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Community health workers experiences of a personal development programme to improve their emotional well-being

by

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American Psychological Association Style 7 (APA 7) referencing was used throughout this mini-dissertation.

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Abstract

Community health workers have become significant to healthcare services provided to communities. They also played a vital role in the prevention and screening of patients during the 2020 Coronavirus pandemic. As such, the role that they play can contribute to the health of the community. Community health workers' own emotional well-being can be affected by the challenges they face in their work. They often have to deliver services and provide treatment to community members that are marginalised and have limited access to official institutions. Community health workers are faced with the challenge of having to provide in community members' basic needs along with providing healthcare services and health education. In other words, they often have to go beyond their role as community health workers to support community members. To assist in understanding how their emotional well-being can be improved, this qualitative study was conducted to explore community health workers experiences of a personal development programme to improve their emotional well-being. Data was collected through semi-structured interviews with eight participants using purposive sampling. A thematic analysis was used to analyse the data by identifying themes. Five main themes were developed from the analysis, namely: 1. problems and challenges in their community work, 2. intrapersonal skills, 3. interpersonal skills, 4. relationship with the environment/work situation, and 5. future interventions. Findings show that the challenges community health workers experience in their personal and professional life influence their emotional well-being negatively. The themes also encompassed the community health workers positive experience of the personal development programme, including the skills and knowledge that they have acquired to assist with the improvement of their emotional well-being. These findings were noteworthy and can be used to develop interventions to community health workers in different areas and contexts.

Keywords: Community health workers, emotional well-being, personal development programme, phenomenological study

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Chapter One: Introduction

Background to the Study

Community health workers (CHWs) have become essential in the distribution of healthcare and other services to communities in developing countries, as they are used in urban and rural areas to improve the health status of community members (Khala et al., 2013; Mathoothe, 2019). CHWs are members of the community where they work, who are selected by the communities and answer to the community, and who deliver selected healthcare services in the community (WHO, 2021). They are supported by the healthcare system and have shorter training than professional workers (WHO, 2021). In this research it is mainly outreach health workers that are involved. They refer people to the clinics and do follow-ups. As part of the primary healthcare approach, health services in resource-limited communities are often in short supply as there is limited access to formal health institutions (Languza et al, 2011; Nxumalo et al., 2016). As such, a task sharing approach is being implemented to compensate for critical shortages in human resources involved in healthcare. Task sharing entails the transference of tasks, from distinctly skilled health workers to health workers with brief training and lower skills, where necessary, in order to allow more productive use of the human resources available for healthcare (World Health Organisation [WHO], 2008). Task sharing is recognised by WHO (2018) as an encouraging approach for addressing the critical lack of healthcare workers to provide basic essential services such as maternal and new born care, and coronavirus care in low income areas. Task sharing allows for a simple diagnosis or supportive intervention to be made by unspecialised health workers as this will allow for more resources to be used in specific and complex cases (Spedding et al., 2015). As such, this allows for a more cost-effective method of delivering healthcare services to more people (Spedding et al., 2015). Thus, the aim of task sharing is to allow CHWs to perform certain tasks and free up some doctors' and nurses' time to provide more clinical care (WHO, 2007), as well as to provide a more rational distribution of tasks and responsibilities among cadres of health workers to improve access to healthcare (WHO, 2018). In essence, the purpose of task sharing is for health services to be provided to everyone, including disadvantaged areas, where resources are limited (WHO, 2007), and improve health literacy in communities (WHO, 2018). Furthermore, task sharing allows healthcare services to be tailored to the local needs of communities. Accordingly, the role of CHWs bridges the gap between the community and primary healthcare facilities (Languza et al., 2011). CHWs often reside in the communities they work in. They assist community members to access health information and primary care services (Academy of Science of South Africa [ASSAF], 2021). Therefore, they have a good understanding of the particular needs of a community to advocate for health services in resource-limited

communities. There are many different categories of CHWs, such as lay counsellors, ward based outreach workers, home-based cares, etc. Outreach health workers are relevant for this research. CHWs visit households to identify people with a variety of health problems and refer them to clinics, do follow-ups and make sure people take their chronic medication (ASSAF, 2021; Languza et al., 2011). Since 2020 and the outbreak of the coronavirus pandemic, they had to screen patients and send those with possible symptoms of the coronavirus to be tested at clinics (Hendricks, 2020).

The contribution of CHWs in primary healthcare has been valuable. Many studies have displayed the improved service delivery and health outcome of the primary healthcare system due to the work of CHWs (Lewin et al., 2010; Mathoothe, 2019). These included improved health and nutrition, and reduced child mortality (Akintola, 2010; Carrera et al., 2013). Thus, CHWs play an important role in filling the healthcare gap left by inadequate government facilities to provide health services in South Africa (Languza et al., 2011).This gap consists of limited access to formal health institutions, staff shortages, limited skill sets, levels of care and management of patients, and poorly funded public health sectors (de Villers, 2021).

However, CHWs are often faced with a lack of physical and psychological resources. They experience a lack of support from organisations, a lack of relevant training and reliable financial support, as they receive a small remuneration (Goudie, 2011; Rodlach, 2009). The challenges they experience and the lack of resources for the work they do, often has a negative influence on their emotional well-being.

