) and they completed a non-standardised questionnaire on their views and perceptions of workplace stress (burnout included), as well as an exploration on how they coped with their work and to explore available psychosocial support from organisations for which they worked. Five supervisors/managers of the home-based care workers were also recruited as secondary participants and their input was sought with regards to their perception on challenges, and possible stress and burnout experienced by the home-based care workers. They were also requested to comment on available workplace support within organisations and its effectiveness, where available.

As previously mentioned, both the qualitative and quantitative data that were gathered from both the primary and secondary participants were analysed, interpreted and triangulated. The findings of the process confirmed that there is a need for a stress management programme for HIV and AIDS home-based care workers in Tshwane which was in line with what the literature consulted and previous studies had already alluded to. The empirical research findings specified that the programme had to address the

following priorities: coping with emotional stress, coping with patient care and availability of regular and structured debriefing sessions (see Chapter 7: section 7.3.2).

Further information was sought from the literature and previous studies with regards to stress management interventions that have proven effective in the healthcare sector. The purpose of the search was to ensure that the stress management programme was comprehensive and that it responded to the target group as home-based care workers were lay healthcare workers. Information gathered, as explained in the literature chapter on stress management interventions (see Chapter 3: section 3.4.), revealed that limited studies and reviews exist on stress management interventions for healthcare workers with nurses and their aides being targeted the most as research participants at the exclusion of other healthcare workers, including the HIV and AIDS home-based care workers. The most frequently used stress management interventions in the healthcare sector were identified as mindfulness-based stress reduction and psycho-education (see Chapter 3: section 3.4). These two interventions were incorporated into the stress management programme, as home-based care workers had similar support needs as other healthcare workers. Cognitive behavioural therapy (see Chapter 3: section 3.3.2.1) was also included in the programme mainly because as it has been lauded as very effective in managing workplace stress. The additional components of the programme were extrapolated from the empirical findings.

The literature and research findings that comprise the programme has been highlighted. Next is a discussion of the theoretical framework (social constructionism) that guided the design of the programme.

8.2.2 Application of social constructionism in the design of the stress management programme

An intervention programme's aim is to effect some form of positive change and impact on the lives of the programme participants. When designing an intervention programme the researcher needs to know how the problem developed, including the contributing risk and protective factors. Once that has been established, the knowledge is transformed through

specific inputs into an intervention programme with clear desirable outcomes (Chen, 2015:3; 5; Fraser et al., 2009:50; Royce, Thyer & Padgett, 2010:5). It is further clarified that every intervention programme has to be based on a credible and sound theoretical framework. The purpose of the framework is to guide the conceptualisation of the causes of the problem under investigation and the resultant solution mechanisms and strategies to the problem (Royce at al., 2010: 8).

Social constructionism, even in this phase of the intervention research process, served as the underlying theoretical framework that guided the researcher in transforming data gathered from the research participants and the literature consulted into an intervention programme that was "authored" by the research participants as it reflected their perceptions and opinions of what they viewed as challenges in their workplace and how and what they envisioned as the programme's content. The relevance of the theory in the programme design comes from its emphasis that research participants are "experts by experience" and that there is no one true explanation of reality (Gergen, 2001b:228; McLaughlin, 2009:16-17). As the programme is for the home-based care workers, its contents should reflect their views and inputs on how best to address the identified workplace challenges through the stress management programme.

Furthermore, social constructionism asserts that in the construction of social reality, individuals (research participants), should engage in this process without reference to already existing knowledge or programmes in light of the fact that the meaning of realities are relative to specific cultural, socio-economic and historical contexts (Burr, 2003:4; Gergen, 2001b:47; Lock & Strong, 2010:7). The construction of the programme, therefore, had to be unique in addressing the felt needs of the research participants and their creativity and critical thinking in terms of programme content and design. In other words, the researcher did not assume the role of an expert, but worked as an equal with the research participants with mutual respect, co-operation and collaboration in the programme design and development.

The use of language is viewed by social constructionists as vital in the construction of knowledge and social reality as it acts as a facilitation medium (Burr, 2003:4; Rodwell, 2015:8). The researcher has, therefore, ensured that the language of the programme is

user friendly, straightforward, easy to understand and refrained from using professional jargon. The aim was to enable the participants to identify with the programme content and, through further exploration of the programme, exchange ideas and give additional input on how best to improve relevance and effectiveness of the programme. An additional benefit was that the simple language supported the interactive style of programme facilitation. Although the programme manual was written in English, the facilitation language was a combination of English and seSotho (as seSotho was predominantly the mother tongue of most of the participants).

The role played by social constructionism in the design of the programme has been deliberated on. Next is a discussion of the contents of the stress management programme.

8.2.3 The contents of the stress management programme

The stress management programme for HIV and AIDS home-based care workers is an interactive programme of which the goal was to equip the participants with skills and knowledge to cope with workplace stress, strengthen existing coping mechanisms and promote resilience in the face of stressful working conditions. The piloting of the programme was group-based and facilitated with twelve participants (home-based care workers). Such a group size enabled healthy development of group cohesion, promotes active participation, sharing of ideas and opinions about the programme, with limited room for cliques resulting in overall participant satisfaction (Greeff, 2011:366; Wheelan, 2009:248).

The programme consisted of seven sessions covering five modules with each session's duration being about 90 minutes. Each session started with an ice-breaker to assist the participants to de-role and focus on the topic of the day, and ended with a written session evaluation. The session evaluation formed part of data gathering for the programme piloting process. The researcher assumed the primary role of facilitator during programme implementation. The programme contents are set out below.

Module 1: Introduction to the stress management programme

The module introduced the participants to the programme, giving it context, including setting group norms, clarifying programme facilitation methods and explaining the piloting of the prototype programme. Further information specific to the module was discussed in session 1 as follows:

- **Session 1:** The focus of the session was on giving **background information on the programme**. The purpose of the session was to familiarise and re-visit the problem under investigation and to ensure common understanding of home-based care in the HIV and AIDS field and workplace stress. The ice-breaker used was the "symbols worksheet." It had previously been successfully used with the Resilient Educators (REds) support programme for HIV and AIDS affected educators (Theron, 2007). It allowed exploration by the participants of their current perceptions of the HIV and AIDS pandemic in relation to home-based care using symbols on the worksheet. Topics discussed included a brief history of home-based care and its place in the fight against the HIV and AIDS pandemic, current global to local HIV and AIDS statistics, and an overview of stress in HIV and AIDS home-based care. The last topic discussed was the contents of the programme where participants were given an opportunity to give input on the division and sequence of the contents.

  Three class activities were facilitated to ensure active participation and that the views and opinions of the participants were known and noted. Class activity 1 was a group task, with participants brainstorming on their understanding of home-based care services. Class activity 2 was an open group discussion on the meaning and possible impact of current South African HIV and AIDS statistics on home-based care. Class activity 3, on the other hand, was an opportunity for the participants to share their views on the causes of stress in home-based care.

Module 2: Understanding illness

HIV and AIDS home-based care is mainly about caring for ill patients at home who are living with HIV and AIDS. The module aimed to impart information on how to cope and manage patients and their families' reactions to the disease.

- **Session 2: The experience and meaning of illness to the patient** was included in the programme because, during the needs assessment process, participants expressed the need to know more about this aspect of their work. The ice-breaker was a slightly modified values exercise from a group dynamics workshop at Wits Business School (Christie & Thomson, 2002). The exercise was about making a decision on who best qualified, among three candidates, for a single vacancy in a life-saving medical procedure. Brief background information on each candidate was given. Its relevance to the programme was that it afforded the participants the opportunity to think about their own personal values when working with patients. The session started with an explanation of terminology such as what is illness, health and disease. This was followed by a discussion of the impact and response of patient and the family to illness. A three-stage model of reactions to an HIV positive diagnosis by Baumgartner (2007) was discussed. Furthermore, participants were introduced to the BREAKS protocol (Background, Rapport, Exploring, Announce, Kindling and Summarising) of Narayanan et al. (2010) which provided guidelines on what the role of a home-based care worker was and what he/she can do in such situations.

  Two class activities were facilitated to ensure that the participants understood the concepts. Class activity 1 involved participants sharing their experiences of reactions to illness by their patients. Class activity 2 was on the practical application of the BREAKS protocol to two case studies.

Module 3: Understanding stress

The programme is about stress management. It was, therefore, appropriate to dedicate a session, explaining as comprehensive as possible the concept of stress to the participants to facilitate understanding. Stress was elaborated on in session 3 in the following manner:

- **Session 3:** Before stress management techniques and interventions could be entertained, it was deemed important that a common understanding of **"what is stress?"** be established. The ice-breaker was a fun clay activity whereby participants were asked to use the clay to mold whatever represented stress for them. The exercise was taken from the REds support programme (Theron, 2007), specifically, the stress management module. It allowed participants to be creative as they had to make something and the researcher viewed it as appropriate to expose the participants to the same activity. The session then focused on the definitions of, and an explanation of stress, eustress and distress. Stress responses were explored which helped to familiarise the participants with the three stress management techniques that formed part of the programme (Module 4).

  The first class activity focused on open discussion by participants on their understanding of stress. Activity 2 was a discussion by individual participants on stress responses they had observed among colleagues, friends or themselves. The purpose was to allow the practical application of knowledge gained on stress and stress responses. The last activity (class activity 3) was a group discussion on stress in HIV and AIDS home-based care. The purpose was to link information on stress and workplace stress in home-based care for a better understanding of the concepts and the lived experiences.

Module 4: Stress management techniques

This module covered session four to session six which comprised the following three stress management techniques.

- **Session 4:** The first technique discussed was the **Rational Emotive– Behavioural Therapy (CBT).** The value of CBT as a stress management technique is in its ability firstly to impart to individuals the skill to analyse and critically reality test the challenging situation they find themselves in. Secondly, it empowered individuals to explore new and better ways of thinking and behaving (Scott, 2009:1; Sheldon, 2011:3, 228). The ice-breaker was a card game. Random cards from the card deck of "The 7 habits of highly effective people" (Covey, 2003) were allocated to participants. An example would be a card written "Be a model not a critic." The participants could then share with the group how they could apply this principle in their daily lives. The exercise prompted participants to start thinking differently about the present situation. It was thus a fitting introduction to the stress management technique of the day, CBT.

  A brief theoretical background of the technique was discussed with the participants. The discussion was followed by a detailed discussion of the ABCDE model of CBT. The model stands for: A: activating event; B: belief about the event; C: consequences; D: disputing irrational thoughts; and E: new effective rational ways of thinking (Ellis, 2007 in Choudhury, 2013:13). The participants were engaged in two class activities with the view to facilitating an understanding of both CBT and the ABCDE model. Class activity 1 involved of brainstorming by the participants on what they understood CBT to be. Class activity 2 was a practical application of the ABCDE. Participants were further given homework to practise the model at home. Feedback on homework was given in the next session.

- **Session 5:** The second technique to be deliberated on was the **Critical Incident Stress Debriefing (CISD)**. The purpose of the technique is to equip participants with skills to facilitate the recovery process after exposure to trauma, and restore adaptive functioning (Pender & Prichard, 2009: 181). As previously mentioned, acquisition of the skill and knowledge of trauma debriefing was identified as a need during the need assessment process. The session started with feedback on homework on CBT by the participants, followed by the ice-breaker of the trust exercise. The trust exercise, also known as the "blind walk" (Trust building

activities…, 2018) involved participants dividing into pairs with one partner blindfolded whilst the other becomes the walker (of the blindfolded partner). The relevance of the exercise was that it promoted awareness among participants on the importance of providing support for one another especially in times of traumatic experiences in their work.

After feedback on the exercise, an explanation of trauma and trauma–related concepts was given followed by a discussion of seven phases of CISD, namely, introductory, fact, thought, reaction, symptom, teaching and re-entry phases (Pender & Prichard, 2009:177-178). In class activity 1, the group was divided into smaller groups (e.g. two groups). The first group discussed their own understanding of stress and crisis whilst the second group focuses on trauma and post-traumatic stress disorder. Feedback was then given to the whole group. The session was concluded with a second class activity - a practical application of the seven phases to a case study by the participants.

- **Session 6: Mindfulness-based stress reduction (MBSR)** was included in the programme because of its popularity as a relaxation method and it has proven to be effective as a self-care strategy in the healthcare field (Irving et al., 2009:65; MacKenzie et al., 2006:108; Shapiro et al., 2007:106). The ice-breaker was an adapted relaxation exercise (Naumberg, 2015:1; Steel, [sa]:1) where participants were requested to tense and relax body parts with soothing music playing in the background. Thereafter, they shared about the experience. The purpose of the exercise was to introduce them to 'body scan' which is one of the mindfulness-based stress reduction techniques. A general overview of the intervention then followed, including its key elements, benefits and the five techniques. Only two techniques were addressed in the programme, namely, body scan and sitting meditation. The reason for the choice was that they are practical and easy to follow. The techniques were combined and were practised in three steps. The participants were then introduced and briefed about the three steps process. Through class activity 1, participants were given an opportunity to give their understanding of what MBSR was. In class activity 2, the participants, guided by the facilitator,

engaged in both 'body scan' and 'sitting meditation' with relaxation music playing in the background. This was to allow for the practical application of what they had learnt in the session. They were also given homework to practise the sitting meditation technique at home. Feedback on the homework was given at the onset of the next session.

Module 5: Building resilience

After imparting skills and knowledge to the participants on techniques to manage stress, the last module of the programme focused on empowering the participants to go beyond managing stress, and be able to stand firm and be resilient in the face of adverse workplace challenges.

- **Session 7: Road to resilience and programme conclusion** was the last module and session of the programme. The purpose of the session was to bring together all that the participants had learnt and skills acquired and use this as a foundation for building resilience. Feedback on homework was given followed by the ice-breaker. The ice-breaker was about each participant identifying one person, a public figure, whom they regarded as resilient and to share that with a partner and then the bigger group. The purpose was to familiarise the participants with the concept of resilience through identification of real life models of resilience. This was followed by the unpacking of the concept resilience through class activity 1 where participants used art to demonstrate their understanding of the concept. The drawings were then shared and discussed in the group. The facilitator and participants thereafter engaged in an open discussion of ways of maintaining mental health in light of the work environment they were exposed to, that from time to time expected them to over-stretch their coping mechanisms. The tree of life model, which comprised class activity 2, was used to assist the participants in identifying values, beliefs and support systems that they had used before and were likely to use again to build resilience (Positive Arcon, 2016). The tree of life exercise was adopted from the "Targeting Talent Programme – Life skills

component" (University of the Witwatersrand, 2015) as it has been proven to be a valuable tool in exploring resilience. Following this activity came the guidelines that participants should use to build and maintain resilience. The session concluded with a candle lighting exercise. Each participant was afforded the opportunity to share with the group, the "light" he/she had received from the programme, that is, what they found valuable about the programme. The facilitator then officiated in the programme closure.

The programme was facilitated through group work methods that are specific to working with adults. The relevance of group work methods was in their ability to allow participants to share their views of reality openly and challenge one another and in the process gain new insights, develop a group identity and achieve mutual understanding over time. Furthermore, the process was participant-centred and both the facilitator and participants related to one another as adults (Jordan, 2011:288; Greeff, 2011:368; Gregory & Thorley, 2013:20). This was in line with social constructionism that emphasised allowing participants to tell their own story their way, rather than the facilitator making assumptions about their perceptions of the pilot programme.

The role of the facilitator then became that of providing direction with the group, ensuring that session objectives are met, encouraging interaction, collaboration and support throughout the programme. The facilitator also took the lead in encouraging participation, without dominating the process, using probing questions with sensitivity, being observant of, and responding to, any group dynamics that might compromise the process, listening actively, reflecting and summarising the process at each session (Freeman, Wright & Lindqvist, 2010:382; Greeff, 2011:368; Gregory & Thorley, 2013:20).

The next focus is on the programme theory that was used to facilitate the evaluation of the prototype stress management programme.

8.2.4 Programme theory

During Phase Three of the intervention research process (Design & Development), focus was not only on the programme design but also on developing procedures for programme implementation and evaluation. As a result, a programme theory had to be adopted. The programme theory portrays the causal logic of the intervention and identifies the target, core activities, change or intervention agents and expected outcomes of the programme. It serves the purpose of achieving understanding of how a programme should work and provide indicators that show whether a programme is effective or not (Fraser et al., 2009: 31; 55; Royse et al., 2010: 9).

There are various theories that could be used as the programme theory. The logic model and theories of change seemed to be the most popular (Chen, 2015:58; Fraser et al., 2009: 55; Fraser & Galinsky, 2010:463). The researcher adopted the logic model because it is frequently used in programme design, implementation and evaluation, and was credited with consistency in producing theoretically sound and evidence-based programmes (Fielden et al., 2007:116,119). A detailed discussion of the model follows, including its application to the prototype stress management programme.

8.2.4.1 The logic model

The logic model is described as a tool, in the form of a diagram that demonstrates the connection between programme objectives, inputs and expected short- and long-term outcomes. Its advantages, amongst others, is that it enables programme evaluators to understand what should be put in place to ensure that the expected outcomes are realised, allow critical examination of the programme and facilitate open communication about strategies, budget, activities and outcomes (Fraser et al., 2009: 55; Royce et al., 2010:108-109). Although there are variations of this model, the core elements of the logic model remain inputs, activities, outputs and outcomes which are linked to programme components. Inputs refer to the raw materials and resources that are needed to accomplish listed activities such as human, financial, organisational and community resources. Activities are the services that the programme provides to achieve its goals

and objectives. Outputs, on the other hand, are the direct products of programme activities, usually measured in terms of the volume of work done and the number of people reached, while the outcomes are the expected changes brought about by the programme. Some models distinguish between short–term, intermediate and long-term outcomes (Chen, 2015:59; Lewis et al., 2012:67; Royce et al., 2010:109, Saunders, 2016:132; Savaya & Waysman, 2005:87). For the purposes of programme, the researcher included objectives in the model and did not distinguish between the terms (period) of the outcomes. Objectives provide the reader with a picture of what is supposed to be achieved per session, that is, the session focus. As the programme was being pilot-tested, the focus was only on immediate/short–term outcomes (Fraser et al., 2009:56). In brief, the model was modified to have the following components: objectives, inputs, activities, outputs and short-term outcomes. A graphical presentation of the logic model to the stress management programme follows.

8.2.4.2 The logic model application to the stress management programme

The model is presented in Table 8.1, a template illustrating the five components (objectives, inputs, activities, outputs and short-term outcomes) and how they were applied to the five modules and seven sessions of the intervention programme.

Table 8.1 The logic model of the stress management programme

Module 1: Introduction to the programme

Session 1: Background information on the programme

OBJECTIVES	INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
1. Explanation of background and the purpose of the programme. 2. Familiarising participants with the programme schedule. 3. Negotiating with the participants on the programme schedule and sequence of content.	- Flip chart - Koki pens - Prestik - Training room - Participant manuals - Symbols worksheets - Attendance register - Session evaluation forms - Facilitator - researcher	The symbols worksheet was used as an ice-breaker. Interactive group discussions and sharing of viewpoints on the following topics: - Description of home-based care, its history and umbrella of services. **Class Activity 1** was used to brainstorm on the understanding of the concept of home-based care. - Current HIV and AIDS statistics (global to local). **Class Activity 2** engaged participants in a discussion of the meaning of the statistics in relation to the current state of home-based care and patient needs. - Workplace stress in HIV and AIDS home-based care. Through Class Activity 3, participants brainstormed on the causes of stress in home-based care. - Appraisal of the content and sequence of sessions by participants.	- Adhering to 90 minutes session time. - Participants attend the session (max 10). - Session evaluation forms completed.	1. Participants are knowledgeable about the history of HIV and AIDS home-based care, its umbrella of services and causes of workplace stress in this field. 2. Participants are familiar with current HIV and AIDS statistics and the relationship to the current status of home-based care. 3. Identification of the place of home-based care in the continuum of care. 4. Successful appraisal of the content and sequence of the programme modules and sessions.

Module 2: Understanding illness

Session 2: The experience and meaning of illness to the patient

OBJECTIVES	INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
1. Familiarise participants with the concepts of health, illness and disease. 2. Gaining insight into how illness is experienced by both patients and their families. 3. Understanding the role of the home-based care worker in working with patients and their families.	- Flip chart - Koki pens - Prestik - Training room - Participants manuals - Values exercise worksheet - Session evaluation forms - Attendance register - Facilitator-researcher	The "values exercise" was used as an ice-breaker. Interactive group discussion and sharing viewpoints on these topics: - Explanation of terminology. - Impact of illness on the patient and reactions. Through **Class Activity 1** participants shared own experiences of patient reactions to illness. - Impact of illness on the family of the patient. - The role of the home-based care worker with chronically ill patients and using BREAKS protocol with people living with HIV and AIDS. Practical application of BREAKS was enacted through role play as **Class Activity 2**.	- The session is completed within the allotted 90 minutes. - All participants attend the full session. - Session evaluation forms are completed.	1. Participants gained knowledge and understanding of the meaning of health and related concepts, the impact of illness on the patient and the family and reactions to illness. 2. Participants understand their role with regards to patients with chronic illness and they are able to intervene using the BREAKS protocol.

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Module 3: Understanding stress

Session 3: What is stress?

OBJECTIVES	INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
1. Definition of what stress is and the different types of stress. 2. Promote understanding of individual stress responses. 3. Promote understanding of workplace stress. 4. Participants to gain insight into stressors in HIV and AIDS home-based care.	- Flip chart - Koki pens - Prestik - Training room - Participants manuals - Modelling clay - Session evaluation forms - Attendance register - Facilitator-researcher	Clay was used for the ice-breaker on stress. Interactive group discussion and exchange of opinions on the following topics: - Description of stress and related terminology including types of stress. **Class Activity 1** was used to brainstorm stress and related concepts. - Individual responses to stress. Participants shared personal experiences and observation of stress responses through **Class Activity 2.** - Revision of workplace stress in HIV and AIDS home-based care and link with Session 1. - Exploration of what could be done to manage workplace stress including a brief mention of stress management techniques that were in the programme.	- Adherence to the allotted time of 90 minutes session time. - All participants attend the full session. - Session evaluation forms completed.	1. Participants gained knowledge and understanding of stress and related concepts, types of stress and individual responses to stress. 2. Refreshed understanding of workplace stress in HIV and AIDS home-based care.