Problem Statement

Community members living in low income communities rely on CHW's to provide the healthcare that they need, as well as, providing education, information and referrals to clinics when needed. CHWs are critical to South Africa's response to the coronavirus pandemic, as the Department of Health is relying on CHWs to assist in tracing and tracking the people who may have been exposed to the virus (Mpulo & Mafuma, 2020). As a result, the coronavirus pandemic has had a negative influence on the work of CHWs (Hendricks, 2020). Besides CHWs' fear of becoming infected while working with community members, their work has become more difficult. They have to see patients outside of their houses due to the risk of contracting the virus, thus, making confidentiality an issue (Hendricks, 2020). Being outside of the patients' houses makes it difficult to assess the patient's living conditions (Society, Work, & Politics Institute (SWOP), 2020) which may have an influence on the extent of treatment they have to provide. Travelling around certain neighbourhoods may also pose many risks that involve robbery and harassment. Furthermore, CHWs have to use their own

money to travel to patients (SWOP, 2020). According to Hendricks (2020), the accumulation of these factors might influence the emotional well-being of CHWs negatively.

CHWs who work with patients, who have serious (e.g. death of a child) or long-term (e.g. coping with chronic illness) emotional difficulties or experienced trauma, may experience symptoms that are parallel to those of the victims they help – referred to as secondary traumatisation (Chandler, 2007). This affects their ability to work efficiently and their overall functioning (Chandler, 2007). Accordingly, there is a connection between emotional well-being and providing effective healthcare in communities (Corey, 2013; Hatzipapas et al., 2017). Depressive symptoms and high levels of stress have been stated as probable negative effects on CHWs, as they are exposed to trauma of their patients, illnesses, hardships, and death, in a context of minimum stipends and lack of recognition (Akintola, 2008; Armstrong, 2000; Hatzipapas et al., 2017). As such, high levels of stress contribute to increased absenteeism, and decreased quality of care and staff morale (De Kock et al., 2021). Other sources of emotional stress include the internalisation of their patient's hardships, not having an emotional outlet, as well as emotional support, and being unprepared for situations that may arise in their work (Mwisongo et al., 2015; Visser & Mabota, 2015). As a result of their limited training, CHWs tend to be over-involved with their patients and can risk experiencing emotional exhaustion (Visser & Mabota, 2015). Many CHWs are also burdened by their personal needs, which may have a negative influence on the quality of care they provide (Cataldo et al., 2015; Hatzipapas et al., 2017). The emotional well-being of such CHWs is imperative as it can positively or negatively influence the quality counselling they provide (Visser & Mabota, 2015).

Understanding the challenges of CHWs and their emotional well-being is significant to provide basic information for effective interventions, which can help CHWs in their future work (Kok et al., 2015; Mathoothe, 2019). Furthermore, placing CHWs in the lead when expressing their emotional well-being can be critical in driving the change that CHWs require when dealing with difficulties that negatively influence their emotional well-being. As a result, for CHWs to be aware, understanding, and to assist their patients, they need high levels of emotional competencies, such as emotional sensitivity, self-regulation of emotions, interpersonal skills, and effective coping with daily life pressures (Visser & Mabota, 2015; Surjaningrum et al., 2018). Studies suggested that community workers who work with patients that have emotional difficulties, tend to focus on those difficult experiences which affect their own well-being (Peltzer et al., 2014).

Justification for the Study

Due to the challenges and emotional difficulties CHWs may experience, the Masters Counselling students of the University of Pretoria (UP), Department of Psychology, in 2020 were tasked to present an intervention to contribute to the enhancement of the emotional well-being of CHWs. An intervention could assist the CHWs to cope with personal and interpersonal challenges related to their work. The researcher was not one of the Masters Counselling students that developed the intervention, but only interviewed the participants to understand their reaction to the intervention. Exploring the CHWs' experiences of a personal development programme can be valuable in providing information on how it affected them. The exploration of their experiences of this intervention can contribute to recommendations and identification of key areas, that should be focused on in future interventions to assist them in improving their emotional well-being to provide quality services to the communities they work in. These CHWs work to improve individual, family and community health. The results may be applicable to promote the emotional well-being of CHWs and other healthcare providers in similar contexts in other provinces.

Aim and research questions

The research question and sub-question:

1) How did the CHWs experience the personal development programme presented to them?
    1.1) How did the programme contribute to their emotional well-being?

Consequently, the aim of this qualitative research was to explore the CHWs experience of a personal development programme to improve their emotional well-being.

Overview of Research Approach

A qualitative research approach was used to encourage the participants to describe their experiences of the intervention presented by the Masters Counselling students. Qualitative research allows the comprehension of people's social reality, as closely as possible as participants experience it (Bogdan & Biklen, 2007). In order to understand the experiences of CHWs, a phenomenological framework was chosen for this research. The focus of phenomenology is to understand the experiences of people related to events or situations and human interactions (Gill, 2020). In unison with the qualitative research methods used, semi-structured interviews were conducted as the data collection method. Thematic analysis of the individual interview transcripts permitted the possibility to understand what meanings people attach to their experiences (Braun & Clarke, 2006).

Overview of the study

In chapter one an overview of the background, motivation, and goal of the research was given. Chapter two presents a review of the existing literature on the role and work of CHWs in the public healthcare system, and the challenges they face which could negatively influence their emotional well-being and the work they do. The intervention in which CHWs participated is also described. Bar-On's (2010) emotional intelligence theory was used in the interpretation of the data.

Chapter three presents a discussion of the methodology used in this research. This chapter begins by presenting an in-depth review of the qualitative research approach as a research paradigm, followed by the research design, the context of the study, how the participants were selected, and the data collection strategies. Thereafter, the analysis of the data, as well as the strategies used to ensure the trustworthiness of the findings, such as credibility, dependability, and conformability are presented. Finally, there is an overview of the ethical considerations applicable to the current study.

Chapter four outlines the research results. Chapter five concludes the current study by presenting a synopsis of the research findings and a discussion in line with the research aims and related literature. The chapter includes the strengths and limitations of the study, and recommendations for future research.

The next chapter discusses the literature on CHWs and their emotional well-being.

Chapter Two: Literature Review

This chapter provides a review of the existing literature on the roles of CHWs within the primary healthcare system. The challenges that CHWs face and the negative influence of these on their emotional well-being will be given. In addition, the intervention presented to the CHWs, by the Masters Counselling students, will be detailed. Lastly, the theoretical stance that informs the study will be highlighted.

Definition of CHWs

The term CHW, is an umbrella term as it attributes to several clusters of health workers, such as lay health workers, community care workers, and community health workers, which are all community and home-based care workers (Languza et al., 2011). In other words, the term comprises of the roles and responsibilities of people working in several health units (Mathoothe, 2019). CHWs can be defined as members of the community where they work, who are selected by the communities and answer to the community, and who deliver selected healthcare services in the community. They are supported by the healthcare system and have shorter training than professional workers (WHO, 2021; Languza et al., 2011). In the past, CHWs were largely governed by NGOs to address the gap that resulted from inequitable health distribution between urban and rural areas (National Department of Health, 2018). However, due to the progression of health concerns, CHWs moved to be part of the Department of Health (DoH) via the Primary Health Care (PHC) re-engineering policy (National Department of Health, 2018). This programme allows CHWs to extend primary healthcare services, such as maternal and child health, home-based care, helping vulnerable children, providing HIV testing and counselling, and lately, they provided screening for coronavirus. They usually work in communities they reside in or in neighbouring communities (Khalala et al., 2013; Languza et al., 2011; Mpulo & Mafuma, 2020). Since CHWs mostly have the same cultural background as the community members – they have a proper understanding of the needs of the people and deliver services using the community members' vernacular. As such, CHWs also assist in addressing the communities and the community members' social, economic, and environmental rights (Perez & Martinez, 2008). This fits within the roles of CHWs, which is discussed next.

The Roles of CHWs

A great demand for services within the public healthcare systems in South Africa resulted in less specific tasks being shifted from doctors and nurses to CHWs (Mathoothe, 2019). As a result, there is greater reliance on CHWs to identify people with health problems and provide some healthcare services at a primary healthcare level (van de Ruit, 2019).

Thus, the role of CHWs bridges the gap between the community and primary healthcare facilities (Languza et al., 2011). In other words, CHWs play an important role in filling the gap left by inadequate government facilities to provide health services in resource-restricted areas in South Africa (de Villers, 2021).

Moreover, CHWs provide services in low-resourced communities, and often treat those that are marginalised, those that have limited access to formal organisations, such as clinics (Mollink, 2007), and those who had little success with official health institutional facilities (Nxumalo et al., 2016). As such, CHWs are often dealing with patients that need care at their homes and have to address the socio-economic factors that aggravate their patients problem, such as not having material resources and limited access to healthcare. This means that they often have to attend firstly to many patients' basic needs before attending to counselling needs and/or medical issues (Nxumalo et al., 2016).

Not all CHWs have the same responsibilities, which results in their roles in healthcare being less well-defined (Mathoothe, 2019). Thomson (2014) highlighted that some of the CHWs' roles have a purpose of improving access and delivery of primary healthcare services in a community, such as services related to child and maternal health, TB and HIV/AIDs, chronic, communicable, and non-communicable diseases, and violence and injury (Lewin et al., 2010; Thomson, 2014; Tsolekile et al., 2014). As such, CHWs provide long-term treatment, on-going support and health education to their patients and their patients' families (Tsolekile et al., 2014). In addition, CHWs play a role in assessing community members' basic needs, to provide food packages given by the government, and other services where needed. In summary, CHWs identify health needs and encourage the community to use health services (Singh et al., 2013; South et al., 2013). Furthermore, CHWs provide psycho-education to community members by taking on a counselling role (Mathoothe, 2019; Tsolekile et al., 2014). The roles and responsibilities of these CHWs are to support individuals, families and communities by providing health promotion and psycho-education, which enables patients to cope with illnesses and improve its treatment efficiency. The roles of the CHWs in this research are mainly that of outreach workers. They have contact with community members to be recruited and refer potential patients to the clinics. They also do follow-up visits at the homes of patients to assure that they use chronic medication and their health improves.