Module 4: Stress management techniques

Session 4: Rational Emotive-behavioural therapy

OBJECTIVES	INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
1. To gain understanding of cognitive behavioural techniques as a stress management strategy. 2. To be able to apply the techniques in their personal and work life.	- Flip chart - Koki pens - Prestik - Pens and exam pads - Training room - Participants manuals - Stephen Covey game cards - Session evaluation forms - Attendance register - Facilitator-researcher - ABCDE model worksheet	Game cards were used for the ice-breaker. Interactive group discussion and giving input on the following topics: - What is cognitive behavioural therapy (CBT) including its stress management techniques. Participants further shared their understanding of CBT through **Class Activity 1.** - Introduction to the ADCDE model of CBT in a didactic manner. Application of the model was practised through **Class Activity 2**. Participants are given homework to practise model further at home.	- Adherence to the allotted time of 90 minutes session time. - All participants attend the full session. - Session evaluation forms completed.	1. Participants understand the ABCDE model of CBT. 2. Participants are able to apply the techniques both in work and personal life to manage stress.

Module 4: Stress management techniques

Session 5: Critical Incident Stress Debriefing

OBJECTIVES	INPUT	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
1. To gain understanding of critical incident stress debriefing (CISD) as a stress management strategy. 2. To be able to apply the strategy in their work life.	- Flip chart - Koki pens - Prestik - Training room - Participants manuals - Blind folds - Session evaluation forms - Attendance register - Facilitator-researcher	Blind folds used for the trust exercise ice-breaker. Interactive group discussion and sharing viewpoints on these topics: - What trauma is and its relationship to stress. Through **Class Activity 1** the discussion of trauma is broadened to facilitate understanding. - Detailed explanation of the seven-phase model of CISD. Participants further practise the seven phases through role play in **Class Activity 2**.	- Adherence to the allotted time of 90 minutes session time. - All participants attend the full session. - Session evaluation forms completed.	1. Participants understand trauma and CISD as both a trauma and stress management strategy. 2. Participants have acquired the skill of practically applying the seven phase model of CISD in their work life to manage stress.

Module 4: Stress management techniques

Session 6: Mindfulness-based stress reduction

OBJECTIVES	INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
1. To gain understanding of mindfulness-based stress reduction (MBSR) as a stress management strategy. 2. To be able to apply the strategy in their work life.	- Flip chart - Koki pens - Prestik - Training room - Participants manuals - CD player - Session evaluation forms - Attendance register - Facilitator-researcher	CD player used to play music for the stretching exercise (ice-breaker). Interactive group discussion on the following: - Firstly **Class Activity 1** where participants shared their understanding of MBSR. - Description of MBSR including its components, benefits and programme techniques. - Specific focus on body scan and sitting meditation. Through **Class Activity 2** participants practised the two techniques. They were also given homework to practise further at home.	- Adherence to the allotted 90 minutes session time. - All participants attend the full session. - Session evaluation forms are completed.	1. Participants gained knowledge and understanding of MBSR. 2. Participants acquired the skill of using MBSR, specifically body scan and sitting meditation as stress management techniques.

Module 5: Building resilience

Session 7: Road to resilience

OBJECTIVES	INPUTS	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES
1. To gain understanding of what resilience is. 2. To share ideas on how resilience can be promoted in home-based care. 3. Exploration of using available support networks to manage stress.	- Flipchart - Koki pens - Training room - Participants manual - Colouring pens - Drawing paper - Candles and matches - Facilitator - researcher	Ice-breaker with participants identifying public figures who were resilient. Interactive group discussion and sharing of perspectives on: - What is resilience? **Class Activity 1** allowed participants to demonstrate their understanding of the concept through a drawing. - What could be done to promote resilience? Participants used the tree of life model in **Class Activity 2** to explore inner resources and support systems that could assist them to manage stress and be resilient. - Ways to build resilience. - Programme closure through a candle lighting exercise.	- Adherence to the 90 minutes allotted session time. - All participants attend the full session. - Session evaluation forms are completed.	1. Participants understand what resilience is. 2. Acquisition of information and knowledge by participants of how to build and maintain resilience.

The logic model (in Table 8.1), enabled a straight forward illustration of what transpires in each module and session, allowing an easy to follow and user-friendly evaluation of the prototype stress management programme with clear objectives and outcomes. The evaluation provides the researcher with data that either endorses the programme as is, or pinpoints areas that need modification, revision and maybe additions. The chapter is summarised in the next section.

8.3 SUMMARY

The chapter mainly provided background information on the design and development of the prototype stress management programme for HIV and AIDS home-based care workers. The links between the needs assessment empirical findings, previous research in the same area of focus and the literature consulted were discussed to ensure that the reader followed how the programme evolved. Social constructionism, the theoretical framework's guiding principles in the design and development of the stress management programme, ensured the programme was not only theoretically sound, but it was also centred on the unique needs of the participants.

The logic model was adopted as the programme theory, and its application to the programme was graphically illustrated to give a visual presentation on how the piloting process was implemented and evaluated. The model consisted of five core elements, namely: objectives, inputs, activities, outputs and short-term outcomes. The researcher is of the view that the model enabled straightforward assessment of what modifications and/or additions would need to be made to the programme to address the workplace support needs of the home-based care workers effectively.

The next chapter deliberates on the outcome of the pilot process, that is, empirical findings of data gathered from the participants regarding their evaluation of the prototype stress management programme. Firstly, the focus is on qualitative data, followed by an interpretation of the quantitative data collected.

CHAPTER 9

QUALITATIVE RESEARCH FINDINGS: EARLY DEVELOPMENT AND PILOT TESTING (PHASE 4)

9.1 INTRODUCTION

The stress management programme for HIV and AIDS home-based care practitioners which was discussed in the previous chapter, had to be pilot-tested before it could be implemented with the broader target group as per the intervention research process. The next phase of intervention research (Design and Development) is Phase Four which focuses mainly on early development and pilot testing of the prototype intervention. As the prototype intervention has already been developed during the design process as explained Chapter 8 (Phase 3), deliberations are only on the pilot testing process. The main purpose of the pilot testing process was to test whether the different components of the intervention work, so that the intervention could be modified accordingly (Fawcett et al., 1994:37; Fraser & Galinsky, 2010:464).

During this phase, both qualitative and quantitative data were gathered from the participants to establish the efficacy and efficiency of the programme. This chapter focuses exclusively on the presentation, analysis and interpretation of the qualitative data gathered. The research design used was the instrumental case study, whilst the data collection instruments were pre- and post- stress management programme semi-structured interview schedules and session evaluation forms. It is a requirement of the intervention research process that the intervention be tested in similar field conditions to those of the final intervention product (Fawcett et al., 1994:37).

The chapter starts with a discussion of the biographical information of the participants (Section A), then analysis and interpretations of the data from the pre-intervention and post-intervention semi-structured interview schedules with themes and sub-themes (Section B) (Appendices G & H), followed with a presentation and interpretation of data

from the sessions' evaluation forms (Section C) (Appendix I), comparison of both pre- and post-intervention data, application of the logic model to the piloting process and concludes with a chapter summary.

9.2 SECTION A: BIOGRAPHICAL INFORMATION OF THE PARTICIPANTS

The criteria for participation in this phase of the research process were similar to those of Phase 1 (problem analysis and project planning). The participants had to have at least one year experience as HIV and AIDS home-based care practitioners, irrespective of age and gender, and be working in the Tshwane metropolitan municipality. Volunteer sampling was used to recruit participants. Among the seventeen home-based care practitioners who attended the recruitment meeting, fourteen volunteered to participate in the piloting of the prototype programme. Two participants later dropped out due to competing work commitments. The initial plan was to have a maximum of ten participants but ended up with twelve participants as the additional members requested to be included with their colleagues.

As part of the data collection process, the participants had to provide information on their age, gender, racial group, marital status, highest qualification level and years of experience as home-based care practitioners. All the participants were African and female. Additional biographical data are provided in a table format in Table 9.1 as follows:

Table 9.1 Biographical profile of pilot study participants

PARTICIPANT NUMBER	AGE	MARITAL STATUS	HIGHEST QUALIFICATION LEVEL	YEARS OF EXPERIENCE AS HOME-BASED CARER
1.	30	Single	Grade 12	6
2.	32	Single	Grade 12	2
3.	31	Single	Post-Grade 12 qualification	2
4.	29	Single	Grade 8-11	7
5.	43	Married	Grade 8-11	6
6.	34	Single	Grade 8-11	6
7.	33	Single	Grade 12	7
8.	25	Single	Grade 12	5
9.	30	Single	Grade 12	1
10.	25	Single	Grade 12	6
11.	32	Married	Grade 12	7
12.	21	Single	Grade 12	2

Table 9.1 illustrates that the ages of the participants ranged from 21 to 43 years of age at the time of the study, with the average age being 30.6 years (SD = 5.50). With regards to marital status, only two participants indicated that they were married, whilst the rest reported being single. Furthermore, Table 9.1 showed that eight participants had attained a Grade 12 certificate, and one had a post-Grade 12 qualification, whilst only three did not have a Grade 12 certificate. It could then be assumed that the majority of the participants (75%) met the minimum standard for educational qualification for a home-based care worker (Department of Health & Department of Social Development, 2009:46).

Another finding was that, with regards to years of experience as home-based care practitioners, there were four participants whose years of experience ranged from one to two, whilst the remaining eight participants' ranged from five to seven years of experience. An assumption could then be made that the eight participants mentioned were likely to

give valuable input during the piloting process as they had spent a sufficient amount of time in home-based care to know what workplace support was needed and/or could work.

Brief background information of who the piloting process research participants were, has been given. Next is the presentation and discussion of data gathered from these participants, using the semi-structured interview schedules.

9.3 SECTION B: RESEARCH FINDINGS FROM THE SEMI-STRUCTURED INTERVIEWS

Data were gathered from the participants before and after exposure to the intervention using the semi-structured interview schedules. This sections gives a brief background concerning the data collection instruments followed by a detailed pre- and post-intervention data analyses and interpretation.

9.3.1 Brief background

During this Phase Four (early development and pilot-testing) of intervention research, the process was guided by the following research question:

"To what extent does the newly developed stress management programme succeed in mitigating the impact of work stress experienced by HIV and AIDS home-based care practitioners in Tshwane?"

To respond to the question and provide explanations, data were gathered from the participants using the semi-structured interview schedules before and after exposure to the stress management programme (intervention). The pre-intervention semi-structured interview schedule (Appendix G) consisted of twelve open-ended questions that the participants had to answer. The questions ranged from inputs of what they enjoyed about their work, the workplace challenges they faced and how they coped, available support systems in the workplace and what they expected from the stress management programme. The post-intervention semi-structured interview schedule (Appendix H) consisted of nine questions which also explored what they enjoyed about their work, the

workplace challenges they faced and how they had coped since participation in the stress management programme. The last four questions (Appendix H, questions 6 to 9) in the schedule focused specifically on evaluation of the prototype intervention.

Both sets of data (pre- and post-exposure to the stress management programme) were subjected to thematic analysis. The credibility of thematic analysis lies in its ability to help the researcher to identify and describe both implicit and explicit ideas within the complex textual data gathered and thereby produce themes and accompanying sub-themes which would make trustworthy interpretations and discussions of the research findings possible (Babbie & Mouton, 2011:412,492; Guest, MacQueen & Namey, 2012:10).

Furthermore, the logic model (see Chapter 8: Section 8.2.4), which is the programme theory that was adopted to guide the pilot testing process, was incorporated in the data collection process. The purpose was to ensure that, at the completion of the data gathering process, the five components of the model (objectives, inputs, activities, outputs and short-term outcomes) could be responded to as part of the intervention evaluation process. The value and relevance of the logic in this study was in its ability to guide the researcher on what should be put in place to ensure that the intervention was critically evaluated and expected outcomes are achieved (Fraser et al., 2009: 55; Royce et al., 2010:108-109).

Social constructionism as a theoretical framework was again used to guide the researcher during the data gathering and analysis process to ensure that the voices and opinions of the participants were audible and not misrepresented in translation and/or interpretation of the data. Discussion of the themes and accompanying sub-themes now includes verbatim quotations of the participants' responses and possible explanations from both the theoretical framework (social constructionism) and the literature.

A presentation and discussion of those themes and sub-themes derived from the data from the pre-exposure to the stress management interviews follows.

9.3.2 Discussion of themes and sub-themes from the pre-intervention data

Through thematic analysis, four themes and accompanying sub-themes were extracted from the interviews with the twelve participants. These are presented in Table 9.2 as follows:

Table 9.2 Themes and sub-themes from the pre-intervention semi-structured interviews

THEMES	SUB-THEMES
1. Job fulfilment indicators: what participants found fulfilling about their work	1.1 Professional growth opportunities 1.2 Enjoyable work 1.3 Opportunity to care for those in need
2. Participants' perception of challenges in the execution of their work	2.1 Lack of material resources that affect the ability to meet patients' needs 2.2 Experience of work as emotionally draining 2.3 Lack of skills to deal with challenging patients
3. Participants' ways of coping with workplace stress	3.1 Individual coping mechanism 3.2 Support from colleagues 3.3 Support from supervisor/social worker 3.4 Support from senior management
4. Participants' expectations of the stress management programme	

Theme 1: Job fulfilment indicators: what participants found fulfilling about their work

Within this theme, three sub-themes were identified among the responses of the participants on what they liked the most about their work as home-based care workers. These were: professional growth opportunities, enjoyable work and the opportunity to care for others in need. The sub-themes demonstrated the differing views that the participants had about what fulfilled them in their work as home-based care workers. In line with social constructionism, all their inputs had to be carefully categorised into sub-

themes to ensure that their views of social reality were accurately captured as there was no view that is better than the other (Gergen, 2001b:228).

Sub-theme 1.1: Professional growth opportunities

The majority of the participants explained that, although challenging, the work provided them with opportunities to stretch themselves and deal with situations that they would not ordinarily deal with if they were not in this field of work. In addition to the work experience they gained, the organisation also made an effort to offer opportunities to attend various short courses and workshops organised for non-governmental organisations to acquire additional skills relevant to their work. The sentiment was captured by one of the participants in this manner:

> "*I like my job because I learn new things every day. It gives me a lot of opportunities…..sometimes they take us to courses… courses offered by Social Development related to psychosocial…… I get challenges every day and I feel like I am achieving something.*"

Another participant was more specific in terms of the learning opportunities:

> "*I like the way we work….we get knowledge….. they teach us everything. We do not only get training from Social Development, we are also taught about health-related matters from the clinic.*"

The EPWP Social Sector Plan's goal, besides providing unemployed women with job opportunities, was to also ensure that they received training and work experience that would assist them to compete in the open labour market (EPWP Social Sector Plan, 2004:7-8). The participants' responses bore testimony to the fact that the programme was upgrading their skills and they were appreciative of the opportunity.

Sub-theme 1.2: Enjoyable work

A few participants' views were that they found their work enjoyable and that is what kept them motivated on a daily basis. Participants expressed their experience by stating that:

> "*I enjoy working with people………..I actually enjoy working with children the most.*"

> "*I enjoy working with children……I did not know how to work with children before I was a home-based care worker. I also enjoy caring for ill people.*"

A South African study and a review of altruism and volunteerism confirmed that working with people living with HIV and AIDS had been frequently cited as a "labour of love" by carers. They engaged in this kind of work presumably for the intrinsic rewards and the good feeling about themselves that they derived from the work (Du Preez & Niehof, 2007:102; Haski-Leventhal, 2009:286).

Sub-theme 1.3: Opportunity to care for those in need

One participant indicated that what she found satisfying about the work was that she got the chance to help those in need. She expressed it as follows:

> *"I like to help children and their families…. Especially those who have lost hope….. and those who have family members that are ill."*

The participant's view of her work could be regarded as altruism at it appeared that she found fulfilment in helping those in need without expectation of any extrinsic reward (Haski-Leventhal, 2009:271).

The three sub-themes discussed so far indicated that the participants found their work stimulating, and contributing in some ways to personal or professional growth and fulfilment. No participant mentioned that they did not find their work satisfying. All inputs and views of the participants were captured as guided by the theoretical framework, that is, all inputs were considered and none was viewed as superior to others (Gergen, 2001b:228). The next theme's focus on their views of workplace challenges.

Theme 2: Participants' perceptions of challenges in the execution of their work

The stress management programme aims to assist the home-based care workers with management of workplace stress. Although a needs assessment had been conducted during Phase 1 of the research process, the researcher was guided by social constructionism to establish from the pilot participants if they experienced the same workplace challenges. The theoretical framework encourages looking at reality from different perspectives to challenge common sense knowledge about the world we live in (Freedman & Combs, 1996 in Botha, 2002:13). The researcher therefore had to consider

the views of the pilot participants and not assume that the needs assessment findings would necessarily be applicable to them, or could not be improved on.

Three sub-themes were extracted from the data, namely the lack of material resources that would affect the ability to meet patients' needs, experience of work as being emotionally draining and lack of skills to deal with challenging patients. These sub-themes were similar to those expressed by the needs assessment participants (see Chapter 6: Section 6.2.1.2). The difference is that, with the pilot participants, what they experienced as work challenges seemed specific to the organisation and community in which they were working.

Sub-theme 2.1: Lack of material resources that affect the ability to meet patients' needs

The participants' responses were varied with regards to this sub-theme. In spite of that, there were two main concerns relating to the lack of material resources that they raised, which were the lack of transport to home visits and the lack of food parcels for impoverished families. More than half of the participants complained of having to walk long distances from one house to the other. They reported that in the communities that they work in, the houses were far apart. A participant expressed her concern in the following manner:

> *"In this kind of work we walk long distances because there is no transport offered by the organisation. When you arrive at home you are tired and you do not have time for your children…..the children need your time and attention. Houses in [name removed] are far apart. You have to walk quite a distance to get to the next patient's home…. this you do in the hot sun."*

Another participant said the following about lack of food parcels:

> *"…..sometimes during visits I will get to a family that has no food at all……..you find that there is nothing I can help with. When I have a meal at home, I think of them and I am overcome with pity. I ask myself if they do have anything to eat."*

A South African study and another in Tanzania confirmed the concerns of the participants that they were sometimes expected to walk from household to another in the communities that they worked in (Greenspan, 2013:6,8; Lund & Budlender, 2009:16). It has also been

found that there were situations where the home-based care workers relied on their families for material support such as food and transportation in the execution of their duties as the non-governmental organisations they were contracted to, could not provide such essential support (Greenspan, 2013:6,8; Lund & Budlender, 2009:16). These were some of the constraints within which the participants had to work. The next sub-theme for discussion is the emotional impact of the work.

Sub-theme 2.2: Experience of work as emotionally draining

All participants had to give specific input in terms of whether they found their work emotionally draining or not. All participants confirmed that they found their work emotionally draining and the following responses were received as explanations:

> *"Sometimes I am emotionally affected by the problems of my patients. I once had a patient that was physically disabled. She was staying with her mute boyfriend. She could not explain what help she needed. I could not communicate with the boyfriend to at least find out how I could help. I did not know where to start or what to do and left feeling frustrated…."*

> *" ……. When you have been unable to help a patient, ..by the time you get home you are irritable with your own family. Sometimes you even end up not wanting to do home visits the next day."*

Two South African studies confirmed that home-based care in the HIV and AIDS field was emotionally and psychologically stressful and also physically burdensome by its nature (Akintola, 2011:54; Ntobeng, 2016:20). It appeared then that what the participants were confirming was somehow expected, given the reality of the kind of work they are engaged in. The next sub-theme is on lack of skills to deal with challenging patients.

Sub-theme 2.3: Lack of skills to deal with challenging patients

HIV and AIDS home-based care workers are lay healthcare workers and therefore, the Department of Social Development (2007:15) had prescribed that, on joining the programme, employing organisations must provide induction of at least three days within a month and thereafter twenty-four days of on-going training per year. Organisations are also expected to arrange accredited training for them in home and community based care. At face value it appears that all these control measures ensured that the home-based care workers were adequately prepared for what they have to deal with in patients' home.

The participants' responses seem to paint a different picture. Some of the responses were:

> *"Sometimes I come across a family that is similar to mine……. We grew up as orphans……..so when I come across families like that, I think about my own situation and I struggle to address whatever is bothering them as I end up being overly sympathetic, I feel overwhelmed and not sure what to do."*

> *"Sometimes you get a family with such serious problems and you begin to think that your own personal problems are nothing as compared to theirs. You wish you could help them but the needs are just too much…….it is beyond my abilities as a home-based care worker………..in such cases I refer to other resources or to our social worker. At least she is able to be of more help to them than me."*

Two South African studies have alluded to the fact that home-base care workers, similar to the participants, complained that their on-going training and education had been neglected, leading to insufficient knowledge and skills. They needed to improve their work skills regularly to stay relevant and capable of servicing the variety of needs that their patients presented with, and also be able to know when and where to refer (Hlophe, 2006:201; Lehmann & Sanders, 2007:19). The spectrum of workplace challenges faced by the participants has been deliberated on, next focus is on how they cope with the challenges.

Theme 3: Participants' ways of coping with workplace stress

The previous theme (Theme 2) highlighted the participants' inputs, views and opinions on what they perceived as challenges that they have to face on a regular basis as they carry out their daily duties. Presumably some of the challenges were manageable, while others contributed towards workplace stress. The participants were asked to explain how they coped with the workplace stress, given that their work was regarded as inherently stressful (Akintola, 2011:54; Ntobeng, 2016:20).

Participants' sources of support and coping mechanisms culminated in four sub-themes. They are individual coping mechanisms, support from colleagues, support from supervisor/social worker and support from senior management. The sub-themes reflected

the social constructionism's notion that in the pursuit of meaning and understanding of human activities, it is possible to generate differing and sometimes inconsistent explanations of knowledge and reality (Lock & Strong, 2010:6; Touminen & Savolainen, 1997:82). The first sub-theme discussed is individual coping mechanisms.

Sub-theme 3.1: Individual coping mechanisms

Some of the participants mentioned that they found their own coping mechanisms being most effective in helping them to deal with work stress. Two participants expressed themselves as follows:

> *"When I feel that the work stress is too much, I get home and start spring cleaning………I do a lot of household chores and manual work like washing clothes, bathing the children ……. Any work that will make me not think about my difficulties with the patients ……I keep busy and I then forget about my work problems."*

> *"When I experience stress that is difficult to deal with, sometimes I deal with the situation head on….. sometimes I pray and ask God to help me."*

Studies among HIV and AIDS lay healthcare workers in the Gauteng province (South Africa) also found that sometimes care workers became creative with what they could do at an individual level to cope with the work stress. Such coping strategies included art, taking walks, humour and other forms of distraction to relax and rejuvenate (Hatzipapas, 2013:54; Visser & Mabota, 2015:173). Coping that was facilitated by support from colleagues is discussed next.

Sub-theme 3.2: Support from colleagues

The participants, as HIV and AIDS home-based care workers, formed part of a team. They were, therefore, expected to be able to work together, more so that they worked in pairs when doing fieldwork, specifically home-visits. Some of the participants indicated that they valued the support they received from their colleagues. The sentiment was expressed as follows by participants:

> *"When I am working with a patient that has serious difficulties, my colleagues are there to support me, especially those who have been through a similar experience. What they do (work) is what I do so they guide me from experience. It is easier that way."*

> *"Sometimes I share my work challenges with my colleagues….. especially those that I have
> a close relationship with.."*

Studies in the healthcare sector (South Africa) confirmed the value of collegial support. Workers reported dependence on one another for social and interpersonal support that resulted in a boost in morale and a feeling of belonging (Hatzipapas, 2013:53; Rabie, Klopper & Coetzee, 2017:4). The next focus is support from supervisors/social workers.

Sub-theme 3.3: Support from the supervisors/social workers

Whilst some participants valued individual coping strategies and collegial support, about half of the participants preferred support from either the social worker or supervisor, with the social worker being the first preference. Some of the participants put their views in the following manner:

> *"I explain to the social worker the difficult situation my patients are facing…..she would then
> intervene and work with the family to address the problem. I then wait for her to tell me to
> do a follow-up visit or something else. I feel better after receiving feedback from the family
> that they got the help that they needed."*

> *"When I am handling a difficult case, once I notify the supervisor, she immediately helps
> me and sometimes this includes accompanying me to the home visit of the family or patient
> in question."*

Findings in studies among lay healthcare workers (South Africa) reiterated the importance of available supervision in the form of emotional and technical support for the workers to enable them to deal with the traumas of HIV work and to improve their competence in rendering quality service to their patients (Daniels, Nor, Jackson, Ekstron & Doherty, 2010:7; Visser & Mabota, 2015:175). The last source of support discussed is from senior management.

Sub-theme 3.4: Support from senior management

A small proportion of participants cited senior management as being a good source of support. Participants motivated their views by saying:

> *"I feel supported by the Director particularly during monthly meetings that she conducts
> and asks each one of us individually about our work……..how it is progressing and where
> are we experiencing difficulties. It shows that she cares."*

> *"I like the fact that the Director sometimes gives me time to study….sometimes she has meetings with us where she attentively listens when we talk about the problems and challenges we face in our work."*

Senior management seemed to form a valuable component of the support structure or team for the lay healthcare workers. Research findings of two South African studies among HIV and AIDS carers highlighted the need among research participants to feel structurally and emotionally supported by senior management and that they found comfort in that kind of support (Hatzipapas, 2013:53; Daniels et al., 2010:8).

The four sub-themes discussed have shed some light on how the participants were currently coping with the work stress. The next theme's focus is on their expectations of the stress management programme as it envisioned that it could enhance the existing coping strategies.

Theme 4: Participants' expectations of the stress management programme

The prototype intervention already had objectives for each programme session that should be met (see Chapter 8, Section 8.2.4.2). Such information was shared with the participants during the recruitment process. The researcher is of the opinion that, as the piloting process has a programme evaluation element, the participants' expectations should therefore be taken into consideration as part of the evaluation.

Sub-themes were not extracted from this theme as the researcher deemed it important to capture what all participants expressed as their expectations. This stance was informed by social constructionism's tenet that proposes that, in the spirit of critical thinking, all perspectives about social reality have to be entertained as they all matter and are important (Gergen, 2001b:228). The majority of the participants mentioned that they would like to learn about what stress is, how to manage and cope with stress. These expectations are articulated by one participant in this manner:

> *"I would like to learn about types of stress……..and also other ways of addressing problems so that I get to know what to do……maybe also learn how to identify signs of stress among children as they do not normally talk about what is bothering them. With the knowledge I*

can see immediately and help rather than only find out after months after I had assumed that they are naughty or disobedient."

Other participants said the following:

"I think the programme will help me to deal with stress from the patients especially that is related to HIV and AIDS….I will also be able to help others to manage stress with the information I get."

"Sometimes I experience a difficult situation with patients and I need to talk to the social worker immediately ……...she is not always available………. The programme will hopefully help me to learn skills to deal with such situations, rather than having to carry that difficulty with me."

"I am hoping to understand more information about HIV and AIDS, to be able to share the knowledge with friends, colleagues and my patients. I also expect to learn about how to manage stress so that I do not carry with me and repress the difficulties I am going through."

From the above-mentioned quotations, it appears that there was general consensus among the participants and that they expected to learn more about stress and acquire stress management skills. What also needs to be noted is that some did not plan to keep the knowledge only for themselves, but also to share with others to whom such information may be beneficial.

The pre-intervention data has been captured and deliberated on. The next topic is on the participants' views, opinions and perspectives on the impact of the stress management programme on their ability to cope with workplace stress.

9.3.3 Discussion of themes and sub-themes from the post-intervention data

After the participants had been exposed to the stress management programme, post-intervention data were collected using the semi-structured interview schedule which had nine questions. The main focus of the interviews was on the challenges that the participants felt they still experienced after exposure to the programme, their perspectives on how the intervention impacted on their ability to cope with workplace stress and recommendations on improvements to the prototype intervention. Through thematic

analysis, four themes were extracted from the data and they are presented in Table 9.3 as follows:

Table 9.3 Themes and sub-themes from the post-intervention semi-structured interviews

Themes	Sub-themes
1. Job fulfilment indicators: what participants found fulfilling about their work	1.1 Professional growth opportunities 1.2 Enjoyable work
2. Participants' perception of challenges in the execution of their work	2.2 Lack of material resources that affect the ability to meet patients' needs 2.2 Experience of the work as emotionally draining
3. The participants' ability to cope with the work challenges after exposure to the intervention programme	3.1 Improvement in coping skills 3.2 Mild improvement in coping skills
4. The participants' evaluative comments on their experience of the intervention programme	4.1 Benefits of the intervention 4.2 Suggestions on improvements to the intervention

Theme 1: What participants found fulfilling about their work

Regarding the theme of job fulfilment indicators, the same trends as with the pre-intervention data were identified. The sub-themes of sources of job fulfilment that were repeated, are opportunities for professional growth and enjoyable work. The majority of the participants still regarded their work as providing opportunities for growth and intellectual stimulation.

The sub-themes are not elaborated on as this had already been done with pre-intervention data. Only verbatim quotations of participants for each sub-theme are offered to support the findings.

Sub-theme 1.1: Professional growth opportunities

Opportunities for professional growth were reported by the majority of the participants as being a main contributing factor to job fulfilment. One participant captured her experience by saying:

> *"The work gives me opportunities to improve myself through access to courses….. Like just before Easter I attended a three-day course on psychosocial support and support groups for OVC's."*

Another participant said:

> *"I like the fact that I have learnt a lot of things. I now understand human behaviour better than before…. I have even learnt how to relate to children and adjusting to their level so that I can understand their challenges."*

Another motivator among the participants was that they found their work enjoyable.

Sub-theme 1.2: Enjoyable work

A small proportion of the participants cited enjoyment of the work as what keeps them going. The sentiment was captured by two participants as follows:

> *"I enjoy working with my patients…..When I visit them at their homes I am always warmly welcomed and I like that because it shows that they appreciate my help."*

> *"I like the fact that through my work, I meet a lot of people from different walks of life…….."*

The participants' input and views about job fulfilment seem to indicate that HIV and AIDS home-based care can be a rewarding experience, although stressful. The next discussion focuses on what participants perceived as workplace challenges after exposure to the stress management programme.

Theme 2: Participants' perception of challenges in the execution of their work

The sub-themes extracted from this theme were also similar to the pre-intervention sub-themes. The main difference was that, after exposure to the intervention, the participants elaborated more on the emotional impact of the work and nothing about a lack of skills to deal with challenging patients. Two main sub-themes evolved, namely lack of material

resources that affect their ability to meet patients' needs and experience of the work as emotionally draining. Interestingly, there were a few comments about the inconsistent and inadequate stipend and the uniform that made them stand out and thus targets of the HIV and AIDS stigma.

The two sub-themes are briefly discussed and only supported by participants' verbatim quotes as they were adequately explained in the pre-intervention discussion.

Sub-theme 2.1: Lack of material resources to meet the patients' needs

Lack of material resources was again highlighted by the participants as being a concern. They also mentioned lack of transport to home-visits as a difficulty (given that the houses are far apart) and limitations with regards to material assistance for their patients, especially food parcels. The majority of the participants raised more concern about the lack of transport, which was also the case with pre-intervention interviews. Some participants expressed the group's sentiments as follows:

> *"I do not like the fact that we have to walk long distances to do home visit. I am also disturbed by the inability to assist clients particularly with material things such as food. There are times when I find my patients' situation being bad………and they need money to buy food. Remember that we are not allowed to give our patients money, but in some situations it is difficult not to…………you then think about the meagre stipend that you receive and you end up not knowing what to do… you need money for yourself and your family…. the organisation does not have the food parcels to help"*

> *"I find walking long distances in the hot sun from house to house, doing home visits really challenging……."*

The participants clearly highlighted service delivery challenges they had to face from time to time and then find ways of coping. Another challenge that was raised was the emotional drain of the work.

Sub-theme 2.2: Experience of the work as emotionally draining

The participants reflected on what they found emotionally draining after exposure to the intervention programme. Only a few participants mentioned that they still found their work emotionally draining. Their responses are concisely put by some of the participants in this manner:

> *"I still feel emotionally affected by my patients' problems, particularly those that I have been unable to help…… those whose problems I have been unable to solve…"*

> *"I sometimes find myself feeling physically tired and emotionally drained……..the high workload also adds to the challenges that I face."*

What the participant seemed to imply was that, in spite of having gone through the intervention, she still experienced the work as draining, particularly with regards to situations over which she has no control. The next theme discusses how participants were coping with such challenges after exposure to the intervention.

Theme 3: The participants' ability to cope with work challenges after exposure to the intervention programme

The participants were asked to give their views with regards to coping after exposure to the intervention programme. Social constructionism proposes that the meaning and understanding of social reality are both derived from social interaction. It was therefore through the interaction during the intervention facilitation process that participants were able to gain insight about and form opinions of what the intervention meant to them (Burr, 2003:4; Freedman & Combs, 1996:23; Gergen, 2001a:2; Lock & Strong, 2010:7; Touminen & Savolainen, 1997:83). All the participants indicated that there was an improvement in their ability to cope. Two sub-theme were identified as a result: improvement in coping skills and mild improvement in coping skills.

Sub-theme 3.1: Improvement in coping skills

The majority of the participants mentioned that there was an overall improvement in their ability to cope with work challenges and they attributed this to the intervention programme. A participant expressed her view as follows:

> *"I feel like a load has been taken off my shoulders. My body used to be painful and I did not understand why. After body scan and meditation all the pain was gone…………I remembered that I had known about meditation but never thought of using it. I was really carrying a lot…………meditation was really helpful."*

Another said the following:

> *"Sometimes I find myself not coping…but then I start to think about the fact that this situation is beyond my control……I accept the situation as it is, from a realistic point of view…….then I see the problems as manageable."*

It appeared that, although participants were still faced with work challenges, they were coping better than before the intervention programme. Their individual coping strategies seemed to have improved. This finding was supported by two studies (South African & USA), one in the healthcare sector. The studies found that participants reported marked improvement in their ability to cope with stress after exposure to a brief stress management programme that focused primarily on self-nurturing techniques to manage stress (Crouch, 2008:74,83; Pipe, Bortz, Dueck, Pendergast, Buchda & Summers, 2009:135)

Sub-theme 3.2: Mild improvement in coping skills

A few participants indicated that there was a slight improvement in their ability to cope mainly because they were still faced with challenges that were beyond their control. Two of the participants expressed their views by saying that:

> *"I sometimes struggle to cope, specifically when I have to work with patients that are experiencing a difficulty that I once experienced. I cannot help but get emotionally involved."*

> *"I struggle to cope sometimes……a situation that I find difficult is when I have to find a way to cope with problems of orphans that are abused and they are afraid to talk about it."*

An example of what the participants thought about the slight improvement in coping skills has been given. The next theme's focus is on the participants' evaluation of the intervention.

Theme 4: Participants' evaluative comments on their experience of the intervention programme

During this phase (Phase 4) of the intervention research process, evaluation of the prototype intervention was at the core of the process. In line with social constructionism

encouragement of critical thinking and that there is no one explanation of reality, participants had to critically evaluate the intervention and give their views and opinions (Gergen, 2001b:228). From the data gathered, two sub-themes emerged: the benefits of the intervention and suggestions on improvements to the intervention.

Theme 4.1: Benefits of the intervention

All the participants mentioned that they benefited from the intervention. Some of their opinions included the following:

> *"I have learned through the ABCDE model to be patient with my patients even when they are difficult."*

> *"....now I can differentiate between different types of stress…… good stress and bad stress."*

> *"All the modules helped me to cope with stress. I particularly liked the part on resilience a lot."*

> *"BREAKS protocol helped me with ways to approach patients that I meet for the first time….helped with breaking the ice. I found all the techniques helpful I also enjoyed the module on the experience of illness… I learned something new."*

> *"I used to make my patient's problems mine whilst I have my own personal problems. Since the programme I have managed to create boundaries………I deal with work stress at work. I do not allow my patients' problems to affect my personal life."*

> *"I now know what to do with work stress and I am able to use the techniques to cope."*

In support of the participants' responses, reviews of stress management interventions among healthcare workers found that there was general improvement in the healthcare workers' ability to cope with occupational stress and burnout after exposure to individual directed interventions. Furthermore, cognitive-behavioural techniques were found to be most effective followed by relaxation techniques, as compared to other interventions used (Richardson & Rothstein, 2008:88; Ruotsalainen et al., 2008:176; Siu, Cooper & Phillips, 2014:80). An assumption can therefore be made that participants found such interventions helpful. The next discussion is on what changes the participants thought should be effected to make the programme even more beneficial to home-based care workers.

Sub-theme 4.2: Suggestions on improvements to the intervention

The majority of participants explained that they experienced the programme as adequate in empowering them to cope with workplace stress and they would not add to or exclude anything from it. They recommended that it be left as is.

However, there were a few participants who gave the following suggestions for improvements:

> *"You can maybe have an additional module on self-care. The information that was given during the resilience module was not enough."*

> *"I wish you could add information on disabilities. Sometimes in my work I come across clients that have disabilities and I do not know what to do."*

> *"I think it would be a good idea to invite some of the management staff to attend the programme with us, at least the first sessions, so that they can experience the programme for themselves and be able to see what it is we are gaining from it. Whoever is available could come, social worker, our supervisor or even one of the social auxiliary workers."*

> *"I suggest that the time allocation for each session be increased particularly for the stress management techniques module……..the time was short. It might also be helpful to have two sessions a day rather than one a day."*

From the participants' input on this theme it appears that there was overall consensus that the programme met their expectations, with a few modifications that were suggested. The researcher is of the opinion that adding information on self-care and inviting a management representative to the programme seem feasible. With regards to increasing the time allocation, the 90 minute per session allocation was inadequate as all sessions on average took an hour longer. A determination was made on the additional time allocation per session when conclusions and recommendations (Chapter 11) were discussed. The comment about information on disabilities seemed outside the scope of the intervention which focused exclusively on stress management. As the programme was in the piloting process, the suggestions would be considered when the programme is refined.

As both pre- and post-intervention data have been elaborated on, the next step is the presentation and interpretation of data form the session evaluation forms.

9.4 SECTION C: RESEARCH FINDINGS FROM SESSIONS' EVALUATION FORMS

The prototype intervention programme was not only evaluated though the pre- and post-intervention semi-structured interviews, the participants also had to give their views and inputs with regard to how each session had been conducted through the completion of session evaluation forms. Feedback on the facilitation process was necessary for a holistic evaluation of the prototype intervention.

9.4.1 Brief introduction

The participants were requested to complete an evaluation form (Appendix I) at the end of each of the seven sessions. They were asked to rate the following about the session: session objectives, duration of the session, style of presentation, medium of instruction, facilitator preparation and knowledge of the subject matter, appropriateness of class exercises and homework and appropriateness of facilitation aids. Rating choices were poor, average and good. There was also space to make additional comments. Few participants took advantage of the chance to elaborate on their ratings through comments. The participants' ratings and comments are discussed next.

9.4.2 Presentation of data from the sessions' evaluation

The participants' inputs per session were collated and are presented in tables. This implies that the data for each session are presented and discussed separately. The purpose was to ensure that all valuable data for the programme piloting process were captured (NB: note that the programme started with fourteen participants and two dropped out). The data are presented as follows:

Table 9.4 Session 1 evaluation: Background information on the programme

ITEM	POOR	AVERAGE	GOOD
NO. OF PARTICIPANTS IN ATTENDENCE: **14**			
1. Session objectives		1	13
2. Duration of the session	1	4	9
3. The style of presentation		1	13
4. Medium of instruction		1	13
5. Facilitator preparation and knowledge of the subject matter		1	13
6. Relevance and appropriateness of class activities and homework		3	11
7. Appropriateness of facilitation aids		1	13

Among the few comments that were made by the participants, the following statements capture the gist of what they were saying:

"Everything was fine and good, but the topic was too long….time management."

"The information was very informative and also examples were relevant to the topic. Only time management is not appropriate. Short breaks and intervals are needed, as at times I was feeling sleepy."

The participants' comments seem to indicate that in general they found the session properly facilitated, as the majority rated all the items as average and mostly good. The concern about the duration of the session was noted as reflected both in ratings and comments. The initial plan was to complete the session in 90 minutes. An additional 50 minutes were added to the session, with the permission of the participants, to be able to complete the activities of the day.

Table 9.5 Session 2 evaluation: The experience and meaning of illness to the patient

ITEM	POOR	AVERAGE	GOOD
NO. OF PARTICIPANTS IN ATTENDANCE: **12**			
1. Session objectives		3	9
2. Duration of the session	3	5	4
3. The style of presentation		4	8
4. Medium of instruction		3	9
5. Facilitator preparation and knowledge of the subject matter		1	11
6. Relevance and appropriateness of class exercises and homework		4	8
7. Appropriateness of facilitation aids		2	10

Additional comments from the participants included:

"I learned about BREAKS. Sometimes we do it, but we did not understand it is BREAKS and now I understand it as a carer."

"Participation was good and the facilitator was explaining things clearly."

The session evaluation indicated a serious concern about the session time; that it went beyond the contracted time of 90 minutes. This time 60 more minutes were spent to complete the session activities. At the beginning of the session the time was re-negotiated, but it seems there were those who did not necessarily agree with the group decision. Session objectives, the medium of instruction, facilitator preparedness and facilitation aids seem to be those aspects of the process that they were satisfied with, given that they rated them average to good.

Table 9.6 Session 3 evaluation: What is stress?

ITEM	POOR	AVERAGE	GOOD
NO. OF PARTICIPANTS IN ATTENDANCE: 12			
1. Session objectives		4	8
1. Duration of the session	2	5	5
2. The style of presentation		3	9
3. Medium of instruction		1	11
4. Facilitator preparation and knowledge of subject matter			12
5. Relevance and appropriateness of class exercises and homework		4	8
6. Appropriateness of facilitation aids		1	11

Additional comments were:

"Today's session took long."

"I've learned about stress and I looked at myself, some of the signs appeared on my mind. Yes I need de-briefing."

Based on the number of responses per line item, an emerging pattern seem once more to be the time factor. It seems the researcher underestimated the time each session would take and so went far beyond the contracted time. Besides the duration of the session, it appears the participants were satisfied with the facilitation process.

Table 9.7 Session 4 evaluation: Rational emotive-behavioural therapy (CBT)

ITEM	POOR	AVERAGE	GOOD
NO. OF PARTICIPANTS IN ATTENDANCE: 11			
1. Session objectives		3	8
2. Duration of the session	1	2	8
3. The style of presentation		2	9
4. Medium of instruction			11
5. Facilitator preparation and knowledge of subject matter		1	10
6. Relevance and appropriateness of class exercises and homework		3	8
7. Appropriateness of facilitation aids		1	10

Some of the comments from the participants are:

"Well prepared and we were more educated. Very good sessions."

"Cognitive behavioural therapy requires more time for us to understand. I think we should take a break in between at the next session for 15 minutes."

The comments made and the ratings seem to tally. The participants appeared to be satisfied with how this stress management technique was being imparted to them. This time concern was that the session time was not enough. There was a request for more time and a break in between.

Table 9.8 Session 5 evaluation: Critical incident stress debriefing (CISD)

ITEM	POOR	AVERAGE	GOOD
NO. OF PARTICIPANTS IN ATTENDANCE: 10			
1. Session objectives		1	9
2. Duration of the session	3	2	5
3. The style of presentation			10
4. Medium of instruction			10
5. Facilitator preparation and knowledge of subject matter			10
6. Relevance and appropriateness of class exercises and homework		1	9
7. Appropriateness of facilitation aids			10

Some participants made the following comments:

"Today's session was a bit overwhelming but I learned a lot."