CHWs in the Primary Healthcare System

The public healthcare system in South Africa consists of three tiers, which is the primary, secondary, and tertiary tiers (Zweigenthal et al., 2009). The first tier consists of the primary healthcare system, which focuses on the local health needs of people through clinics

(Zweigenthal et al., 2009). The primary healthcare system provides early diagnosis, treatment management, and disease prevention services (Dookie & Singh, 2012; Mathoothe, 2019). As such, when services are not accessible at the first tier, a referral is made to the secondary tier (Zweigenthal et al., 2009). The secondary tier provides services through a district hospital (Zweigenthal et al., 2009). The tertiary tier consists mostly of an academic hospital, which includes progressive treatments and diagnosis (Zweigenthal et al., 2009).

The Department of Health (DOH) implemented a community-based health model, which planned to deliver primary health services through CHWs (DOH, 2011a). This model was driven by the government's judgement to guarantee fair, accessible, and affordable healthcare services for the diverse populations within South Africa (Nsibande, 2011). In addition, the contribution of CHWs in primary healthcare has been valuable. Studies have displayed improved service delivery and health outcomes of the primary healthcare system due to the work of CHWs (Lewin et al., 2010). These included improved health and nutrition, reduced child mortality, increased screening of coronavirus, and immunizations (Akintola, 2010; Carrera et al., 2013). A study done in Ekurhukeni health district, in South Africa by Thomas and colleagues (2021), illustrate the roles of CHWs in this district with approximately 280 000 households with 1 million people. CHWs provided early screening and referrals for pregnant women and children under the age of five, according to the findings of the study. Condoms and chronic medication were distributed to houses. They screened for hypertension, diabetes, HIV and TB, and referred patients accordingly. Defaulter and contact tracing were also done by the teams, the majority of which was for HIV and TB patients. In addition, it was reported that many more patients returned for follow up services to clinics for treatments, independent of the pandemic, due to the help and care of CHWs (Thomas et al., 2021).

Challenges faced by CHWs

As been discussed, CHWs often have to deliver services and provide treatment, such as providing chronic medication, patient care, and counselling, to community members that are marginalised and have limited access to official institutions. CHWs are often faced with the challenge of having to pay attention to many of the community members' basic needs, along with providing healthcare services and counselling. They often go beyond their role as a CHW to provide in people's basic needs (Brodie, 1998; Languza et al., 2011). As such, CHWs are not only faced with having a lack of resources, but they also have to work with patients that have been through formal channels with multiple problems and little success (Brodie, 1998; Languza et al., 2011). Consequently, CHWs have to address the presenting problem of their patient and also several socio-economic factors that aggravate the problem.

It is rather common that CHWs provide counselling and help for many patients' mental and emotional well-being. The focus on community mental health as part of primary healthcare services has been at a lowest for a long time. The health expenditure towards mental health is at about 5% of the total health expenditure, and this is mostly used for mental health institutions treating people with serious psychopathology (WHO, 2007). This gap is a result of a lack in finance, reorganisation of institutions and services, or slow or lack of response to problems related to mental health (Languza et al., 2011). This gap adds to the role of CHWs, as they have to assist in the provision of healthcare and mental healthcare to community members who are not accommodated by government institutions.

Moreover, CHWs work with many patients who are dealing with numerous difficulties associated with environmental, social and psychological problems (Brodie, 1998). Due to secondary traumatisation, CHWs who work with patients who have emotional challenges and have experienced trauma, may develop symptoms that are similar to those of the victims they assist (Chandler, 2007). Secondary trauma is a syndrome that mirrors the symptoms of post-traumatic stress disorder (PTSD), such as symptoms of avoidance, invasion, and arousal, and follows as a result of care between persons, one of whom has been predominantly traumatized and the other who is influenced by the experience of traumatization of the first person (Figley & Kleber, 1995; Peltzer et al., 2014). Secondary traumatisation refers to the negative effects with regard to CHWs' ability to work efficiently and their overall functioning (Chandler, 2007). In addition, health workers dealing with patients who have emotional difficulties, frequently display symptoms similar to those of PTSD, which can encompass depression, shock, exhaustion, increased sensitivity to violence, among others (Chandler, 2007). Moreover, the negative influence on the emotional well-being of CHWs includes experiencing the same vulnerabilities and fears as the patients whom they provide services for (Visser & Mabota, 2015).

The Emotional Well-being of CHWs

CHWs may tend to over-identify with their patients, without a healthy awareness of how their work is affecting their own lives (Gillespie, 2013). Additionally, previous research demonstrated that CHWs felt guilty and responsible for their patients' illnesses, and this guilt causes them a great deal of discomfort (Peltzer et al., 2014). For example, CHWs also reported that their patients blamed them if the patients' HIV test results were positive. When CHWs are living in the community of their patients, they may experience a lack of boundaries, as their patients would come to their homes to confront them or to seek advice when their patients experience problems. According to Peltzer et al. (2014), such experiences added to the increased stress levels of CHWs.