"In need of more exercises on debriefing phases."

The participants' ratings and comments seem to indicate that the facilitation process was conducive to learning and therefore they managed to gain some knowledge from the session. The ratings were mostly good, with the exception of "duration of the session."

Table 9.9 Session 6 evaluation: Mindfulness-based stress reduction

ITEM	POOR	AVERAGE	GOOD
NO. OF PARTICIPANTS IN ATTENDANCE: 10			
1. Session objectives			10
2. Duration of the session			10
3. The style of presentation			10
4. Medium of instruction			10
5. Facilitator preparation and knowledge of subject matter			10
6. Relevance and appropriateness of class exercises and homework			10
7. Appropriateness of facilitation aids			10

Some of the comments were:

"Session was so good and we have learned so much as if it can continue again. Hope we will teach even those who don't know how to deal with stress."

"Today I learnt how to meditate and stop thinking about the problems I had."

The participants appear to have been highly satisfied with how and what transpired during the session. All the line items were rated good. It was the only session which obtained such good ratings. No dissatisfaction was even noted about the session time.

Table 9.10 Session 7 evaluation: Road to resilience and programme conclusion

ITEM	POOR	AVERAGE	GOOD
NO. OF PARTICIPANTS IN ATTENDANCE: 12			
1. Session objectives			12
2. Duration of the session			12
3. The style of presentation			12
4. Medium of instruction			12
5. Facilitator preparation and knowledge of subject matter			12
6. Relevance and appropriateness of class exercises and homework		1	11
7. Appropriateness of facilitation aides		1	11

Comments from the participants were:

"Thank you for every session. I learned about resilience, I know about it."

"The session was good, it made me to improve myself."

The participants' ratings and comments are similar to those of session 6. It seems at this stage of the programme, both the facilitator and participants were moving at the same pace and had a common understanding of the process.

9.4.3 Discussion of data from the session evaluations

Observation of the ratings and comments in all the seven sessions seemed to show a pattern where, with the first four sessions, the ratings varied from poor to good. Exceeding the session time allocation was raised as a concern which seemed not to have been contained by pre- arrangement before the beginning of each session. A brief review of four stress management programmes in the healthcare field demonstrated that programmes differ and each programme needs to be custom made for its target group. In one study the participants had six monthly sessions that lasted the whole day, whilst another programme consisted of ten weekly sessions each lasting three hours. Another was six hourly sessions twice a month for three months, and lastly there was a

programme of seven, one-hour weekly meetings (Kravits et al., 2008: 135; McDonald, Jackson, Wilkes & Vickers, 2011: 381; Redwood & Pollak, 2007: 43; Shapiro et al.,2007:108). Adjustment of the session time may need to be effected for future use of the intervention as this concern was also raised with the post-intervention data.

Sessions five to seven were rated better than the first four. Sessions six and seven were rated as good by almost all participants and these could therefore be labelled as the sessions that the participants were most satisfied with (facilitation process and presumably contents of the sessions). Session attendance was good, with each session having a minimum of ten participants. The overall impression of the session evaluations seems to highlight that the participants did gain valuable knowledge from the intervention and that was evidenced by their ratings, comments and consistent attendance.

Data gathered from all the qualitative instruments have been discussed. The next focus is on comparing pre and post-intervention data to establish if there are any identifiable patterns of differences.

9.5 COMPARISON OF PRE- AND POST-INTERVENTION DATA

The participants' views, inputs and opinions before and after exposure to the prototype stress management programme have been captured, analysed and interpreted. In order to establish further whether the programme was effective and efficient in meeting the workplace support needs of the HIV and AIDS home-based workers, the pre- and post-exposure data were compared to assess if there were any notable differences. The comparison was done using the themes that were extracted from both sets of the data. A comparative discussion follows.

Theme 1: Job fulfilment indicators: what participants found fulfilling about their work

From the pre-intervention data, the participants indicated that their source of job fulfilment came from those professional growth opportunities they received, the enjoyment that they

derived from the work and lastly the opportunity to help others. The majority of the participants valued professional growth opportunities more as compared to the other two.

A similar pattern was observed with the post-intervention data. The only difference was that participants viewed job fulfilment coming mainly from opportunities for professional growth and enjoyment of the work they did. Again professional growth opportunity was cited by the majority. The researcher's view is that the difference between the pre- and post-intervention data is negligible as it was only one participant who had mentioned that she valued the opportunity to help others in need at the pre-intervention data collection.

Theme 2: Participants' perception of challenges in execution of their work

The participants' responses, during the pre-intervention phase, highlighted that they were challenged by firstly, the lack of material resources that affected their ability to meet the needs of their patients with the lack of transport to home visits and the lack of food parcels being cited as priorities. The lack of transport was mentioned as the greatest need. Secondly, experience of the work was identified as emotionally draining, and lastly there was a lack of skills to deal with challenging patients.

The post-intervention data also highlighted the same sentiments that participants shared with regards to lack of resources. With regards to seeing the work as emotionally draining, this time only a few participants indicated this and it was mainly situations that they felt were out of their control. There was no mention of the lack of skills to cope with challenging patients. An assumption can then be made that, after the intervention, the participants felt empowered to deal with their work challenges. The matter of the lack of resources appear to be mainly something that can be successfully addressed by the organisations' management.

Theme 3: How participants coped with work stress

Data gathered before the participants were exposed to the intervention revealed that the participants used various levels of support to cope with the work stress. They were:

individual coping mechanisms, support from colleagues, support from supervisors and/or social workers and senior management. As previously highlighted, the majority of the participants preferred consulting with the social worker/supervisor the most, followed by individual coping mechanisms and collegial support, and lastly support from senior management.

After exposure to the intervention, participants reported that, although they still valued the support from the social worker/supervisor, colleagues and senior management, they felt empowered by the intervention in that their individual coping mechanisms have improved and therefore did not need the support as much as they previously did. The comparison of the pre- and post-intervention data therefore seem to suggest that there was a noticeable improvement in the participants' ability to cope with work stress after exposure to the intervention.

The participants' comments on the evaluation forms and ratings of session five to seven (CISD, MBSR and Road to resilience) supported the fact that there had been an improvement in their coping skills.

Theme 4: Participants' expectations of the intervention versus their experience of the intervention

With regards to what the participants expected from the intervention, all participants expressed the desire and need to learn something about stress and stress management with the emphasis being on understanding stress and acquiring stress management skills to cope with the work stress they were faced with. Some even mentioned that they were planning to share the knowledge and skills with others who were not part of the programme. The post-intervention data confirmed that their expectations of learning about stress and acquiring stress management skills were met, as all participants were enthusiastic about what it is they had gained from the programme. A few even gave suggestions on improvements of the programme such as increasing the time allocation for sessions and adding more information on self-care for home-based care workers. The

suggestion of increasing session time allocation was also highlighted with the session evaluation comments and ratings.

To conclude, comparison of pre- and post-exposure to the intervention data, have demonstrated that the participants' voiced the intervention to be successful in equipping them with knowledge and stress management techniques that are relevant and appropriate to home-based care work. This finding was further supported from the participants' ratings and comments from the sessions' evaluations.

As the research process is using the mixed methods approach, pre- and post-intervention data, data from the sessions' evaluation forms will be triangulated in next chapter (Chapter 10) together with the quantitative data.

The role played by the logic model in ensuring a theory based pilot testing is discussed next.

9.6 APPLICATION OF THE LOGIC MODEL TO THE PILOT PROCESS

The logic model that was adopted for the study consisted of five categories, namely; objectives, inputs, activities, outputs and short-term outcomes (see Chapter 8: section 8.2.4.2). The objectives per session were clearly spelt out and so were the inputs and activities needed to achieve the objectives. The expected outputs per session were identified and the short-term outcomes indicators were also listed.

Throughout the piloting process, the model guided the researcher to ensure that all the indicators that were tabulated in the logic model, were addressed and attended to.

The model guided the piloting process in the following manner:

- At the beginning of each session, the objectives of the session were explained to the participants in addition to introduction of the topic of the day.
- All the inputs per session were prepared for on time by the facilitator (researcher).
- The facilitator (researcher) familiarised herself adequately with the activities of each session and other content delivery related matters to ensure that she is

articulate during session facilitation and did not have to rely on the manual all the time.

- With regards to outputs, an attendance register was completed after every session to monitor attendance, so were session evaluation forms. The session evaluation forms provided some of the data that were used to assess whether the short-term outcomes had been achieved or not.

- Additional data to assess achievement the short-term outcomes were obtained from the semi-structured interviews.

The model therefore proved to be a valuable tool in ensuring that the data collection process was theory-directed and was as holistic as possible.

9.7 SUMMARY

The qualitative research findings from piloting the prototype stress management programme have been discussed. Three sets of data were collected to capture all the information necessary to be able to make an adequately informed decision on the efficacy and effectiveness of the intervention. Semi-structured interviews before and after exposure to the intervention were held with the twelve participants who volunteered to be part of the pilot process. The pre- and post-intervention data were compared to identify trends, gaps and areas that needed modification. Additional data, which spoke specifically to the facilitation process and how participants experienced each session, were gathered using session evaluation forms.

Social constructionism guided the researcher to gather data in a manner that reflected the true views and opinions of the participants and also allowed them to critically evaluate the process. It appeared from the data gathered that the intervention did meet the participants' workplace support needs. The only modification that needs to be considered is increasing the session allocation time. This concern was raised from the post-intervention data and the session evaluation forms.

The qualitative research findings of the piloting process have been successfully interpreted and discussed. The next chapter deals with the presentation and interpretation

of the quantitative data gathered during the pilot testing process, including triangulation of all data gathered during this phase (Phase 4) of the intervention research process.

CHAPTER 10

QUANTITATIVE RESEARCH RESULTS: EARLY DEVELOPMENT AND PILOT TESTING (PHASE 4) & DATA TRIANGULATION

10.1 INTRODUCTION

The adopted mixed methods approach dictates that both qualitative and quantitative data have to be gathered during the research process. The previous chapter (Chapter 9) gave an account of qualitative data analysis and interpretation during this phase (Phase 4 of the intervention research process), namely, early development and pilot testing. The focus of this chapter is therefore on the analysis and interpretation of the quantitative data gathered whilst pilot testing the prototype intervention, that is, the stress management programme for HIV and AIDS home-based care practitioners.

The chapter is divided into two sections, Section A covers a discussion of the biographical information of the two groups of participants (the experimental and comparison groups), pre- and post-test results analysis and interpretation for both groups on the two constructs measured through the Oldenburg Burnout Inventory, namely disengagement and exhaustion; and, finally deliberation on the comparison of the pre- and post-test results (of both groups) with the participants' highest qualification levels. Section B on the other hand focuses on the triangulation of qualitative and quantitative gathered during Phase 4. The chapter concludes with a summary.

10.2 SECTION A: QUANTITATIVE RESEARCH RESULTS AND INTERPRETATION

Quantitative data were gathered from both the experimental and comparison groups using the Oldenburg Burnout Inventory (see Chapter 5: Section 5.7.1), which is a group-administered standardised questionnaire that is in the public domain and has been previously used in South Africa to measure workplace stress (including burnout) among

those in human service professions successfully (Demerouti & Bakker, 2007:2). The research design implemented to pilot test the intervention was the comparison group pre-test – post-test design. The section focuses on the discussion of the participants, followed by a detailed discussion on the presentation, analysis and interpretation of the research results.

10.2.1 Brief background

As reported in the previous chapter (Chapter 9), the quantitative data gathered also aimed at providing responses to the research question (hypothesis):

"To what extent does the newly developed stress management programme succeed in mitigating the impact of work stress experienced by HIV and AIDS home-based care practitioners in Tshwane?"

In order to provide an answer to the research question, data were collected from the research participants (experimental and comparison groups) by requesting them to complete the Oldenburg Burnout Inventory (OLBI) at the pre- and post-test level. The comparison group was not exposed to the prototype intervention programme as it was a control group. The OLBI questionnaire has 16 items that measure two constructs, which is disengagement and exhaustion. The odd numbered statements (1,3,5,7,9,11,13,15) measure disengagement, whilst the even numbered statements (2,4,6,8,10,12,14,16) measure exhaustion. Disengagement is defined as "distancing oneself from one's work in general, work object and work content." Exhaustion is "a consequence of intense physical, affective and cognitive strain" (Demerouti & Bakker, 2007:4-5).

The research results obtained from the two groups of participants were firstly analysed through descriptive statistics (mean, standard deviation and median). Bivariate analysis was used to compare the two groups' scores on both disengagement and exhaustion, at both the pre- and post-test levels. Additional statistical tests, suitable for analysing data from two individual groups, had to be chosen to analyse further the data. In deciding which tests to use specifically, the Shapiro-Wilk test, which is suitable for small samples, was computed to calculate the normality of the distribution of scores. The scores are shown

in Table 10.1 confirming that the scores were normally distributed. To establish the homogeneity of variances of scores, the Levene's test was implemented and Table 10.2 illustrated that the variances were indeed homogeneous.

Table 10.1 Results of tests of normality of distribution

Construct	Group	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	**Sig.**
Pre_Disengagement	Experimental	.185	12	.200[*]	.937	12	**.464**
	Comparison	.180	7	.200[*]	.930	7	**.555**
Post_Disengagement	Experimental	.170	12	.200[*]	.939	12	**.481**
	Comparison	.258	7	.175	.925	7	**.513**
Pre_Exhaustion	Experimental	.166	12	.200[*]	.961	12	**.800**
	Comparison	.214	7	.200[*]	.954	7	**.769**
Post_Exhaustion	Experimental	.221	12	.107	.919	12	**.280**
	Comparison	.208	7	.200[*]	.930	7	**.553**

Table 10.2 Results of test of homogeneity of variances

		Levene Statistic	df1	df2	Sig.
Post_Disengagement	Based on Mean	**.980**	1	17	.336
	Based on Median	**.885**	1	17	.360
	Based on Median and with adjusted df	**.885**	1	12.450	.365
	Based on trimmed mean	**1.005**	1	17	.330
Post_Exhaustion	Based on Mean	**.197**	1	17	.662
	Based on Median	**.136**	1	17	.717
	Based on Median and with adjusted df	**.136**	1	13.907	.718
	Based on trimmed mean	**.218**	1	17	.647

Based on the results of both tests (Shapiro-Wilk and Levene's), two parametric tests, the *t*-test for independent groups, and one-way analysis of variance (ANOVA), were selected to further analyse the data. The next discussion provides a brief overview of the research participants' biographical information.

10.2.2 Biographical information of the participants

Two groups of participants were recruited through volunteer sampling from two organisations that participated in Phase One (i.e., problem analysis and project planning) of the IR process. The same selection criteria were used as for participants in Phase One (see Chapter 5: Section 5.6). With the experimental group, fourteen participants initially volunteered to participate in the study. Early in the process two participants dropped out due to competing work commitments. This left the experimental group with twelve participants. Regarding the comparison group, eight participants initially volunteered and one dropped out, leaving the group to consist of seven participants.

The biographical information that the participants had to provide included their age, gender, racial group, marital status, highest qualification level and years of experience as home-based care practitioners (Appendix F). All the participants were African and mainly female. There was only one male in the comparison group. The biographical information of the experimental group was discussed in the previous chapter (see Chapter 9: Section 9.2). Therefore, the focus now shifts to the comparison group. The information is presented in Table 10.3 as follows:

Table 10.3 Biographical profile of the comparison group participants

PARTICIPANT NUMBER	AGE	MARITAL STATUS	HIGHEST QUALIFICATION LEVEL	YEARS OF EXPERIENCE AS HOME-BASED CARER
1.	30	Single	Grade 8-11	1
2.	29	Single	Post- grade 12 qualification	1
3.	35	Single	Grade 12	Less than 1
4.	33	Single	Grade 8-11	Less than 1
5.	38	Single	Grade 8-11	1
6.	44	Single	Grade 8-11	Less than 1
7.	30	Single	Grade 8-11	3

Table 10.3 outlines that the comparison group members' age ranged from 29 to 44 years, with the average age being 34.1 years (SD = 4.99). This is close to the average age of the experimental group which was 30.6 at the time of the study (see Chapter 9: Section 10.2.1). All the participants were single which showed a similar trend as the experimental group, where only two participants were married. With regards to highest qualification level, five participants had a Grade 8-11 qualification, one a Grade 12 certificate, whilst another one had a post-Grade 12 qualification. A comparison between the experimental and the comparison groups highlighted that in the experimental group most participants had a Grade 12 certificate (eight participants), whilst in the comparison group the majority of the participants had a Grade 8-11 qualification (see Chapter 9: Table 9.1).

The years of experience as HIV and AIDS home-based care workers was another variable considered with regards to biographical information. Three participants had one year's experience as home-based care workers, another three participants had less than one year of experience, whilst one had three years of experience as a home-based care worker. The experimental group, on the other hand, showed a different trend where only one participant had one year experience as a home-based care worker. The rest of the participants' years of experience ranged from two years to seven years (see Chapter 9: Table 9.1). It can be assumed then that the two groups differed mainly in terms of highest qualification levels and years of experience as home-based care workers. The

experimental group appeared to have better educational qualifications and to be more experienced as home-based care workers than the comparison group.

The reader has been familiarised with the participants of both groups. Subsequently, a discussion of the pre-test results on OLBI follows.

10.2.3 Experimental and comparison groups' pre-test research results

The OLBI was used to gather data from both the experimental and the comparison groups on disengagement and exhaustion before exposure to the intervention. The responses were in a Likert scale format and were coded as 1 = strongly agree; 2 = agree; 3 = disagree and 4 = strongly disagree. A high score in either of the constructs (disengagement or exhaustion) implied that the participants experienced high levels of either disengagement and/or exhaustion. The same principle applied with low scores (Demerouti & Bakker, 2007:14-15). The pre-test results on both disengagement and exhaustion are presented through descriptive statistics (Table 10.4, Figures 10.1 & 10.2) and t-test (Table 10.5).

Table 10.4 Pre-test descriptive statistics for experimental and comparison groups

Construct	Group	Mean	Median	Standard deviation
Disengagement	Experimental group (n = 12)	19.4	20.0	2.54
	Comparison group (n = 7)	17.1	17.0	2.48
Exhaustion	Experimental group (n = 12)	21.7	21.5	3.14
	Comparison group (n = 7)	19.0	19.0	3.16

According to Table 10.4, the pre-test disengagement mean of scores for the experimental group was 19.4 (M = 19.4, SD = 2.54) whilst that of the comparison group was 17.1 (M =

17.1, SD = 2.48). A simple comparison of the two means seems to indicate that, as the experimental group's mean was higher than that of the comparison group, the experimental group experienced more disengagement from their work. With regards to exhaustion, a similar pattern seems to have emerged, with the experimental group showing higher levels of exhaustion. The mean of scores for the experimental group was 21.7 ($M = 21.7$, SD = 3.14), whilst the comparison group's mean of scores was 19.0 ($M = 19.0$, SD = 3.16). The difference between the scores of the two groups is further illustrated visually by boxplots (Figures 10.1 and 10.2) using the median. Boxplots are cited as being effective in conveying data in a way that makes features and trends easily identifiable (Bryman & Cramer, 1997:90; Marsh & Elliott, 2008:167).
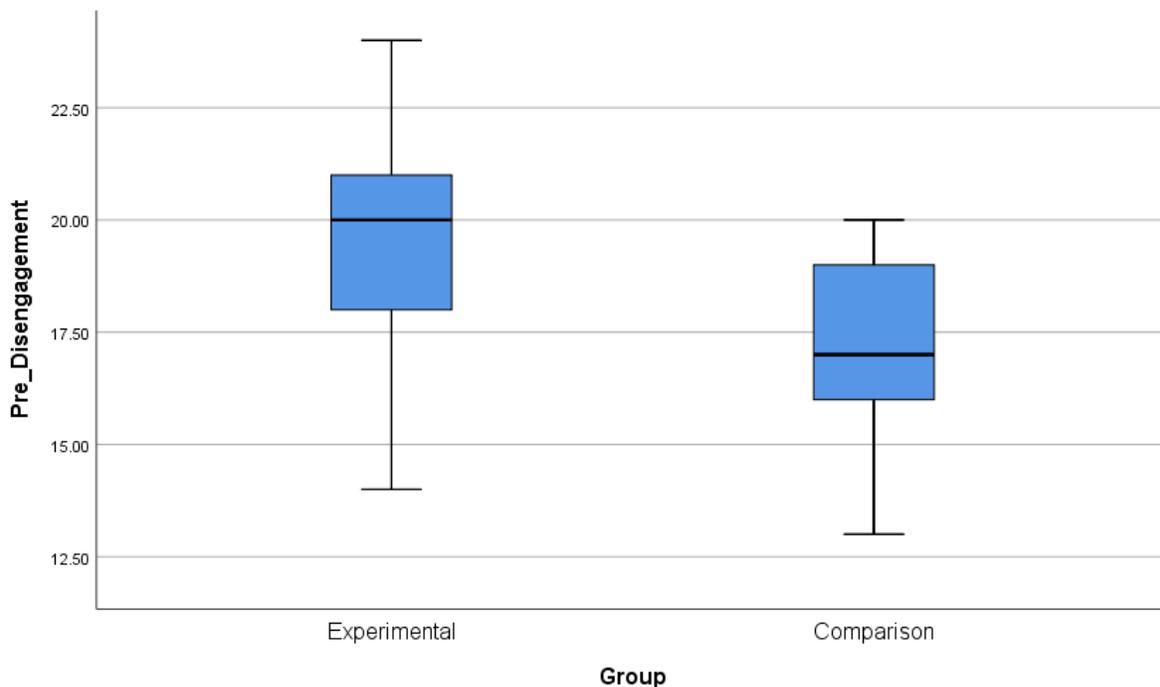
Figure 10.1 Boxplot on pre-test results on disengagement
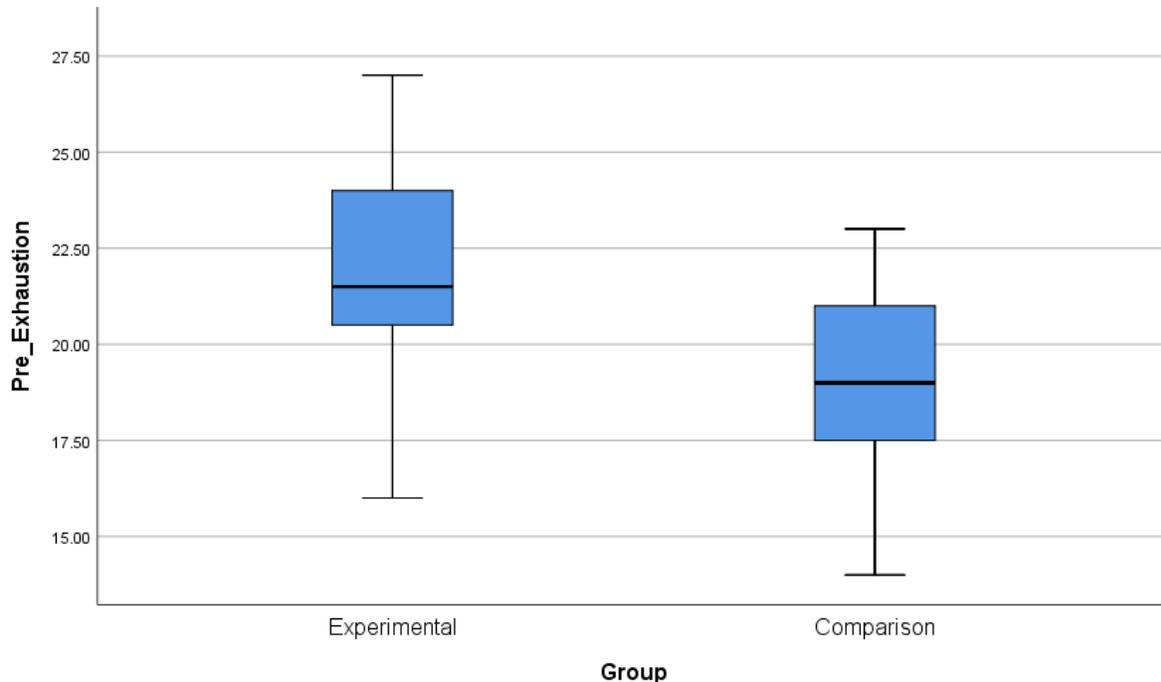
Figure 10.2 Boxplot on pre-test results on exhaustion

The **bold line** in the boxplot (Figure10.1) shows the median for both groups: 20.0 for the experimental group and 17.0 for the comparison group. Figure 10.2 on the other hand presents the median for exhaustion which was 21.5 for the experimental group and 19.0 for the comparison group. Based on the descriptive statistics presented, it could be assumed that the experimental group members presented with higher levels of disengagement and exhaustion as compared to the comparison group. It has to be noted that the differences between the scores of both groups on disengagement and exhaustion only show a small margin.

Conclusive findings could not be made by subjecting the data to only one type of analysis, especially given the small margin between the scores obtained with descriptive statistics. Consequently, an inferential test, the *t*-test for independent groups was computed to subject the data to further scrutiny. As earlier mentioned, the *t*-test is most suitable for measuring the difference between the means of two groups, in this instance, the experimental and comparison groups. The results of the *t*-test are presented in Table 10.5 as follows:

Table 10.5 Pre-test *t*-test results for experimental and comparison groups

Construct		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Disengage-ment	Equal variances assumed	.002	.968	1.81	17	.075	2.27	1.20	-.252	4.800
Exhaustion	Equal variances assumed	.003	.960	1.78	17	.093	2.67	1.50	-.493	5.83

The *t*-test for independent groups was performed to establish whether the differences between the mean of scores on disengagement and exhaustion were statistically significant or not, across the experimental and comparison groups. The values of the test statistics obtained when comparing the mean disengagement scores across group were $t(17) = 1.81$, p = .075, whilst for exhaustion the test statistics were $t(17) = 1.78$, p = .093. In both instances, the differences between the mean scores were greater than 0.05 (p>0.05) and are therefore not statistically significant. It can be concluded that there is no statistically significant difference between the pre-test scores of both the experimental and comparison groups with regards to disengagement and exhaustion.

Studies in the healthcare sector on stress, work engagement and exhaustion in different countries, for example, Australia, Italy and Tanzania, were consulted to establish whether similar patterns of workplace challenges would be found. The Australian study explored among a variety of healthcare professionals, disengagement as a mediating mechanism on the relationship between emotional exhaustion and work attitudes. The Tanzanian study, on the other hand, investigated the impact of work stress, motivation and perceived ability to meet patients' demands, whilst the Italian study focused on identifying the role of organisational and personal factors in predicting work engagement among nurses. The research findings, in summary, highlighted that, as a result of frequent exposure to job stressors, healthcare workers tend to be prone to work disengagement as a coping

strategy. The aim is to preserve energy levels so that they are able to meet the demands of the job and at the same time protect themselves from possible exhaustion. Furthermore, exhaustion has been found to be a major factor in low staff retention and commitment among healthcare workers. Thus, as part of addressing the human resources challenges in the sector, organisations need to explore how best to support motivation, and improve job satisfaction among healthcare workers through both financial and non-financial incentives (cf. Fiabane, Giorgi, Sguazzin & Argentero, 2013:2614, 2620; Siril, Hirschhorn, Hawkins,Garcia, Li, Ismail, Mdingi, Chalamilla, Fawzi & Kaaya, 2011:14; Thanacoody, Newman & Fuchs, 2014:1850-1851). The studies confirmed that the display of disengagement and exhaustion is not unique to the home-based care practitioners (participants) but is identified amongst other healthcare professionals internationally.

The pre-test results have been explored and assumptions made based on the statistical analyses. The post-test results are discussed next.

10.2.4 Experimental and comparison groups' post-test research results

After the pre-test questionnaire (OLBI) had been completed, the experimental group was exposed to the stress management programme which lasted seven weeks (one session per week). The comparison group on the other hand were not exposed to any intervention. The value of having the comparison group was that it added an additional evaluative component to the pilot-testing process. Rather than depend only on the input of the experimental group, there was another group of participants to compare with. The *t*-test for independent groups and ANOVA were used to analyse the post–test data for both groups on disengagement and exhaustion. Table 10.6 presents the descriptive statistical results as follows:

Table 10.6 Post-test descriptive statistics for experimental and comparison groups

Construct	Group	Mean	Median	Standard deviation
Disengagement	Experimental group (n = 12)	18.3	17.5	2.96
	Comparison group (n = 7)	18.3	18.0	5.12
Exhaustion	Experimental group (n = 12)	21.8	22.0	3.49
	Comparison group (n = 7)	20.1	20.0	2.41

The descriptive statistics (Table 10.6) show that the post-test disengagement means of scores for both the experimental and comparison groups are the same. The mean of scores obtained for the experimental group was 18.3 ($M = 18.3$, SD = 2.96), whilst that of the comparison group was also 18.3 ($M = 18.3$, SD = 5.12). It should be noted that the standard deviation for the comparison group was high compared to that of the experimental group (5.12 compared to 2.96). Although the means of the two score were the same, the scores for the comparison group were much larger. This is an interesting finding for the researcher in light of the fact that the comparison group was not exposed to the intervention. It is difficult to make any assumptions from the results as members of both groups, although selected according to the same criteria, do exactly the same work, but at different organisations (meaning their work settings [location] differ).

With regards to the post-test results for exhaustion, the mean of scores for the experimental group was 21.8 ($M = 21.8$, SD = 3.49) and that of the comparison group was 20.1 ($M = 20.1$, SD = 2.41). Although the experimental group scored higher than the comparison group, the difference between the two mean scores seemed to be within a small margin. To verify whether the results of the descriptive statistics were statistically significantly different between the groups, the *t*-test for independent groups was computed. The results are presented in Table 10.7.

Table 10.7 Post-test *t*-test results for experimental and comparison groups

| | | Levene's Test for Equality of Variances | | t-test for Equality of Means | | | | | | |
| | | F | Sig. | t | df | Sig. (2-tailed) | Mean Difference | Std. Error Difference | 95% Confidence Interval of the Difference | |
									Lower	Upper
Post_Disengagement	Equal variances assumed	.980	.336	-.019	17	.985	-.036	1.84	-3.91	3.84
Post_Exhaustion	Equal variances assumed	.197	.662	1.07	17	.299	1.61	1.50	-1.56	4.77

The table (Table 10.7) demonstrates a comparison of the mean of scores of both groups with regards to post-test scores of disengagement and exhaustion, respectively. The aim was to establish whether there would be a statistically significant difference between the means of scores of the experimental and the comparison group on each construct. The values of the test statistics for the comparison of the means of scores of both groups on disengagement were $t(17) = -.019$, p = .985. With regards to exhaustion, the results were $t(17) = 1.07$, p = .299. The p-values obtained for both disengagement and exhaustion were greater than 0.05 level (p>.05). The results, therefore, implied that the mean of scores' differences obtained for post-test disengagement and exhaustion for the two groups were not statistically significant.

In addition to the *t*-test, the one way ANOVA (analysis of variance) was computed to analyse the data further, after it had been established through the Shapiro-Wilk test that the data had a normal distribution and that the variances were homogeneous through the Levene's test. The aim was to explore whether the post-test data were statistically significantly different within and between groups. The results are presented in Table 10.8 as follows:

Table 10.8 Post-test results on the ANOVA for the experimental and comparison groups

		Sum of Squares	df	Mean Square	F	Sig.
Post_Disengagement	Between Groups	.006	1	.006	.000	.985
	Within Groups	253	17	14.9		
	Total	253	18			
Post_Exhaustion	Between Groups	11.4	1	11.4	1.15	.299
	Within Groups	169	17	9.95		
	Total	180	18			

The results obtained from the ANOVA (Table 10.8) with regards to the post-test scores for disengagement for the two groups were: $F(1, 17)$ = .000, p = .985, whilst for post-test exhaustion were, $F(1, 17)$ = 1.15, p = .299. The results of the ANOVA also show that the p-values obtained for post-test scores on disengagement and exhaustion were greater than .05 (p>.05), and therefore not statistically significant. In light of the results obtained from the descriptive statistics, *t*-test for independent samples and the ANOVA, it can be assumed then that there was no statistically significant difference between the post-test scores of the two groups on disengagement and exhaustion.

Similar quantitative studies in the healthcare field where both the experimental and comparison groups were utilised, were sought to verify whether similar results were found. Two Canadian reviews on the effectiveness of stress management interventions among healthcare professionals and two other similar independent studies carried out in the United States of America (USA), focusing specifically on mindfulness-based stress reduction, were consulted. The studies, on the contrary, reported that the participants of the experimental groups showed an overall improvement after the interventions. There were notable lowered distress levels, lowered negative affect and anxiety, increased relaxation, and a decrease in symptoms of burnout and exhaustion as compared to the control/comparison groups who were not exposed to the interventions (Irving et al., 2009:63; Jain, Shapiro, Swanick, Roesch, Mills, Bell & Swartz, 2007:18; McKenzie et al., 2006:107; Ruotsalainen et al.,2008:173-174; Shapiro et al.,2007:110).

Given the findings from the post-test statistical analysis, another analysis, which involved comparing how each group scored on each of the constructs, a statistical test to compare the pre- and post-test scores was computed for each group. The results are discussed next.

10.2.5 Presentation of post-test minus pre-test results on disengagement and exhaustion per group

After the comparison of pre- and post-test results between the experimental and comparison groups on disengagement and exhaustion, a further statistical analysis was performed to   compare the differences between scores on pre- and post-test results on the disengagement and exhaustion scores for each group. The aim of the analysis was to investigate further whether there were any more findings that can be drawn from the research results, in light of the fact that the previously discussed comparisons did not yield findings that convincingly demonstrated the effect of the stress management programme among the participants. The post-test scores were deducted from the pre-test scores for both constructs on each individual group, and descriptive statistics for these differences are displayed in Table 10.9 in the following manner:

Table 10.9 Post-test minus pre-test results on disengagement and exhaustion

Construct	Group	Mean	Median	Standard deviation
Post minus pre disengagement scores	Experimental group (n = 12)	-1.17	-2.50	3.33
	Comparison group (n = 7)	1.14	2.00	5.81
Post minus pre exhaustion scores	Experimental group (n = 12)	.083	.500	3.18
	Comparison group (n = 7)	1.14	2.00	3.44

As Table 10.9 shows, when the members of the experimental group's post-test scores on disengagement were subtracted from their pre-test scores, a negative mean difference of -1.17 (M = -1.17, SD = 3.33) was obtained. The difference indicated that on average the pre-test scores were higher than the post-test scores. This indicates that after the intervention, the group was less disengaged from their work. This could suggest that their work engagement improved as a result of exposure to the intervention (stress management programme). The mean difference of the post-test and pre-test scores on exhaustion obtained was .083 (M = .083, SD = 3.18). This indicated that on average, the post-test scores were slightly higher than the pre-test scores. This implies that the experimental group indicated that they were more exhausted after the intervention than before the intervention. In short, after exposure to the intervention, they were less disengaged, but more exhausted.

The comparison group had different results. The mean difference of post- minus pre-test scores on disengagement was 1.14 (M = 1.14, SD = 5.81). This implied that on average the post-test scores were higher than the pre-test scores, meaning that they were more disengaged at the post-test level. With exhaustion, the post-test scores were also subtracted from the pre-test scores and the mean difference obtained was 1.14 (M = 1.14, SD = 3.44). The findings seem to suggest then that the comparison group members were more disengaged from their work and more exhausted at the post-test level.

Studies in Germany, South Africa and a meta-analysis of international studies on the effectiveness of stress management interventions in several occupational groups were consulted to investigate whether similar trends existed. The German study focused on the evaluation of a recovery training programme, measuring pre- and post-test experiences of psychological detachment from work (after work), relaxation and mastery experiences (referred to recovery experiences) of participants sourced from the public and private sectors including a university. The results from the study were that, although the participants in the experimental group reported improved recovery experiences as compared to the control group, they still experienced exhaustion at the post-test level. The South African study evaluated a stress management intervention (pre- and post-test) in one private sector organisation using play therapy mediums (drawings, sand tray, clay,

metaphors & fantasy). The post-test results revealed an overall reduction in the stress levels of the participants and the ability to cope with stress. Furthermore, the meta-analysis of 36 independent international studies (majority with control groups) and 55 stress management interventions involving various professions (nurses, teachers, office workers, welfare services workers, other public sector and private sector employees) was also consulted. The interventions fell under the following categories: cognitive-behavioural, relaxation, organisational, multimodal and alternative interventions. The analysis concluded that the interventions had positive effects on the participants' ability to cope with stress. In addition, the cognitive-behavioural interventions and relaxation techniques were cited as being the most popular and effective (Hahn, Binnewies, Sonnentag & Mojza, 2011:210-211; Nel & Spies, 2008:34,49; Richardson & Rothstein, 2008:90).

The cited studies therefore revealed that in most instances, there was a positive difference among participants after exposure to a stress management programme, particularly among experimental group participants. In the case of this study, the results show improvement within the experimental group only with disengagement, the participants remained exhausted as was the case with the German study. In terms of the comparison group, the results obtained at post-test level were difficult to explain as the group did not have contact with the researcher between the pre- and post-test period. The next topic focuses on a further analysis of the research results with specific focus on the effect of the participants' highest qualification levels (as the categorical variable) on the pre- and post-test disengagement and exhaustion scores, respectively, of the all participants.

10.2.6 Comparison of the research results of combined experimental and comparison groups with highest qualification as a variable

The pre- and post-test results of both groups on disengagement and exhaustion were subjected to several statistical tests in an effort to assess the effectiveness and efficiency of the prototype intervention programme. As part of the piloting process, it became necessary to compare the results with at least one demographic variable. The variable

chosen was the highest qualification level. The reason for choosing this variable was that it might shed some light on whether there is an association between educational qualifications and the experience of disengagement and exhaustion, at pre- and post-test levels. In order to explore this, the two groups were combined to form one group of 19 members. The combined group was then divided into two groups. The first group consisted of those with Grade 8-11 qualification level and the second group of those with Grade 12 and post-Grade 12 qualification levels. The groups are displayed through cross-tabulation in Table 10.10 where the two highest qualification groups are represented in the rows and the experimental and comparison groups in the columns. The data for the combined group, with the focus on the highest qualification levels and pre- and post-test scores on disengagement and exhaustion were then subjected to statistical analysis using the *t*-test. The results are presented in Tables 10.11 and 10.12.

Table 10.10 Groups' cross-tabulation on highest qualification levels

| | | | Group | | Total |
			Experimental	Comparison	
Highest qualification grouped	**Grade 8-11**	Number	3	5	8
		Column %	25.0%	71.4%	42.1%
	Grade 12 and higher	Number	9	2	11
		Column %	75.0%	28.6%	57.9%
Total		Number	12	7	19
		Column %	100.0%	100.0%	100.0%

The table (Table 10.10) combined the highest qualification levels of members with their membership of either the experimental or the comparison group. The experimental group had three participants with Grade 8-11 qualification level, whilst the comparison group had five which totals eight participants in the combined group. The experimental group had nine participants with Grade 12 and higher qualification, whilst the comparison group had only two participants, totalling 11. The analysis therefore clarified that in the combined group, the majority of members had a qualification level of Grade 12 and higher. Within

the experimental group, the majority of members (9 compared to 3) had Grade 12 or a higher qualification. The majority of participants in the comparison group fell in the category Grade 8 – 11 (5 compared to 2).

The highest qualification levels' groups have been discussed and therefore the focus shifts to the results of the *t-* test results. The presentation is on post-test minus pre-test disengagement and exhaustion scores for the two groups per highest qualification level (Table 10.11 & Table 10.12).

Table 10.11 Descriptive statistics on comparison of the groups' post-test minus pre-test results on disengagement and exhaustion with highest qualification as categorical variable

Construct	Highest qualification group	Mean	Median	Standard deviation
Post minus pre disengagement scores	Grade 8-11 (n = 8)	2.50	3.50	3.82
	Grade 12 & higher (n = 11)	-2.36	-3.00	3.61
Post minus pre exhaustion scores	Grade 8-11 (n = 8)	1.50	1.50	2.78
	Grade 12 & higher (n = 11)	-.272	.000	3.44

Table 10.12 *T*-test results on the comparison of the groups' post-test minus pre-test results on disengagement and exhaustion with highest qualification as categorical variable

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Post Min Pre-disengagement scores	Equal variances assumed	.085	.774	2.794	17	.012	4.86364	1.74059	1.19131	8.53596
Post Min Pre-exhaustion scores	Equal variances assumed	1.091	.311	1.199	17	.247	1.77273	1.47878	-1.34723	4.89269

The mean of scores (that is, the difference of post-test minus pre-test disengagement), as displayed in Table 10.11 obtained for the Grade 8-11 group was 2.50 (M = 2.50, SD = 3.82). The Grade 12 and higher group on the same calculation, obtained a disengagement mean of scores of -2.36 (M = -2.36; SD = 3.70). The results indicate that the Grade 12 and higher group had lower post-test disengagement scores, meaning they were more engaged at the post-test level. The *t*- test result t (17) = 2.79, p = .012, clarified that the mean difference of the disengagement scores between the two groups were statistically significant as p < .05.

Regarding the comparison of post-test minus pre-test exhaustion scores for the two groups per highest qualification levels (as a categorical variable), the mean of scores obtained for the Grade 8-11 group, after the exhaustion pre-test scores had been subtracted from the post-test score was 1.50 (M = 1.50, SD = 2.78). For the Grade 12 and higher group, the mean of scores (that is, difference of post-test scores minus pre-test) was -.272. The finding meant that the one group (Grade 12 and higher) had on average, slightly lower post-test exhaustion scores than their pre-test scores. This therefore meant that there was minimal improvement in their exhaustion levels at the post-test level. The *t*-test compared the mean difference between the two groups scores

and the result was; $t(17) = 1.20$, p = .247. The finding was not statistically significant as the p-value was higher than .05, meaning p > .05.

Based on the results obtained from the *t*-test, it appears that an assumption can be made that the group with Grade 12 and higher qualification, experienced lowered disengagement from work at the post-test level as compared to the Grade 8-11 group. The same trend was observed with regards to exhaustion, with the group of Grade 12 and higher qualification, recorded with slightly lowered exhaustion. The comparison of the mean differences between the two groups' scores (post-test minus pre-test) on disengagement was statistically significant, whilst that of exhaustion was not statistically significant. In other words, there was an association between highest qualification level and disengagement, whilst no association was found between highest qualification and exhaustion.

Studies, which focused on stress management interventions and their outcomes among healthcare professions and several other occupations were consulted to verify whether associations between educational qualifications and the stress management programme experience were explored (Hahn et al., 2011; Hatzipapas, 2013; Kravits et al., 2007; Nel & Spies, 2008; Richardson & Rothstein, 2008; Routsalainen et al.,2008; Shapiro et al., 2008). The outcome of the literature control was that, although in most of the studies educational qualifications formed part of the biographical data, its association to how the participants experienced the programme was not explored. Instead, demographical data such as gender, years of work experience and work environment (for example, public service versus private sectors) and their association to the study outcomes were better explored. The researcher is of the opinion that there seems to be a knowledge gap in this area of research and therefore studies may be needed to explore in more detail the association between educational qualification levels and stress management interventions outcomes particularly in the healthcare field.