The emotional well-being of the CHWs is important, as it has a significant influence on their ability to deliver health services and counselling (Corey, 2009; Visser & Mabota, 2015). Emotional well-being can be defined as a range of interconnected social and emotional capabilities that determine how well an individual can understand themselves and others, how well they are able to express themselves, and cope with daily life pressures (Bar-On, 2010). Various authors theorised that high emotional intelligence would lead to greater feelings of emotional well-being (Goleman, 1995; Salovey et al., 1995; Schutte et al., 2002). Individuals who can better understand and regulate their emotions generally maintain a healthier view of life and experience better emotional health (Schutte 2002). Evidence that emotional intelligence is related to emotional well-being stems from research that indicated higher emotional intelligence is associated with less depressive symptoms (Schutte et al., 1998; Schutte, 2002), higher life satisfaction (Ciarrochi et al., 2000), and higher optimism (Schutte et al., 2002). Thus, previous research suggests a link between emotional intelligence and emotional well-being. This is inextricably related to Keyes' (2002) concept of mental health, as he maintained that dimensions of emotional, psychological, and social well-being must be considered to be mentally well (flourishing) (Keyes, 2002). These concepts, emotional well-being and mental health, are not the same, but related and at times used interchangeably. Emotional well-being encompasses a diverse set of interconnected social and emotional skills that can help people better understand themselves and others. This involves, among other things, the ability to demonstrate empathy, regulate emotion and being socially aware (Visser & Mabota, 2015). Since sensitivity to the needs of their patients is central to CHWs work in their communities, high levels of emotional competency and skills are vital. Previous research reported CHWs experience being emotionally drained when they provide counselling (Surjaningrum et al., 2018). Factors for their emotional distress includes being unprepared for circumstances that may rise when delivering services, much emotional involvement, and internalisation of their patients adversities, as well as a lack of support to cope with all these intense and negative emotions (Held & Brann, 2007; Peltzer & Davids, 2011;). Moreover, they reported that they perceived their work to be overwhelming, stressful, and exhausting, making them feel drained and affecting their emotional well-being and mental health (Kupa & Geyer, 2020).

In contrast, several studies, such as those by Akintola (2010), Ramukumba (2019), and Visser and Mabota (2015), indicated the positive influence of their service delivery with regard to CHWs' emotional well-being. Many CHWs acknowledged their growth, strength, and psychological development, and perceived this as a reward for providing support (Visser & Mabota, 2015). Apart from the psychological benefits of these positive feelings of social connection and value, positive emotions can act as a barrier against emotional distress

(Akintola, 2010; Visser & Mabota, 2015) and build their overall well-being (Fredrickson, 2009).

However, the many limiting factors as to CHWs emotional well-being and mental health cannot be denied. A lack of resources is one of the main restricting factors for CHWs as they often experience a lack of support from organisations, a lack of relevant training and reliable financial support, and a small remuneration (Goudie, 2011; Languza et al., 2011; Rodlach, 2009). In addition, most CHWs do not work under specific job contracts, thus, their work interests are not protected (Tshitangano& Olaniyi, 2018; White et al., 2017). Furthermore, CHWs are also faced with other challenges, especially a lack of recognition like other health workers and a lack of opportunities to grow their career within the CHW system (White et al., 2017). Seemingly, the burden of many challenges and the lack of resources involved in their work influences the emotional well-being of CHWs in negative ways. In addition, an enormous responsibility has been placed on CHWs, as they continue to be in the frontline in the delivery of services, including for coronavirus and in the primary health sector. They perform essential services in response to the coronavirus, such as regular monitoring, conducting health assessments, and referring them to formal care (Palafox et al., 2021). Health workers have reported feelings of exhaustion, discomfort, and pain from their prolonged hours and new work routine (Lotta et al., 2022; Shaukat et al., 2020), as well as psychological symptoms, such as anxiety and depressive symptoms stemming from traumatic situations, isolation, social distancing, and exhaustion (Khanal et al., 2020).

In addition, CHWs are expected to educate community members about several diseases, infections, and viruses such HIV/AIDS and coronavirus, encourage behavioural change, assist those who are ill, deliver test results, and assist with emotional, social and psychological challenges of their patients (Languza et al., 2011; Mpulo & Mafuma, 2020; Van Dyk, 2013). As a result, CHWs are exposed to severe emotional circumstances during their work and the counselling they provide, even though they have not been provided with training to handle such circumstances (Visser & Mabota, 2015). Furthermore, CHWs are faced with a lack of job security as they do not have the benefits or protection of formally employed health workers (Health-e News, 2020). These circumstances can result in CHWs experiencing a burnout.