To conclude, the quantitative data analysis seem not to have provided enough evidence that the prototype intervention did positively impact on the reduction of disengagement and exhaustion in the workplace for the experimental group. Instead the results showed that the experimental group was slightly more exhausted than the comparison group at

post-test level. It was only through the comparison of the highest educational level and pre- and post-test results, that some impact was noted with the Grade 12 and higher group. They reported slightly reduced disengagement and exhaustion at post-test as compared to the Grade 8-11 group. A possible explanation for such a result could be that, although the OLBI was adapted for use in English speaking countries, South Africa included, it appears that some of the terminology may have been difficult to understand for whom English is not their first language. The assumption is supported by a South African study in the construction industry that used the OLBI, where 59% of the participants had Grade 10-12 qualification. Footnotes were used on the questionnaire to explain any terminology that appeared prone to misunderstanding. This was done as a control measure for those participants who did not use English as a first language and presumably had limited exposure to the language given their academic qualifications (Demerouti, Mostert & Bakker, 2010:219; Halbesleben & Demerouti, 2005:218).

In the case of the study, it was the Grade 12 and higher group that reported some improvement at post-test level. The group was composed of a majority of members from the experimental group. It can then be assumed that their understanding of the language used in the questionnaire was better and enabled them to respond to the questionnaire items with some understanding of the unfamiliar words. Probably the footnote explanations of the "difficult" words would have made a difference.

The next topic then focuses on triangulation of both qualitative and quantitative research findings to draw conclusions on the outcome of the piloting process.

10.3 SECTION B: TRIANGULATION OF QUALITATIVE AND QUANTITATIVE RESEARCH FINDINGS

Both qualitative and quantitative data have been analysed and interpreted in an effort to appraise the piloted prototype intervention programme. Qualitative data analysis and interpretation was discussed in Chapter 9. This section discusses the comparison of both sets of research findings, in line with the mixed methods approach, in order to make assumptions and draw conclusions on the efficacy and effectiveness of the piloted

prototype programme. Through triangulation, the researcher drew from both the qualitative and quantitative research findings the strengths and the areas of improvement of the prototype programme. The outcome of the process informs advanced development and refinement of the prototype programme.

Firstly, the findings of the qualitative data analysis from the pre- and post-exposure to the intervention as per the data collection through interview schedules and the session evaluation forms (see Chapter 9: section 9.4 & 9.5) are pointed out, followed by the quantitative findings. Finally, conclusions from the comparisons of both sets of data are discussed.

The **qualitative research findings** are summarised as follows:

- Participants found their work fulfilling mainly because of opportunities for professional growth and that they enjoyed their work. The sentiment was expressed before and after exposure to the intervention programme (i.e. the stress management programme).
- With regards to the perception of work challenges, before exposure to the intervention programme, the participants reported that they experienced challenges in respect of the lack of material resources to meet patients' needs, and they experienced the work as emotionally draining and lacked skills to deal with challenging patients. After exposure to the intervention programme, they reported that they felt empowered to deal with the emotional drain of the work and patient challenges proactively and they were no longer a concern. Lack of material resources was a matter deferred for discussion with management.
- The participants further reported that their ability to cope with work stress improved after exposure to the intervention. This finding was reflected in both the post-test interviews and session evaluation forms. They found all the stress management techniques relevant and useful, with the relaxation exercises of the mindfulness-based stress reduction being the most popular.
- Finally, the participants' expectations from the intervention of learning about stress and acquiring stress management skills were met. Feedback given was that after exposure to the intervention programme, they had a better understanding of stress

as a concept, stress reactions, symptoms of stress, coping strategies and how to enhance the coping behaviour through guidelines given in "promoting resilience."

The **quantitative research findings** focused on measuring disengagement and exhaustion among the participants' pre- and post-test between both the experimental and comparison groups. The results are summarised as follows:

- Pre-test results on disengagement and exhaustion: the results indicated that the experimental group was more disengaged from their work and exhausted than the comparison group.
- Post-test results on disengagement and exhaustion: the results demonstrated that both the experimental and comparison groups experienced the same level of disengagement, whilst the experimental group reported slightly higher exhaustion than the comparison group.
- Post-test scores minus pre-test scores on disengagement and exhaustion: the experimental group were less disengaged but more exhausted after exposure to the intervention. The comparison group on the other hand were more disengaged and exhausted at post-test.
- Association between disengagement and exhaustion and the participants' highest qualification level: the group who had obtained Grade 12 and higher showed decreased disengagement from their work and slightly lowered exhaustion at post-test level as compared to the group who obtained Grade 8-11.

Comparison of both qualitative and quantitative research findings yielded differing outcomes. Whilst qualitative findings clearly demonstrated that the prototype programme was effective, efficient and the participants' ability to cope with workplace stress improved, the quantitative results only reported a minimal impact by the programme. Contributing factors to differing outcomes with the same participants are difficult to identify. The one factor that the researcher assumes played a role is the language used for the questionnaire as for the majority of the participants, English is a second language. The assumption is supported, as earlier described, by the result that when the groups were composed according to highest qualification level, those who were better qualified (Grade 12 & higher group) reported improved work engagement at post-test level.

The qualitative data collection was conducted in the participants' mother tongue even though the semi-structured interview schedule was in English (researcher translated). In the case of quantitative data collection, the participants had to complete the questionnaire (OLBI) on their own. The researcher was available to explain and give clarification for statements on the questionnaire that were unclear. Few participants asked for assistance which gave the impression that they understood the questionnaire. Probably there is a possibility that OLBI, although standardised for English speaking human service professionals, including healthcare workers, its validity for use with lay healthcare workers in the South African context, with English as a second/third language, needs further investigation.

A study investigating the reliability and validity of the English translation of OBLI in the USA with a wide variety of professionals (healthcare workers included), obtained results that validated reliability, factorial validity and construct validity for the instrument. The researchers, acknowledging that the OLBI has been properly standardised based on the outcome of their study, encouraged and recommended further research in this area of validating the OLBI English version (Halbesleben & Demerouti, 2005:217-218). The suggested further investigation of the OLBI would therefore be in line with the recommendations of the study.

To conclude, the researcher was inclined to assume that the piloting of prototype intervention programme was successful with the programme having demonstrated, through mainly qualitative research findings, that it met the workplace support needs of the research participants. The qualitative findings have also provided recommendations for refinement of the programme (see Chapter 9: section 9.3.3).

10.4 SUMMARY

The quantitative research findings have been presented, interpreted and assumptions have been made based on the findings. Statistical tests were computed to manipulate the data in an effort establish whether the piloted prototype intervention did have a positive impact on the participants' ability to cope with workplace stress. The findings

communicated that there was no statistically significant difference between the pre- and post-test results of both the experimental and comparison groups. There was only minimal improvement noted with the Grade 12 and higher group when comparisons were made using the highest qualification level as criterion.

Both the qualitative and quantitative results were then triangulated in line with the mixed methods approach. The conclusion reached was that it appeared the qualitative results yielded insightful outcomes that provided workable feedback with regards to the pilot testing process.

The next chapter, which is the last chapter of the thesis, discusses the key findings from the research process, conclusions and recommendations on the possible refinement of the intervention programme for future application and further research.

CHAPTER 11

KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

11.1 INTRODUCTION

The previous chapters (Chapters 1 to 10) presented a detailed discussion of the research process which also included the analysis and interpretation of both the qualitative and quantitative research findings and results during Phase One (Problem analysis and project planning) and Phase Four (Early development and pilot testing) of the intervention research (IR) process. The focus of this chapter is on the integration of all that has been learnt, confirmed and discovered during the research process. The information and knowledge gained are consolidated through an overview of the research goal and objectives, a discussion of the key findings of the study, together with conclusions drawn from the key findings, and recommendations.

The **goal** of the study was as follows:

"To design, implement and evaluate a stress management programme for HIV and AIDS home-based care practitioners in Tshwane."

The objectives of the study aimed to provide answers to the following **research questions**:

- What are the workplace support needs of HIV and AIDS home-based care practitioners in Tshwane that could be addressed through a stress management programme?
- What are the main themes to be covered in the stress management programme for HIV and AIDS home-based care practitioners in Tshwane?
- To what extent does the newly developed stress management programme succeed in mitigating the impact of work stress experienced by HIV and AIDS home-based care practitioners in Tshwane?

The chapter also offers a discussion on the key findings, conclusions, and recommendations with regards to necessary refinements and adjustments that need to be effected to the structure and content of the stress management programme, including future research. The chapter concludes with a summary.

11.2 OVERVIEW OF OBJECTIVES, KEY FINDINGS AND CONCLUSIONS FROM THE STUDY

To achieve the goal of the study, six objectives, some with sub-objectives, were formulated which outlined the process followed to attain the desired goal. Each objective is individually discussed primarily highlighting the literature review, the empirical findings and conclusions (where applicable).

Objective 1: To provide a theoretical framework that guided and underpinned how the research process was conducted and data interpreted

The theoretical framework that underpinned the research process was social constructionism. As previously explained (see Chapter 1: section 1.3) the motivation for the study was informed by the fact, that in spite of previous research findings (Chimwaza & Watkins, 2004:803; De Wet & Du Plooy, 2012:36; Majaja et al., 2009:16; Orner, 2006:237) that confirmed a need for a stress management programme for HIV and AIDS home-based care practitioners, the researcher, using various search methods, could not find any documented programme for the target group. Such a situation meant that the researcher had to adopt a theoretical framework that allowed for an unbiased exploration of the research problem with the research participants being afforded the status of experts in view of their experience of workplace stress.

Through a **literature review** (see Chapter 4), the researcher was familiarised with social constructionism and its broad approach to the interpretation of social reality and knowledge, and was capacitated to approach the research process with the attitude of someone who would be "taught" by the research participants about their experiences of

workplace stress and what should be the content of the stress management programme (see Chapter 4: section 4.2.3). By adopting the role of a non-judgmental researcher, all the inputs and opinions of the participants were treated with equal importance in line with social constructionism's view that there is no one absolute and acceptable view of social reality. An added advantage of the framework is it's similarity with some of the fundamental principles of social work research. Both social constructionism and social work research put their emphasis on respect for the human condition, the importance of language and communication, non-judgmental interactions, acceptance of differing worldviews and concern for society (O'Connor, 2015:3-4) (see Chapter 4: section 4.3.2).

Objective 1 was therefore achieved in the adoption of a theoretical framework that allowed open and critical exploration of the workplace challenges that participants experienced and how a stress management programme could address the identified workplace support needs. It can then be **concluded** that social constructionism was the appropriate theoretical framework for the study particularly that, it is also in line with what social work research and practice aim to achieve.

Objective 2: To assess the stress-related workplace support needs of HIV and AIDS home-based care practitioners in Tshwane

The objective was broken down into two sub-objectives as it became imperative that, before initiating the needs assessment, the researcher had first to recruit participants for the study.

The **sub-objectives** were as follows:

2 (a): The identification and recruitment of home-based care practitioners and their supervisors/managers for participation in the research study

In the process of recruiting research participants for the study, it became necessary for the researcher to become immersed in the world of the participants. The aim was to gain insight into the evolution of HIV and AIDS home-based care as a community service, its spectrum of services and who the home-based care practitioners and their

supervisors/managers were. The **literature review** (see Chapter 2) acquainted the researcher with the world of HIV and AIDS home-based care work and also assisted in defining criteria for the recruitment of the research participants.

The minimum requirements for HIV and AIDS home-based care practitioners are set out below (Department of Health & Department of Social Development, 2009:45; Schneider et al., 2008:182).

- They must be 18 years of age and above.
- They must meet the relevant legislative determinants (such as the provisions of the Children's Act when working with children).
- They had to be residents of the communities within which they intend to work.
- They must have a minimum of Grade 12 and those without this level of education should be encouraged to attend Adult Basic Education and Training.
- They must be South African citizens.
- They must have a support system in a form of non-governmental/community-based or faith-based organisation to which they are attached.

For the purposes of the study, the criteria for participation were that the home-based care practitioner had to be 18 years of age and older, "employed" by a home and community-based care organisation that had among its service users people living with HIV and AIDS (registered with the Department of Social Development as a not for profit organisation) and have at least one year's experience as home-based care practitioner.

Regarding the supervisors/managers of the home-based care practitioners, the selection criteria was that besides being first line of report for the home-based care practitioners in the respective organisations, they had to have some experience in HIV and AIDS home-based care supervision.

Prospective primary participants (home-based care practitioners) were recruited through purposive sampling, whilst secondary participants (supervisors/managers) were recruited using key informant sampling in the four regions of the Tshwane metropolitan city.

The **result** was that thirty-five (35) HIV and AIDS home-based care practitioners and five (5) supervisors/managers from the five regions of Tshwane metropolitan city volunteered to participate in the study (see Chapter 5: section 5.6). The home-based care practitioners met the selection criteria, with the exception being educational qualifications and years of experience as home-based care practitioners. The majority of the available and potential participants (home-based care practitioners) had attained Grade 8-11 and lower, whilst those with Grade 12 and higher were in the minority. With regards to years of experience, only six participants had less than one year of experience as home-based care practitioners (see Chapter 6: section 6.2.1.1). The supervisors/managers also met the criteria with all of them with more than two (2) years of experience in the position and the majority with post-Grade 12 qualifications (see Chapter 6: section 6.2.2.1).

The sub-objective was achieved in that prospective research participants were successfully identified and recruited. They made themselves available for both qualitative and quantitative data collection of **Phase One of the IR process**.

The **conclusion** drawn is that the researcher compiled selection criteria for participation in the study that were in line with HIV and AIDS home-based care national practise standards. The additional requirement of at least one year experience in home-based care was met by the majority of the participants (home-based care practitioners and the supervisors/managers) which enabled informative and insightful input relating to their experience of workplace stress.

2 (b): The identification and analysis of the workplace support needs expressed by the participating home-based care practitioners and their supervisors/managers

Through the **literature review** (see Chapter 2)**,** the researcher investigated documented studies of workplace stress among HIV and AIDS home-based care practitioners. The review started with workplace stress in healthcare and eventually narrowed this down to HIV and AIDS home-based care. The literature consulted confirmed that the HIV and AIDS home–based care practitioners were exposed to workplace stress (see Chapter 2: section 2.6). The main contributing factors to workplace stress were as set out below.

- The work was undermined and labelled as insignificant and "dirty work."

- HIV and AIDS work was more demanding and stressful as compared to other critical illnesses like cancer.

- They had to endure secondary stigma because of working with people living with HIV and AIDS.

- They experienced the work as emotionally draining and exhausting.

- They had difficulty coping with the high workload.

- They had to deal with unrealistic expectations of the patients' families.

- The work was physically straining (for example, walking from house to house during home visits and lifting bed-ridden patients).

- They experienced over emotional involvement with patients.

- They were prone to burnout.

Qualitative data, through semi-structured interviews guided by an interview schedule (Appendix D) and quantitative data, using a non-standardised questionnaire (Appendix C) were collected from the primary participants (35 home-based care practitioners). Only qualitative data were gathered from the secondary participants (5 supervisors/managers) using an interview schedule (Appendix E). The purpose was to identify the workplace support needs of the participants, as HIV and AIDS home-based care practitioners working in Tshwane and not assume that they experienced the same challenges as those found reported in completed studies and the available literature.

The **empirical findings,** from analysis and interpretation of qualitative and quantitative data gathered from both primary (i.e., HBCs) and secondary participants (i.e., supervisors/managers), revealed that, although they had similar experiences as the participants in the cited studies, they identified the pressing workplace support needs which are listed below (see Chapter 6: section 6.2.1.2, theme 3, sub-themes 3.1, 3.2 & 3.3; section 6.2.3; Chapter 7: section 7.3.1.).

- Difficulty in dealing with the **emotional stress** of the work: all participants cited that the work was draining and they struggled to cope, to the extent that some were not able to de-role once they were back home.

- Challenges with coping with **patient care demands**: they were unprepared for what they had to deal with in reality with regards to patient care and this compromised their ability to cope.
- The need for **regular and structured debriefing sessions** was cited as an important workplace support service to help them cope with daily challenges and demands of the work.
- **Lack of resources**: there were problems with transport to home visits and for patients to healthcare facilities, food parcels and some form of financial incentives.
- Difficulty to deal with the **high workload**.

The supervisors/managers (secondary participants) added that they observed the following symptoms of stress and burnout among the primary participants (see Chapter 6: section 6.2.2.2, theme 2):

- fatigue;
- demotivation;
- lack energy and drive;
- anger shown in late submission of work, reduced commitment, not answering work calls when out of the office;
- social withdrawal; and
- sadness.

These needs provide evidence that the primary participants were experiencing workplace stress and needed support to be able to function optimally and deliver quality service to their patients. The sub-objective was therefore met in that the workplace support needs, as expressed by both the primary and secondary participants were identified and documented.

In **conclusion,** the mixed methods data collection, coupled with sourcing input from two groups of participants, enabled the researcher to elicit responses from the participants that allowed them to express their version of what their workplace support needs were. The result was workable data that, after analysis and interpretation, provided insightful understanding of what the participants regularly faced in the execution of their duties.

Objective 3: To consult the relevant literature and existing effective stress management programmes in the healthcare field to gather additional data for insightful synthesis of data gathered from the research study participants

The previous discussion outlined the outcome of the need assessment process which formed an integral part of the problem analysis and project planning phase (Phase One) of the IR process. The need for a stress management programme for the participants was confirmed, and this necessitated preliminary investigations with regards to the existing effective stress management programmes in the healthcare field and also consulting relevant literature on stress management. The aim was to design and develop a programme that would integrate sound theoretical grounding, lessons from working stress management programmes and the input of the participants.

The **literature review** (see Chapter 3) started with a detailed discussion of the concept of stress, then an explanation of the organisation centred and employee/individual centred stress management programmes ending with available stress management programmes in the healthcare field. The review revealed that the most effective stress management programmes in the healthcare field were the individual centred interventions (see Chapter 3: section 3.4). Secondly, there is a scarcity of researched and documented stress management programmes for lay healthcare workers. Furthermore, findings from existing studies in stress management highlighted the following interventions as being the most effective (see Chapter 3: section 3.3.2.1; section 3.4):

- Relaxation through meditation using mindfulness-based stress reduction (MBSR). This technique was found to be particularly effective with professionals in the healthcare field.

- Psycho-education with a specific focus on understanding stress and the stress response, guided imagery training and creation of a personalised wellness plan. This was another intervention that proved relevant for professional healthcare workers.

- Cognitive-behavioural therapy (CBT), specifically the rational emotive behavioural (REB) techniques. The techniques were identified as being among the most effective individual stress management interventions and not specific to any sector.

The literature review findings and the research findings from Phase One of the study had to be integrated in the design and development of the stress management programme for the HIV and AIDS home-based care practitioners.

The objective was achieved in that input from various sources, were sought and synthesised to ensure that the programme would be relevant, appropriate and effective in meeting the support needs of the participants. It is **concluded** then that input on what the contents of the intervention programme should be, has been identified. The next step, in accordance with intervention research process, was to design the programme.

Objective 4: To design a stress management programme with clear procedures on how the intervention will be implemented using the information gathered from the participating home-based care practitioners, their supervisors/managers, literature and successful stress management programmes models in the healthcare field

At this stage of designing the prototype programme, the researcher had already obtained guidelines from consulting the relevant literature and successful models of stress management programmes in the healthcare field as explained in the previous objective (Objective 3). The important activities with this objective included formulating clear procedures of how the programme would be implemented and what would be its contents. The researcher had to make informed decisions concerning what topics would be addressed in the programme, the duration of the sessions, how many sessions in total, the development of the programme manual, who would facilitate, the facilitation methods and the aids to be used.

Using the knowledge gained from **literature reviews** (see Chapters 2 & 3), the **empirical findings** (see Chapters 6 & 7) and the researcher's experience as a trainer in the HIV and AIDS field, a programme manual was developed. The programme consisted of five modules spread over seven sessions of approximately 90 minutes each. The researcher assumed the role of facilitator and the facilitation methods were interactive and centred around the participants (see Chapter 8: section 8.2.3). In brief, the programme addresses the **topics** set out below.

- **Module 1. Introduction to the programme:** the module provides an overview of the programme, current HIV and AIDS statistics and a brief discussion of the history and spectrum of services in HIV and AIDS home-based care.

- **Module 2. Understanding illness:** the module imparts knowledge to the participants on the experience of illness, and how it impacts on the patient and family and what intervention strategies to use when rendering services. This module was aimed at assisting the participants to gain the skills and knowledge needed to cope with general patient care demands and expectations.

- **Module 3. Understanding stress:** through psycho-education the module aims to assist participants to understand stress and be able to identify symptoms in themselves and colleagues.

- **Module 4. Stress management interventions:** three stress management interventions are discussed over three sessions. The mindfulness stress reduction and the cognitive-behavioural interventions are included, based on their success and relevance to other healthcare professionals. The critical stress debriefing is included as there was a request for regular debriefing, given their stressful work environment.

- **Module 5. Building resilience:** the module focuses on equipping participants with additional self-care and stress coping skills to ensure that what they learn in the programme is sustained.

The objective was successfully achieved in that findings from previous research, theory and the input of the research participants were all incorporated and integrated into the design, contents and implementation of the stress management programme for HBCs in Tshwane. In **conclusion,** a theoretically sound intervention programme was designed and developed, with the research participants as co-authors of the programme. The (prototype) programme then needed to be piloted.

Objective 5: To implement and evaluate the prototype stress management programme to assess its effectiveness in supporting the HIV and AIDS home-based care practitioners in Tshwane in terms of workplace stress

The prototype intervention programme manual was compiled and ready to be implemented in similar field settings. Phase Four (early development and pilot testing) of the intervention research process dictated that any newly developed programme had to be piloted before it could be used with the broader target group. In order to achieve the objective, three sub-objectives were formulated and they are discussed separately below.

5 (a): Recruit sixteen to twenty participants for the pilot testing of the prototype stress management programme

In the pilot testing process, both qualitative and quantitative data were gathered. With the qualitative approach, the instrumental case study research design was adopted whilst the quantitative research design was the comparison group pre-test–post-test design. The quantitative design then consisted of the experimental and the comparison group. The group had to have a maximum of ten participants. Two groups of participants were then recruited from two different organisations who participated in Phase One of the IR process (see Chapter 5: section 5.6).

A group of twelve participants were recruited for qualitative data collection from one organisation. This group also formed the experimental group (exposed to the prototype intervention programme) for the quantitative data collection. The comparison group was recruited from another organisation and only seven home-based care practitioners volunteered to participate in the study. All participants met the same criteria as those for the Phase One primary participants (home-based care practitioners).

The sub-objective was achieved as in total, nineteen participants were recruited and they participated in the study throughout the pilot testing process.

5 (b): Implementing the prototype stress management programme through pilot testing to establish whether the programme is practical and effective in meeting the identified needs

After the research participants for the pilot testing were secured, the venue for the implementation of the prototype intervention and the time were successfully negotiated with the management of both organisations. It needs to be noted that the comparison group was not exposed to the prototype intervention. The researcher gathered pre-test data and post-test data from both groups of participants. The logic model was adopted as the programme theory that guided the implementation and evaluation of the prototype intervention (see Chapter 8: section 8.2.4).

The logic model enabled the researcher to understand what should be put in place to ensure that the expected outcomes would be realised, allowed critical examination of the programme and facilitated open communication about the strategies, activities and outcomes of the pilot testing process (Fraser et al., 2009: 55; Royce et al., 2010:108-109). The core elements of the logic model are inputs, activities, outputs and outcomes which are linked to programme components (Chen, 2015:59; Lewis et al., 2012:67; Royce et al., 2010:109, Saunders, 2016:132). For the purposes of the study, objectives and short-term outcomes were included (see Chapter 8: section 8.2.4.1).

The programme ran over seven Monday mornings, starting in February 2018 and ending in April 2018. The session allocated time was 90 minutes, but in practise each session took at least an hour longer. The ice-breakers, class activities and homework ensured that participants actively engaged in what was discussed in the sessions and gained the expected knowledge and skills. After every session the participants were further asked to complete a session evaluation form that allowed them to reflect on the session and make comments on how they experienced the session (see Chapter 8: section 8.2.3).

The qualitative and quantitative data gathered during programme implementation provided feedback on the practicality and effectiveness of the prototype intervention programme. Additional data were also sought from the session evaluation forms (Appendix I).

The sub-objective was attained as all the required pre- and post-test data were gathered and the intervention programme was implemented, guided by the logic model and as laid out in the programme manual. The analysis and interpretation of the data is discussed next.

5 (c): Analysing and interpreting both the qualitative and quantitative data gathered from the pilot testing

Qualitative data before and after exposure to the prototype intervention programme were gathered from the participants (experimental group) using semi-structured interviews, guided by interview schedules (Appendix G & H) and session evaluation forms (Appendix I). The data were analysed and interpreted (see Chapter 9). The overall qualitative findings were that the prototype intervention programme was practical and effective in meeting the workplace support needs of the HIV and AIDS home-based care practitioners. The main **qualitative findings**, are summarised in point form (see Chapter 9: section 9.5) as follows:

- **Participants' perception of challenges in execution of their work:** before exposure to the intervention programme, participants reported that they were challenged by lack of material resources that affected their ability to meet the needs of their patients with the lack of transport to home visits and shortage of food parcels as priorities, experience of the work as emotionally draining, and lack of skills required to deal with challenging patients. After exposure to the intervention, only a few participants reported finding the work emotionally draining. Furthermore, the participants reported feeling empowered to deal with challenging patients. The participants further expressed that the issue of lack of resources would best be addressed by the organisations' management.

- **Coping with work stress:** before exposure to the intervention programme participants mentioned that they used individual coping mechanisms, support from colleagues, support from supervisors and/or social workers and senior management to cope with work stress. After exposure to the intervention, although they still valued the support from social worker/supervisor, colleagues and senior

management, they felt empowered by the intervention and therefore did not need as much support from senior staff as they previously had done.

- **Benefits of the intervention programme:** After exposure to the intervention programme, the participants reported that their expectations of learning about stress and acquiring stress management skills were met. Suggestions on improvements of the intervention programme such as increasing the time allocation for sessions and adding more information on self-care for home-based care workers were also made.

Quantitative data on the other hand were gathered using the Oldenburg Burnout Inventory (OLBI), a standardised group administered questionnaire which measures disengagement and exhaustion in the workplace (Appendix F). The OLBI was administered pre- and post-test to the experimental and the comparison groups and the data were analysed using statistical tests. The **quantitative results** did not convincingly articulate that the prototype intervention programme met the support needs of the participants. A summary of the main results follows (see Chapter 10: section 10.3):

- **Pre-test results on disengagement and exhaustion:** the experimental group reported being more disengaged from their work and exhausted than the comparison group.

- **Post-test results on disengagement and exhaustion:** both the experimental and comparison groups experienced the same level of disengagement, whilst the experimental group reported slightly higher exhaustion than the comparison group.

- **Post-test scores minus pre-test scores on disengagement and exhaustion:** the experimental group were less disengaged but more exhausted at post-test level. The comparison group reported higher disengagement and exhaustion at post-test level.

- **Association between disengagement and exhaustion and the participants' highest qualification level:** the group who had obtained Grade 12 and higher level of education showed decreased disengagement from their work and slightly

lowered exhaustion at post-test level, as compared to the group who obtained Grade 8-11.

The previous discussion provided evidence that the sub-objective was successfully met as both the qualitative and quantitative data were analysed and interpreted. The findings and the results gave feedback in terms of how the participants experienced the prototype intervention programme (experimental group) and suggestions for refinement of the programme were also expressed.

In **summary**, Objective 5 was achieved as the prototype intervention programme was implemented and evaluated as planned. The data gathering methods, using the mixed methods approach, were effective in sourcing valuable feedback from the participants regarding the prototype programmes' practicality and effectiveness. Through data analysis and interpretation, conclusions were drawn, based mainly on the qualitative findings, that the prototype intervention was practical and effective in meeting the workplace support needs of the research participants. Recommendations for future refinement of the intervention programme, are discussed in the next objective.

Objective 6: Make recommendations, based on the qualitative findings and quantitative results of the pilot testing process, on the refinement and adjustment of the stress management programme for HIV and AIDS home-based care practitioners, for future use

The previous objective reported on the outcome of the pilot testing process with specific reference as to whether the prototype intervention programme was effective and practical in supporting the research participants to manage the workplace stress. With Objective 6 the research process continues by detailing the participants' articulated inputs with regards to the future refinements and adjustments that need to be effected to the intervention to improve its ability to assist the HIV and AIDS home-based care practitioners in Tshwane in managing workplace stress.

The qualitative data gathering process made it possible to source the relevant input and opinions from the research participants through the interviews and session evaluation

forms. The main points that were raised by the participants as areas that need improvement are set out below (see Chapter 9: section 9.3.3, sub-theme 4.2; section 9.4.2).

- With regards to the 90 minutes allocated time per session, there was general consensus that the time allocation needed to be increased, particularly with the stress management techniques module.
- The self-care portion of "building resilience" module should be extended to include additional information on "first aid for (the carer's) mental health."
- Furthermore, the immediate supervisor and/or management representative should attend the sessions as observers so that they are able to support the HBCs in maintaining what they have learnt from the intervention programme.
- There was a request to add general information on disabilities as HBCs sometimes have to work with patients who are disabled.

Despite the mentioned suggestions, the majority of participants felt that the intervention programme was adequate in meeting their workplace support needs and did not need any modifications. It is just the session time allocation that needs adjustment.

The researcher is of the opinion, and with the study embedded within social constructionism as a theoretical framework, that all the suggestions of the participants need to be incorporated into the overall recommendations from the study with the exception of the topic on disability. Disability falls outside of the area of focus of the stress management programme. The need will be communicated to the organisations' management for inclusion in their respective in-service training programmes.

The objective of sourcing input and views from the participants in respect of the refinement and adjustment of the prototype intervention programme has been achieved. This step then lays the foundation for discussion of overall recommendations emanating from the study.

In summary, the six objectives of the study which are in line with the intervention research process have been achieved. Evidence of how each objective was achieved was

discussed with each highlighted objective and sub-objectives (where applicable). Briefly, this doctoral study has **achieved** the points set out below.

- A theoretical framework for the study, social constructionism had been adopted.
- The needs assessment, with carefully selected primary and secondary participants, using the mixed methods approach, has been successfully carried out.
- The outcome of the needs assessment and review of existing and successful stress management programmes in the healthcare field has enabled the design and development of a prototype stress management programme for HIV and AIDS home-based care practitioners in Tshwane.
- The prototype intervention programme has been successfully piloted and evaluated, using the mixed methods approach, allowing inputs on future refinements and adjustments to the intervention programme by the participants (qualitative approach). This achievement is arguably the most important emanating from the doctoral study. The stress management progamme for HBCs in Tshwane is an original and unique contribution that the researcher is making to the knowledge base of social work and the social work profession.
- Finally, the suggestions and recommendations of the participants on programme refinement have been identified and listed.

In light of the detailed discussion on how the objectives were executed, **conclusions** drawn are that **the goal of the study has been achieved**.

The **research questions were also satisfactorily answered** in that:

- The workplace support needs of the HIV and AIDS home-based care practitioners have been identified through the needs assessment in Phase One of the IR process.
- The main themes covered in the stress management programme were a product of the findings and results of the needs assessment process and literature review of successful stress management programmes in the healthcare field.

- The pilot testing process (Phase Four of the IR), from a qualitative perspective, has confirmed that the newly developed intervention programme was successful in mitigating the impact of workplace stress experienced by the HIV and AIDS home-based care practitioners. The quantitative perspective on the other hand has revealed that the intervention programme had minimal effect in mitigating the impact of the workplace stress. The programme therefore needs refinements, advanced implementation and evaluation to determine clearly its success in mitigating the impact of workplace stress among home-based care practitioners in Tshwane.

A detailed discussion of recommendations, based on the findings and results of the research process is discussed next.

11.3 RECOMMENDATIONS

In the process of designing, implementing and evaluating the prototype stress management programme for HIV and AIDS home-based care practitioners in Tshwane, trends were identified, lessons learnt and various notable inputs received from the research participants. Recommendations from the study are discussed in terms of the conceptual framework, the structure and content of the stress management programme for HIV and AIDS home-based care practitioners, the implications for social work training and practise, policy amendments for home and community-based care workers, workplace support and for future research.

11.3.1 Conceptual framework

HIV and AIDS home-based care services, although regulated by the Department of Social Development and Department of Health guidelines in terms of how, where, when and by whom it should be practised, have to be context-specific and relevant. It is for this reason that in situations where the felt needs of the clients need addressing that the clients themselves are given the opportunity to voice their needs and social work practitioners,

among others, need to see a way to attend to the needs practically. Social constructionism as a theoretical framework guided the researcher in "learning" from the research participants and adopting a non-judgemental attitude in familiarising herself with the views and the social reality of the HBCs in Tshwane. The use of social constructionism and/or similar theoretical frameworks in social research is endorsed and recommended for a theory-driven and comprehensive research process whose findings and/results are grounded in and validated by theory.

Furthermore, the logic model, which was the programme theory adopted during pilot testing, provided a simple step by step procedure that ensured that a comprehensive, theory-based programme evaluation was implemented. The model itself provided checks and balances in every step of the testing and proved to be a valuable guide. The use of theory-based pilot testing and programme evaluation, like the logic model, in this and similar studies is recommended, more so in that it allows adaptation to specific contexts (within limits).

11.3.2 Structure and content of the stress management programme

Based on the suggestions of the research participants and the researcher's experience whilst facilitating the stress management programme, the following recommendations are put forward with regards to the content and structure of the programme.

- The sequence, frequency and how each session was structured be left as is with no changes.
- Time: the session time allocation to be increased from 1 hour and 30 minutes to 3 hours, because each session took an hour longer on average during the piloting process. A 15 minutes break in between the 3 hours is suggested to improve participants' concentration and participation.
- Module 5: Building resilience should be expanded to include additional information on "first aid for mental health" of the home-based care practitioners, with class activities to facilitate practical application.

- Additional class activities are needed for each of the three stress management techniques (Cognitive-Behavioural Therapy, Critical Incident Stress Debriefing & Mindfulness-Based Stress Reduction) for improved integration of theory and practise.

- The orientation and final sessions of the stress management programme should include both the home-based care practitioners and their supervisors/managers. The aim would be to familiarise all stakeholders with what the programme is about and for the supervisors/managers to have the necessary insight in order to provide the required support to supervisees during and after the programme.

- Alternatively, a train-the-trainer workshop on the HIV and AIDS home-based care practitioners' stress management programme should be available to the supervisors/managers as a form of capacity building so that they are skilled to facilitate the programme without relying on the researcher/research-practitioner.

- A follow up evaluation session is further suggested after four months of programme completion, attended by both programme participants and their supervisors/managers to assess the sustainability of the skills acquired during programme implementation to inform the future refinement and adjustment of the programme.

11.3.3 Social work training and practise

Social work is a profession that promotes social change and development, empowerment and enhancement of the well-being of the people it serves (International Association of Schools of Social Work, 2014:1). It is for this reason that it has to adapt its practise to the needs of the service users. In light of the knowledge gained from the results and findings of the study, the following are thus recommended in respect of social work training and practise:

- More attention needs to be given to training on Critical Incident Stress Debriefing (CISD) to undergraduate social work students. It was highlighted during the needs assessment process that it was the service that the HIV and AIDS home-based

care practitioners most needed on a regular basis. The purpose is to ensure that qualified social workers are able to provide the service (facilitation and/or training) in both government and non-governmental organisations (NPO partners) when needed by home and community-based care workers.

- The Professional Board for Social Work of the South African Council for Social Service Professions must promote and encourage practising social workers to attend a CISD re-fresher workshop every five years as part of Continued Professional Development.

- Promotion of social constructionism theoretical framework in social work research and practise is essential in light of the fact that both share the common belief in respect for the human condition, attention to language and communication, non-judgmental interactions and the acceptance of differing worldviews of service users.

11.3.4 Policy change directive

In light of the workplace support needs identified through the study, the following policy adjustment with regards to support for home and community-based care workers is recommended:

- The national norms and minimum standards for home and community-based care and support programme's guidelines on "Governance and Leadership" (Department of Social Development, 2007:16), should be amended with regards to the provision that home and community-based care workers receive at least two hours of debriefing monthly. The recommendation is that the workers receive one hour of group debriefing weekly.

- A closer working partnership between the Department of Social Development and Department of Health to ensure the smooth implementation of the programme.

11.3.5 Future research

The following future research recommendations are made based on the findings and results of the current study:

- A condensed form of the HIV and AIDS home-based care practitioners stress management programme with specific focus on the stress management techniques, should be designed and implemented as part of basic home-based care training (e.g. during induction programmes).
- The validity of the Oldenburg Burnout Inventory among lay healthcare workers who use English as a second/third language needs to be investigated. The instrument could be further refined for use in South Africa among lay workers whose mother tongue is often not English.
- Furthermore, test developers and publishers should invest in standardising measuring instruments with African samples for utilisation in African countries irrespective of financial gain.
- Proposal to adapt the stress management programme for use by other home-based care practitioners who are not working in the HIV and AIDS field.
- As the programme was implemented with and evaluated among home-based care practitioners who worked for non-governmental organisations, it is proposed that the programme be adapted and made available to lay healthcare workers employed by government/public health facilities particularly community health clinics.
- The stress management programme was piloted in a predominantly African community. It is thus recommended that the programme be further piloted with other racial groups within the Tshwane metropolitan city.

11.4 SUMMARY

The chapter, which is the final chapter of the study, provided an overview of the key findings, results and the conclusions drawn from the phases of the intervention research process. The goal, objectives, sub-objectives and research questions of the study and

how they were achieved were discussed in detail. Final conclusions were drawn from the discussion was that the goal and objectives of the study were successfully attained, and the research questions have been answered.

In addition to the discussion of key findings and conclusions, recommendations in terms of the conceptual framework with reference to social constructionism were made. The content and structure of the stress management programme, the refinement of, and adjustments to, were stated. Additional recommendations were made concerning the study's implications on the future training and practise of social work, policy change directives and possible areas for future research based on the results and findings of the study. All that was discussed in the chapter has therefore served as a final report on the research process and thus concludes it.

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APPENDIX A

FACULTY OF HUMANITIES RESEARCH ETHICS COMMITTEE APPROVAL LETTER

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

11 June 2015

Dear Prof Lombard

Project:	**A stress management programme for HIV and AIDS home-based care practitioners in Tshwane**
Researcher:	**P Kupa**
Supervisor:	**Dr LS Geyer**
Department:	**Social Work and Criminology**
Reference number:	**26404185 (GW20150515HS)**

Thank you for your response to the Committee's correspondence of 9 June 2015.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 11 June 2015. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof. Karen Harris
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: karen.harris@up.ac.za

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

Research Ethics Committee Members: Prof KL Harris(Acting Chair); Dr L Blokland; Prof M-H Coetzee; Dr JEH Grobler; Prof B Hogmeyr; Ms H Klopper; Dr C Panebianco-Warrens; Dr C Puttergill; Prof GM Spies; Dr Y Spies; Prof E Taljard; Dr P Wood

APPENDIX B

PERMISSION LETTERS FROM NON-GOVERNMENTAL ORGANISATIONS (4)

NKGODISENG HOME BASED CARE

. Reg. No. 069-612 NPO & PBO No. 930035267

1403 Portion 9
Cnr. Sejamothopo Str & Old Warmbaths Road (R101)
Hammanskraal
Gauteng Province
nkgodisenghbc@gmail.com

P.O. Box 2366
Hammanskraal
0400
Republic of South Africa
Cell: 072 367 2489
082 595 3341

"A Community Based Organization initiated by the members of the community"

Ms Peni (Viola) Kupa
penikupa@gmail.com
073 172 0604

Dear Madam.

> Your correspondence dated 17 October 2013 and your personal visit on Monday 21 October 2013 refers:-

- Kindly note that your request to conduct research with our HIV and Aids Home Based Carers as described as "An Employee Assistance Programme" has been acknowledged and accepted with thanks

Hope you find this in respect

Yours in Community Services,

28/10/2013

1. William Sello Leseka
   The Project Director

2. Robert Ntlori Mogale
   The Secretary

MISSION STATEMENT

Teach the community to love, care and heal the nation.

Board of Directors: Mr. W.S Leseka (Founder & Director), Mr. B.B Ditlamelo (SAPS & Chairperson), Miss M.M. Skosana (Professional Nurse & Secretary), Miss P.E. Mamaila (Social Worker & Treasure), Mr. T.J. Mogosetsi (Community Member & Ass. Chairperson), Mr. S. Ntjana (Pastor & Ass. Secretary) and additional members: Miss M.J Matlou (Professional Nurse) and Mr. M.M. Kgosana (Factory Manager)

P.O. BOX 77980 MAMELODI WEST 0101
227 VAMSANDA STREET
MORETELE VIEW, PRETORIA
SOUTH AFRICA

NPO REGISTRATION No: 031 – 196
PBO Section 18A no 930 026 373

E-mail: tateni@telkomsa.net

Website: www.tateni.co.za

Telefax: +27 (0)12 805 2752
Direct: +27 (0)12 805 9109

Home Care Nursing Service

04 February 2015

THE DEPARTMENT OF SOCIAL WORK

UNIVERSITY OF PRETORIA

PRETORIA

TO WHOM IT MAT CONCERN

PERMISSION TO CONDUCT A RESEARCH STUDY

On behalf of Tateni Home Care Nursing Services, I hereby express our approval to permit Mrs Penelope Kupa to undertake her research on "A Stress Management Programme for HIV/AIDS Home –Based Care Workers", on Tateni 's Home Care Workers.

We wish her a successful outcome of her research, and promise to assist her as far as possibly permissible.

With kind regards,

....

Regina D. Mokgokong: Executive Director

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ST. JOHN THE BAPTIST CATHOLIC CLINIC

ST. JOHN THE BAPTIST CATHOLIC CLINIC	TELEPHONE: 083 273 2472
PRIMARY HEALTH CARE	082 399 7446
P.O. BOX 911-039	FAX: (086) 567 2642
ROSSLYN 0200	NPO-019-947
1048 KEKANA STAND	Email: info@stjohncatholicclinic.org.za

04 MARCH 2015

Ms Penelope Kupa

Dear Madam

Re: Your request for Hiv/Aids workers stress management research.

Greetings:
Thanks for the above request dated 03/03/2015. Which we have gone through it and understand the process and results thereof and are satisfied.

Chairperson of the board of management has been informed about the request and has no problem in you using our organisation for the research.

So you are permitted to go on with it after you have given us the date of commencement. What we request from you madam is to give us feed back in writing of the results of your research after completion.
Hoping that you will enjoy working with us during the research.

Thank You

Yours Sincerely
Mrs T.R.Mojapelo
(Manager)

ST. JOHN THE BA.
CATHOLIC CLIN₊C
P.O. Box 911-039
Rosslyn, 0200
Cell : 082 399 7446
Cell :

St. Joseph's Care and Support Trust
AT SIZANANI VILLAGE
IT: 3652/03

05/11/2013

Dear Penny

This is to confirm that St. Joseph Care and Support trust has granted you permission to come and conduct research with our Staff.

Looking forward to working with you.

Kind Regards,

Audrey

O A Montshiwa
Executive Director
St. Joseph's Care and Support Trust
Tel: 013 932 6645
Fax: 013 932 6651
Email: audrey@stjosephcare.org.za

APPENDIX C

NON-STANDARDISED QUESTIONNAIRE – PHASE ONE (IR)

Phase 1: Questionnaire for primary respondents	For office use only

Respondent number

SECTION A: BIOGRAPHICAL INFORMATION

1. Gender

Female	1		Male	2

A1 ☐

2. How old are you? .... years

A2 ☐☐

3. According to the Employment Equity Act of SA, to which population group do you belong?

African	1
Coloured	2
White	3
Asian	4
Other (specify)	5

A3 ☐

4. Highest qualification level

No formal schooling	1
Grade 1 - 7	2
Grade 8 - 11	3
Grade 12	4
Post Grade 12 qualifications	5
Other (specify)	6

A4 ☐

5. Marital status

Married	1
Divorced	2
Widowed	3
Single	4
Other (specify)	5

A5 ☐

6. How long have you been working as a home-based care practitioner? .... Years

A6 ☐☐

SECTION B: MY WORK AS A HOME-BASED CARE PRACTITIONER

Below are statements with which you may agree or disagree.