Burnout

The term “burnout” covers an extensive scope of a set of symptoms and situations (Morse et al., 2012). For the purpose of this research, the emphasis will be on literature related to burnout among CHWs. The term “burnout” was developed by Freudenberger

(1975) when describing behaviour, he observed amongst volunteers working as caregivers (Gillespie, 2013). He observed that the caregivers became less committed, emotionally exhausted, and unenthusiastic after a period of extensive care giving (Gillespie, 2013). Currently, burnout is described as a 'psychological syndrome in response to chronic interpersonal stressors on the job' (Maslach et al., 2001, p. 397). Burnout contains three dimensions namely; 1) the depletion of emotional resources, 2) being unmotivated, and 3) a feeling of hopelessness (Peltzer et al., 2014). A vital aspect to be noted in relation to this research is that former research displayed a strong relationship between CHWs and burnout (Brodie, 1998; Peltzer et al., 2014; Visser & Mabota, 2015). CHWs display a tendency where they try to fulfil their own need to be cared for by caring for others (Morse et al., 2012). Instead of taking time for self-care, they put more effort into taking care of others, which makes them extremely vulnerable to experience burnout (Morse et al., 2012).

Moreover, CHWs also receive little compensation, called a stipend- for their work. Since much of their motivation to work as CHWs come from feedback of their patients, they develop a negative image of themselves as 'not doing enough' (Peltzer et al., (2014). As a result, despite high levels of commitment, CHWs are vulnerable to experience burnout (Visser & Mabota, 2015).

Furthermore, experiencing burnout does not only negatively influence a person's perception of oneself and others, but also the way they interact with others (Sanders & Linda, 2018). CHWs evaluate themselves based on the feedback of their patients, as they often feel that they are incompetent because they cannot change the patient's life situation. As a result, CHWs who experience burnout begin to show high levels of frustration and low levels of motivation (Sanders & Linda, 2018). In some studies, health workers with burnout moved from optimistic and concerned to negative and uncaring (Morse et al., 2012).

Another major characteristic of burnout is an inclination to withdraw from contexts where they have contact with patients (Sanders & Linda, 2018). The effects overlap with the CHWs personal life and other contexts that do not involve work (Peltzer et al., 2014). Thus, having symptoms of burnout can be negative on the CHWs ability to provide a caring service and on their overall functioning. The literature on burnout (Peltzer et al., 2014; Sanders & Linda, 2018) is particularly useful in providing an understanding of the mechanisms that would lead to CHWs feeling that they could not cope with their work, and thus, affecting their emotional well-being.

There are three types of interventions used to address burnout: individual-focused, structural or organisational, and combined interventions. Individual-focused interventions include self-care workshops, mindfulness, communication skills, and stress-management

techniques (Panagioti et al., 2017; Zhang, et al., 2020). Structural or organisational interventions include training to work in a team and coping with work or organisational stress and workload (DeChant et al., 2019). Lastly, combined interventions entail stress management training, personal training, and conflict resolution between colleagues (Clough et al., 2017; Dreison et al., 2018).

The intervention developed by the Masters Counselling students addressed the possibility of burnout with CHWs by implementing an individual-focused, structural, and combined intervention. Individual-focused sessions were on communication skills, mindfulness and meditation practices, such as the Loving Kindness Meditation (Sorensen et al., 2019). Structural and combined intervention sessions focused on communication skills between colleagues, team work, coping with daily work pressures, boundary setting, conflict management, and stress management techniques. As such, the intervention developed and implemented by the Masters Counselling students outlined below, can assist the CHWs with improving their emotional well-being by addressing some of the challenges they experience.

The personal development programme

Due to the challenges and emotional difficulties that CHWs experience with regard to their involvement in the community and their lack of training and support, the Masters Counselling students of the University of Pretoria, Department of Psychology, in 2020 were tasked to develop an intervention that could contribute to the development of the emotional and psychological well-being of the CHWs working at two clinics in Tshwane. The personal development programme was based on the needs identified and personal and interpersonal skills needed by the CHWs in their work situation. Concepts from the Bar-On's (2010) emotional intelligence model were used as a foundation for the intervention. The personal development intervention aimed to assist the CHWs in coping with personal and interpersonal challenges that negatively influenced their emotional well-being.

Theoretical framework

According to Bar-On (2010), emotional intelligence can be defined as a range of interconnected social and emotional capabilities that determine how well an individual can understand themselves and others, how well they are able to express themselves, and cope with daily life pressures (Bar-On, 2010). As previously stated various authors posited that high emotional intelligence would lead to greater feelings of emotional well-being (Goleman, 1995; Saarni, 1999; Salovey et al., 1995; Schutte et al., 2002). Individuals who can better understand and regulate their emotions generally maintain a healthier view of life and experience better emotional health (Schutte 2002). As such, evidence that emotional

intelligence is related to emotional well-being stems from research that indicated higher emotional intelligence is associated with less depressive symptoms (Schutte et al., 1998; Schutte, 2002), higher life satisfaction (Ciarrochi et al., 2000), and higher optimism (Schutte et al., 2002). Thus, there is a suggested link between emotional intelligence and emotional well-being. Considering that Bar-On's (2010) model encompasses effective emotional functioning referring to specific components in the model which assists with positive functioning (Bar-On, 2005), it is reasonable to explore Bar-On's (2010) model as a theoretical framework for exploring CHWs experiences of a personal development programme to improve their emotional well-being.