Using the scale, please indicate how strongly you agree or disagree with each statement by **circling** the number that best corresponds with your opinion.

Indicate your level of agreement with the following statements.

		Strongly disagree	Disagree	Agree	Strongly agree		
1.	I feel good about my work as a home-based care practitioner	1	2	3	4	B1	
2.	The challenges I experience at work are manageable	1	2	3	4	B2	
3.	I get fulfilment from being able to help others in need	1	2	3	4	B3	
4.	I would encourage others who are interested in becoming home-based care practitioners	1	2	3	4	B4	
5.	I receive the support I need from management of the organisation to help me cope with my work	1	2	3	4	B5	
6.	Lately I experience my work as draining all the energy I have	1	2	3	4	B6	
7.	I feel I am carrying the problems of those I help with me	1	2	3	4	B7	
8.	I think that a lot is expected from me in terms of the amount of the work I have to cover	1	2	3	4	B8	
9.	I have difficulty sleeping if I think about the experiences of those that I help at work	1	2	3	4	B9	
10.	After handling a very ill patient, I feel worried about going to work the following day	1	2	3	4	B10	

APPENDIX D

SEMI-STRUCTURED INTERVIEW SCHEDULE FOR HIV AND AIDS HOME-BASED
CARE PRACTITIONERS – PHASE ONE (IR)

INTERVIEW SCHEDULE FOR HIV AND AIDS HOME-BASED CARE PRACTITIONERS - (PHASE ONE: INTERVENTION RESEARCH)

SECTION A: DEMOGRAPHIC DATA

1. Initials (for identification purposes, only):

2. Age:

3. Gender:

4. Ethnic group:

5. Marital status: married / divorced / widow- widower / single / other

6. Educational qualifications:

7. Years of experience as a home-based care practitioner:

SECTION B: INTERVIEW QUESTIONS

1. What attracted you to become a home-based care practitioner?

2. What, in brief, does your work entail on a daily basis?

3. Do you work alone or in a team? Please explain your answer.

4. What is the reporting structure in your organisation, with specific reference to the work you do?

5. In your opinion, what are the challenges and/or problems in terms of doing HBC?

6. Supervision in most instances is about sharing information, skills, knowledge and providing support of the supervisee.   How does supervision address these needs in your situation?

7. In light of what you have mentioned so far, what additional support would you need from your manager/supervisor?

8. What has been a highlight in your work in the past 6 – 12 months?

9. What has been "a low point" in your work in the past 6 – 12 months?

10. Given an opportunity to mentor a newly employed HIV and AIDS home-based care practitioner, what are the first things you would tell him/her about being a home-based care practitioner?

APPENDIX E

SEMI-STRUCTURED INTERVIEW SCHEDULE FOR SUPERVISORS/MANAGERS – PHASE ONE (IR)

INTERVIEW SCHEDULE FOR THE MANAGER/SUPERVISOR OF THE HIV AND AIDS HOME-BASED CARE PRACTITIONERS

(PHASE ONE: INTERVENTION RESEARCH)

SECTION A: DEMOGRAPHIC INFORMATION

1. Initials (for identification purposes, only):

2. Age:

3. Gender:

4. Ethnic group:

5. Marital status: married / divorced / widow- widower / single / other

6. Educational qualifications:

7. (a) What is your professional relationship with the HIV and AIDS home-based care workers (for example, manager, team leader, supervisor)?

  (b) For how long (duration of the relationship)?

SECTION B: INTERVIEW QUESTIONS

1. In your experience, what are common challenges that HIV and AIDS home-based care practitioners experience in carrying out their daily tasks?

2. 1 What is your understanding of stress?

2.2 In your opinion, are the HIV and AIDS home-based care practitioners stressed by the work they do? Yes/ No. Please motivate your answer.

3.1 What is your understanding of burnout?

3.2 Have you observed signs of burnout among the HIV and AIDS home-based care practitioners? Yes/No

3.3 If yes, what was done about this?

4. Do you think the work impacts on their personal life? Please explain.

5. In your opinion, do the home-based care practitioners find their work fulfilling? Please explain.

6. What workplace support services are available for the home-based care practitioners in the organisation?

(i)   If available, are they effective?   Please explain.

(ii)   If the support services are ineffective, what can be done to improve the effectiveness?

(iii)   If not available, what are the main reasons for not providing such a service to employees?

APPENDIX F

OLDENBURG BURNOUT INVENTORY – PHASE FOUR (IR)

Phase 4: OLDENBURG BURNOUT INVENTORY		For office use only

Phase 4: OLDENBURG BURNOUT INVENTORY

Respondent number

SECTION A: BIOGRAPHICAL INFORMATION

1. Gender

Female	1		Male	2

2. How old are you? .... years

3. According to the Employment Equity Act of SA, to which population group do you belong?

African	1
Coloured	2
White	3
Asian	4
Other (specify)	5

4. Highest qualification level

No formal schooling	1
Grade 1 - 7	2
Grade 8 - 11	3
Grade 12	4
Post Grade 12 qualifications	5
Other (specify)	6

5. Marital status

Married	1
Divorced	2
Widowed	3
Single	4
Other (specify)	5

6. How long have you been working as a home-based care practitioner? .... Years

SECTION B: OLDENBURG BURNOUT INVENTORY

Below are statements with which you may agree or disagree.

Using the scale, please indicate how strongly you agree or disagree with each statement by **circling** the number that best corresponds with your opinion.

Indicate your level of agreement with the following statements.

		Strongly agree	Agree	Disagree	Strongly disagree		
1.	I always find new and interesting aspects in my work	1	2	3	4	B1	
2.	There are days when I feel tired before I arrive at work	1	2	3	4	B2	
3.	It happens more and more often that I talk about my work in a negative way	1	2	3	4	B3	
4.	After work, I tend to need more time than in the past in order to relax and feel better	1	2	3	4	B4	
5.	I can tolerate the pressure of my work very well	1	2	3	4	B5	
6.	Lately I tend to think less at work and do my job almost automatically	1	2	3	4	B6	
7.	I find my work to be a positive challenge	1	2	3	4	B7	
8.	During my work I often feel emotionally drained	1	2	3	4	B8	
9.	Over time, one can become disconnected from this type of work	1	2	3	4	B9	
10.	After working, I have enough energy for my leisure activities	1	2	3	4	B10	
11.	Sometimes I feel sickened by my work tasks	1	2	3	4	B11	
12.	After work, I usually feel worn out and weary	1	2	3	4	B12	
13.	This is the only type of work that I can imagine myself doing	1	2	3	4	B13	
14.	Usually I can manage the amount of my work well	1	2	3	4	B14	
15.	I feel more and more engaged at my work	1	2	3	4	B15	
16.	When I work, I usually feel energised	1	2	3	4	B16	

Thank you for your participation

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APPENDIX G

PRE-TEST SEMI-STRUCTURED INTERVIEW SCHEDULE – PHASE FOUR (IR)

PRE-TEST INTERVIEW SCHEDULE FOR THE HIV AND AIDS HOME-BASED CARE PRACTITIONERS

(PHASE FOUR: INTERVENTION RESEARCH)

SECTION A: DEMOGRAPHIC INFORMATION

1. Initials (for identification purposes, only):

2. Age:

3. Gender:

4. Racial group: African /Coloured / White / Asian / Other

5. Marital status: Please mark appropriate box with **X**

Married	Divorced	Widowed	Single	Other(specify)

6. Highest Educational qualifications: Please mark appropriate box with **X**

No schooling	Grade 1 - 7	Grade 8 - 11	Post Grade 12 qualification	Other (specify)

7. Years of experience as a home-based care practitioner:

SECTION B: INTERVIEW QUESTIONS

1. What do you like about your work?

2. What do you dislike about your work?

3. Do you think your clients/patients value the service that you render? Please explain your answer.

4. I am going to ask you about the emotional impact of your work:

4.1   Are you emotionally affected by the problems of your clients/patients? Please explain your answer.

4.2   If you are affected, how do you cope?

5. Describe what you find challenging about your work.

6. What is your understanding of stress?

7. How do you manage workplace stress?

Complete the following sentences:

8. I feel supported by my manager/supervisor when

9. I feel supported by my colleague/s when

10. I feel supported by my organisation/employer when

11. My expectations of a stress management programme are

12. What are your professional goals for the next two years (where do you see yourself as a home-based care practitioner in the next two years)?

APPENDIX H

POST-TEST SEMI-STRUCTURED INTERVIEW SCHEDULE – PHASE FOUR (IR)

POST-TEST INTERVIEW SCHEDULE FOR THE HIV AND AIDS HOME-BASED CARE PRACTITIONERS

(PHASE FOUR: INTERVENTION RESEARCH)

SECTION A: DEMOGRAPHIC INFORMATION

1. Initials (for identification purposes, only):

2. Age:

3. Gender:

4. Racial group: African / Coloured / White / Asian / Other

5. Marital status: Please mark appropriate box with **X**

Married	Divorced	Widow - Widower	Single	Other

6. Educational qualifications: Please mark appropriate box with **X**

No schooling	Grade 1 - 7	Grade 8 - 11	Post Grade 12 qualification	Other (specify)

7. Years of experience as a home-based care practitioner:

SECTION B: INTERVIEW QUESTIONS

1. What do you like about your work?

2. What do you dislike about your work?

3. Do you think your clients/patients value the service that you render? Please explain your answer.

4. I am going to ask you about the emotional impact of your work:
4.1 Are you emotionally affected by the problems of your clients/patients since you have been through the stress management programme? Please explain your answer.

4.2 If you are affected, how do you cope?

5. Describe what you find challenging about your work.

5.1 How do you cope with the challenges?

Complete the following sentences:

6. I have experienced the stress management programme as helpful because

7. I have experienced the stress management programme as unhelpful because

8. I suggest that the following should be excluded from the stress management programme in future

9. I suggest that the following should be included in the stress management programme in future

APPENDIX J

SESSION EVALUATION FORM

SESSION EVALUATION FORM

Session No.

Participant Initials:

Date:

PLEASE RATE YOUR VIEW ABOUT HOW THE SESSION WAS PRESENTED BY MARKING WITH "X" IN THE APPROPRIATE BOX.

ITEM	POOR	AVARAGE	GOOD
1. Session objectives			
2. Duration of the session			
3. The style of presentation			
4. Medium of instruction (language used)			
5. Facilitator preparation and knowledge of subject matter			
6. Relevance and appropriateness of class exercises and homework			
7. Appropriateness of facilitation aides such as flipchart etc.			

Additional Comments

_____

_____

_____

APPENDIX J

INFORMED CONSENT FORM FOR HIV AND AIDS HOME-BASED CARE
PRACTITIONERS – PHASE ONE (IR)

Faculty of Humanities
Department of Social Work & Criminology

Researcher: Penelope Kupa

Tel. numbers: Cell: 073 1720 604

Home: (011) 803 4447

Name of organisation: ....

Participant's name: ....

INFORMED CONSENT

Phase 1: Intervention research (primary participants)

1. **Title of the study:** A stress management programme for HIV and AIDS home-based care practitioners in Tshwane.
2. **Purpose of the study:** The purpose of the study is to design, implement and evaluate a stress management programme for HIV and AIDS home-based care practitioners in Tshwane.
3. **Procedures:** I expect to complete a survey and also be interviewed by the researcher. Both the survey and the interview will be administered individually and will focus on my perceptions and experience of workplace stress (burnout included), my coping mechanisms, and available support systems at the organization where I work. I will further be asked to offer suggestions for support in my work as a HIV and AIDS home-based care worker. The process will take approximately 90 minutes: 30 minutes for the completion of the survey and 60 minutes for the interview. A time will be scheduled at my convenience.
4. **Risks and discomforts:** There are no known risks or discomforts associated with the study. There is the possibility that I may experience emotional distress resulting from my expression of my workplace challenges. Should I experience any distress, I will inform the

researcher whom I will expect to arrange a counselling session for me with a suitably qualified counselor.

5. **Benefits:** I understand that there are no direct benefits to me for participating in the study. However, the results of the study will assist the researcher to gain a better understanding of the workplace challenges and associated stress of HIV and AIDS home-based care practitioners.

6. **Participant's rights:** I may withdraw from participating in the study at any time, without any negative consequences.

7. **Financial compensation:** I will receive no financial compensation for my participation in this study.

8. **Confidentiality:** In order to record accurately what I say during the interview, an audio recorder will be used. The recording will be listened to only by the above-named researcher. I understand that the data obtained will be kept confidential unless I ask that it be released. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.

9. **Queries:** If I have any questions or concerns, I can call Penelope Kupa at 073 1720 604.

I understand my rights as a research participant and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for fifteen years.

I will receive a signed copy of this consent form.

----------------------------------   ------------------------

Signature of participant   Date

Signature of researcher

APPENDIX K

INFORMED CONSENT FORM FOR THE SUPERVISORS/MANAGERS- PHASE ONE
(IR)

Researcher: Penelope Kupa

Tel. numbers: Cell: 073 1720 604

Home: (011) 803 4447

Name of organisation: ....

Participant's name: ....

INFORMED CONSENT

Phase 1: Intervention research (manager/supervisor)

1. **Title of the study:** A stress management programme for HIV and AIDS home-based care practitioners in Tshwane.
2. **Purpose of the study:** The purpose of the study is to design, implement and evaluate a stress management programme for HIV and AIDS home-based care practitioners in Tshwane.
3. **Procedures:** I expect to be interviewed by the researcher individually and understand that the focus will be on my perceptions of the challenges, possible stress and burnout experienced by the primary participants (HIV and AIDS home-based care practitioners) in the workplace. Secondly, during the interview it will be explored what workplace support system is available in the organisation for the primary participants, as well as its effectiveness, where applicable. The interview will take approximately 45-60 minutes of my time and it will be scheduled at my convenience.
4. **Risks and discomforts:** There are no known risks or discomforts associated with the study. Should I experience any distress, I will inform the researcher whom I will expect to arrange a counseling session for me with a suitably qualified counsellor.

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University of Pretoria   Fax: Number   00 27 12 420 2093
PRETORIA 0002
Republic of South Africa

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5. **Benefits:** I understand that there are no direct benefits to me for participating in the study. However, the results of the study will assist the researcher to gain a better understanding of the workplace challenges and associated stress of HIV and AIDS home-based care practitioners.

6. **Participant's rights:** I may withdraw from participating in the study at any time, without any negative consequences.

7. **Financial compensation:** I will receive no financial compensation for my participation in this study.

8. **Confidentiality:** In order to record accurately what I say during the interview, an audio recorder will be used. The recording will only be listened to by the above-named researcher. I understand that the data obtained will be kept confidential unless I ask that it be released. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records, or identity, will not be revealed unless required by law.

9. **Queries:** If I have any questions or concerns, I can call Penelope Kupa at 073 1720 604.

I understand my rights as a research participant and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for fifteen years.

I will receive a signed copy of this consent form.

---------------------------------   -----------------------

Signature of participant   Date

Signature of researcher

APPENDIX L

INFORMED CONSENT FORM FOR THE EXPERIMENTAL GROUP – PHASE FOUR
(IR)

Researcher: Penelope Kupa

Tel. numbers: Cell: 073 1720 604

Home: (011) 803 4447

Name of the organisation: ....

Participant's name: ....

INFORMED CONSENT

Phase 4: Intervention research (experimental group) [early development and pilot testing]

1. **Title of the study:** A stress management programme for HIV and AIDS home-based care practitioners in Tshwane.

2. **Purpose of the study:** The purpose of the study is to design, implement and evaluate a stress management programme for HIV and AIDS home-based care practitioners in Tshwane.

3. **Procedures:**

- I expect, together with other seven or nine participants, to attend a stress management programme for HIV and AIDS home-based care practitioners. I understand that the dates, time, duration of sessions, including break time, will be agreed upon by the group, that is, it will be based on group consensus.

- I expect to complete a standardised group administered questionnaire, the Oldenburg Burnout Inventory, before and after exposure to the stress management programme. This will take approximately thirty minutes each time.

- The researcher will also interview me individually, before and after exposure to the stress management programme. In order to record accurately what I say during the interview, an audio recorder will be used. The recording will be listened to only by the above-named

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Lefapha la Bomotho

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researcher. I am aware that the aim of the pre-test interview schedule is to gather information mainly on the workplace challenges that I experience, coping mechanisms that I use to cope with stress and my expectations regarding the intervention programme. The post-test interview schedule will also look at the same issues, the only difference will be that it will ask me to comment on whether my pre-test expectations were met and request me to offer suggestions for the improvement of the programme, where applicable.

4. **Risks and discomforts:** There are no known risks or discomforts associated with the study. Should I experience any distress, I will inform the researcher who will conduct a counselling session for me.

5. **Benefits:** I understand that there are no direct benefits to me for participating in the study. However, the results of the study will assist the researcher to refine the stress management programme so that it meets the workplace stress support needs of HIV and AIDS home-based care practitioners.

6. **Participant's rights:** I may withdraw from participating in the study at any time, without any negative consequences.

7. **Financial compensation:** I will receive no financial compensation from the researcher for my participation in this study.

8. **Confidentiality:** I understand that the data obtained will be kept confidential unless I ask that it be released. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.

9. **Queries:** If I have any questions or concerns, I can call Penelope Kupa at 073 1720 604.

I understand my rights as a research participant and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for fifteen years.

I will receive a signed copy of this consent form.

------------------------------------ ----------------------
Signature of participant   Date

Signature of researcher

APPENDIX M

INFORMED CONSENT FORM FOR THE COMPARISON GROUP – PHASE FOUR
(IR)

Department of Social Work & Criminology

Researcher: Penelope Kupa

Tel. numbers: Cell: 073 1720 604

Home: (011) 803 4447

Name of organisation: ....

Participant's name: ....

INFORMED CONSENT

Phase 4: Intervention research (comparison group) [early development and pilot testing]

1. **Title of the study:** A stress management programme for HIV and AIDS home-based care practitioners in Tshwane.

2. **Purpose of the study:** The purpose of the study is to design, implement and evaluate a stress management programme for HIV and AIDS home-based care practitioners in Tshwane.

3. **Procedures:**
   - I expect, together with other seven or nine participants forming the comparison group, to complete a standardised group administered questionnaire, the Oldenburg Burnout Inventory. This will take approximately 30 minutes each time.
   - The Oldenburg Burnout Inventory will be administered twice. There will be a time lapse of about two months between the first and the second administration of the data collection. During these two months, I will be exempted from attending the stress management programme. I will however, be eligible to benefit from the programme once it is finalised and ready for use amongst HIV and AIDS home-based care workers in Tshwane.

4. **Risks and discomforts:** There are no known risks or discomforts associated with the study. Should I experience any distress, I will inform the researcher who will conduct a counselling

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Lefapha la Bomotho

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session for me.

5. **Benefits:** I understand that there are no direct benefits to me for participating in the study. However, the results of the study will assist the researcher to refine the stress management programme so that it meets the workplace stress support needs of HIV and AIDS home-based care practitioners.

6. **Participant's rights:** I may withdraw from participating in the study at any time, without any negative consequences.

7. **Financial compensation:** I will receive no financial compensation for my participation in this study.

8. **Confidentiality:** I understand that the data obtained will be kept confidential unless I ask that it be released. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.

9. **Queries:** If I have any questions or concerns, I can call Penelope Kupa at 073 1720 604.

I understand my rights as a research participant and I voluntarily consent to participation in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for fifteen years.

I will receive a signed copy of this consent form.

------------------------------------   -------------------------
Signature of participant   Date

Signature of researcher

APPENDIX N

LETTER FROM THE EDITOR

FREELANCE WRITER, PROOF READER AND EDITOR
WEB RESEARCHER AND RESEARCH STRATEGIST
ENGLISH SPECIALIST
ESTABLISHED 1987

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Cell 072 287 9859
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30 September 2018

P O Box 940
LONEHILL 2062
South Africa

### To whom it may concern: Certificate of Editing

This letter serves to confirm that **in** September 2018 I did the
proofreading and the language editing for the thesis of
PENELOPE MONINI KUPA
Student Number 26404185
Titled: *A stress management Programme for HIV and AIDS home-based care practitioners in Tshwane*
This document is being submitted in fulfilment of the requirements for the degree
DOCTOR PHILOSOPHIAE (Social Work)
In the Department of Social Work and Criminology
Of the FACULTY OF HUMANITIES
At the UNIVERSITY OF PRETORIA

I have proofread and edited the entire body of the thesis, but have not been asked to edit the introductory pages, the list of references or the appendices. This editing principally involves proofreading, language, style and grammar editing; and also checking the text for clarity of meaning, sequence of thought and expression and tenses. I have also noted any inconsistencies in thought, style or logic, and any ambiguities or repetitions of words and phrases, and have corrected those errors which creep into all writing. I have written the corrections on the hard copy and have returned the document to the author, who is responsible for inserting these. Please note that this confirmation refers only to editing of work done up to the date of this letter and does not include any changes which the author or the supervisor may make later.
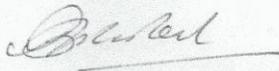
30 September 2018

Bernice McNeil   BA Hons NTSD
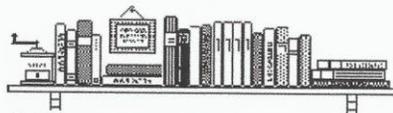
If editors respect the academic purpose of thesis writing and the priority of the supervisor, we can help students (and ourselves). As one member told us: "We are a valuable resource for students as long as we edit these papers in an ethical way—a way in which ... the work that students submit is indeed their own, only more polished." Guidelines for Editing Theses - The Editors' Association of Canada/l'Association canadienne des réviseurs

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Proprietor: Bernice McNeil BA Hons, NSTD Member of the Classical Association of South Africa
Member of the English Academy of Southern Africa

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