Bar-On's (2010) model of emotional intelligence was used to conceptualise terminology used in the research. This model comprises of interconnected emotional and social capabilities, which determine one's ability to effectively express oneself, understand others, and cope with daily pressures. Interrelated emotional and social competencies include intrapersonal and interpersonal aspects which refer to emotional regulation, self-understanding, self-expression, and coping skills. Coping effectively with daily demands refers to the challenges and pressures, and knowledge and skill acquired to deal with certain situations.

According to Bar-On (2010), self-understanding and self-expression is the ability to objectively assess and evaluate oneself, which can eventually lead to acceptance and respect. Respecting oneself is being able to accept oneself, with all of the "good points" and "poor points" (Bar-On, 2010). In other words, this is the ability to accept both positive and negative characteristics, capabilities, and shortcomings, as well as limitations and opportunities (Bar-On, 2010). Self-awareness is linked to this component of the emotional intelligence model (Bar-On, 2010; Schutte et al., 2002).

The ability to detect and distinguish between one's many emotions is known as emotional regulation (Bar-On, 2010). Furthermore, it is not just the ability to recognize and differentiate between emotions, but also the capacity to understand why one feels the way they do (Bar-On, 2010). Knowing what one is experiencing and why they are feeling it, as well as what produces these sensations, is associated with emotional regulation (Bar-On, 2010). It is also linked to other essential components, such as interpersonal skills which include the ability to appropriately understand and express others' feelings, as well as the ability to effectively manage and control emotions (Bar-On, 2010). A previous study by Karimi et al. (2013) using Bar-On's (2010) model indicated that health workers with a higher ability to control their emotions demonstrated better well-being. People with a high level of

emotional regulation are considered to be "in touch with their feelings" and have a clear understanding of their own inner selves (Bar-On, 2010).

Interpersonal skills include the ability to have a clear understanding of others' feelings and needs, as well as the ability to form and maintain sympathetic, productive, and equally fulfilling relationships (Bar-On, 2010). This skill involves verbal and non-verbal communication skills, self-respect and respecting others, conflict management, and relating and collaboration skills (Petrovici & Dobrescu, 2014). It translates into the individual's ability to differentiate among many interpersonal relationships and the ability to respond to respective situations (Petrovici & Dobrescu, 2014).

Bar-On (2010) refers to stress management as the ability to cope with difficult events and situations without becoming overwhelmed by stress. The ability to cope with stress is based on deciding on a course of action for dealing with stress, which requires being resourceful and efficient, being capable of coming up with appropriate solutions, and recognizing what to do and how to do it (Bar-On, 2010). It is also linked to the ability to remain calm and composed in the face of adversity without being carried away by strong emotion (Bar-On, 2010). In addition, the ability to recognize, understand, and control emotions is also associated with stress management (Bar-On, 2010). Another study indicated that Bar-On's (2010) description of emotional intelligence buffered against psychological stress and helped to manage stress relating to workload (Newton et al., 2016). Stress management has to do with the ability to cope with environmental pressures, stressful occurrences, and taking the necessary steps to cope with the stressful situation (Bar-On, 2010).

There is a connection between emotional well-being and providing effective healthcare (Visser & Mabota, 2015). As such, for CHWs to be emotionally aware, understanding, and to assist their community patients, they need certain emotional qualities, such as self-regulation, emotional sensitivity, interpersonal and effective skills to cope with daily pressures (Surjaningrum et al., 2018). This theory can be seen in the development of the intervention as many of the sessions were focused on identifying and dealing with challenges that the CHWs experienced, on emotional awareness and emotional regulation, and on assertive communication which contributed to boundary setting. The intervention will be outlined below.

Intervention

The Masters Counselling students introduced the intervention to CHWs in-person at Daspoort clinic before the coronavirus pandemic started. The intervention was part of their

course-work training and was developed to provide support to the CHWs. Due to the coronavirus pandemic and resulting lockdown, starting in March 2020, the sessions were temporarily put on hold for three months. When the lockdown restrictions where eased, the Counselling students continued with their intervention and included the CHWs from the Woodlands clinic.

A needs assessment with the CHWs at both clinics was conducted. This assessment indicated challenges and emotional difficulties that the CHWs experience related to the involvement in their work in the community. They assisted the CHWs to identify the challenges they experience on personal, interpersonal, clinic and community levels especially during the coronavirus pandemic. Thereafter, the CHWs were tasked to identify the resources that they could use to address these challenges. The development of the intervention was not part of this research.

The Counselling students presented three sessions virtually for the Daspoort CHWs and another three sessions in-person. Because the intervention was not compulsory for CHWs, there were 12 of the 30 CHW reporting to Daspoort clinic that joined the sessions. The students then extended their intervention to include the CHW reporting to Woodlands clinic with eight participants, and were conducted in-person.

Based on the specific needs expressed during these sessions, intervention topics were identified.

At **Daspoort clinic** the following topics were addressed:

The group intervention started by developing group rules, such as confidentiality and respectfulness. This would assist the CHWs to feel safe in the group and to allow honest communication in the group sessions (Allan, 2016).

The first session included creating a safe therapeutic space for the CHWs to build relationships, and to work on emotional awareness and emotional regulation. The goal of this session was to help the CHWs identify and understand their emotions. To assist with this task, the CHWs were invited to become aware of their emotional experiences by identifying situations and people that made them feel good and bad about themselves (Beck, 1964). Group support was used to contain their feelings, while cognitive behavioural therapy (CBT) was used to help them cope with negative feelings. This session contributed to the CHWs emotional well-being, as it made them emotionally aware and assisted with their emotional regulation, which contributed to their personal development.

The assertive communication and conflict management session was centred on teaching CHWs different communication styles (assertive, aggressive, and passive). The objective of this session was to teach the CHWs the different communication styles and how to use them in order to manage conflicts. The value of assertive communication was highlighted in situations where CHWs had to protect their own personal boundaries and in conflict situations. CHWs participated in scenarios to practice assertiveness in different situations. Assertiveness assisted the CHWs to communicate honestly in interpersonal relationships and to protect personal boundaries in professional relationships.

The two sessions on gender-based violence and how to deal with their own emotions, focused on learning the different types of gender-based violence, discussing their views on it, and the factors that contributed to gender-based violence. This session was requested by the CHWs in order to tackle more controversial topics. These sessions also involved the ways in which to report gender-based violence, how to take action against it, and identify the warning signs. They were, thus, equipped with knowledge to prepare them to deal with difficult situations which are part of their work context. Bronfenbrenner's (1977) ecological theory was used in this session to explore gender-based violence far beyond the individual level and to focus on resources and potential modes of eradicating it.

The next session was structured around knowledge about substance abuse that many CHWs are confronted within their work. The method used in this session involved the CHWs creating a poster on substance abuse. The way the poster had to be conceptualised, including its purpose and information content, was left up to the CHWs. The aim of the session was to refine the CHWs skills with regard to obtaining relevant information that may become relevant within the community. The sessions on gender-based violence and substance abuse provided the CHWs with knowledge and skills to use in their work by preparing them for the emotions they might feel, and teaching them how to deal with their emotions and the situation.

The final session included reflections and feedback from CHWs. This included the CHWs mentioning what they found valuable, what they have learnt, and what they would like to be included in future sessions. From the reflections and feedback provided by the CHWs, the experience of burnout that CHWs might feel was addressed. The facilitators highlighted how they could use the skills that they have developed from the intervention, such as emotional awareness and emotional regulation, assertive communication, stress management, and preparing to deal with difficult situations (such as gender-based violence and substance abuse), to prevent and overcome burnout. This allowed the CHWs to establish personal boundaries and deal with their emotions appropriately.

Due to the different needs identified by CHWs at **Woodlands** clinic and the shorter time frame that students were involved with the CHWs (four sessions), the intervention was customised to their specific needs, and thus, differed from the intervention at the Daspoort clinic. The intervention consisted of the following sessions:

Session one of the intervention at the Woodlands clinic consisted of introductions, building rapport, and identifying the personal, interpersonal, clinic and community challenges as a needs assessment.

Session two focused on resource identification to address the challenges that they experienced (Onwuegbuzie et al., 2013) on each level: personal, interpersonal, clinic and community level. The Counselling students facilitated a group discussion in which the CHWs identified resources in the form of a mind map. The CHWs were surprised about the number of resources they had at their exposal to use in difficult situations. The session was ended by a dancing activity where the best “Jerusalema” dancer was identified (this was an activity widely practiced among various groups during the lockdown situation in South Africa). This was done to add some fun after difficult discussions, and to build cohesion in the group so that they could support one another.

Session three of the intervention involved boundary setting and stress relief. This session aimed to assist the CHWs in understanding and implementing boundaries on a personal and professional level. They have to learn to be assertive to say ‘no’ to protect themselves from exploitation by patients. The CHWs completed a worksheet on boundary setting. In addition, they were introduced to healthy ways to manage their stress. This was followed by an explanation on and practice of the Loving Kindness Meditation (Sorensen et al., 2019).

Session four focused on the feedback and reflections of the CHWs. This session involved receiving feedback from the CHWs on the interventions and included discussing what they have learnt, what helped them and what did not. The session was concluded by a dancing activity and eating snacks. In addition, each of the CHWs received a gift and a personalised thank you letter; to thank and encourage them for all that they do and contribute to their community. The intervention presented aspects of social and emotional skills, such as identifying and addressing challenges, establishing personal and professional boundaries, and ways to deal with stress, which allowed the CHWs to understand themselves and their patients, and cope with daily life stressors.

The personal development intervention sessions at both sites were employed in a workshop format, in which the Counselling students introduced topics and activities, and

enabled discussions. The sessions were mostly 90 minutes long and comprised of a check-in, an icebreaker, introduction to a specific theme per session, followed by a reflection on how they can use what they have learned in their personal lives and in practice with their patients. The sessions often ended in giving a practical assignment to implement what they have learned outside of the session. The CHWs who were part of these sessions, actively participated, which included sharing their experiences and joining the specific activities for each session. The sessions were presented in an open-floor discussion format, in which the CHWs were given an opportunity to provide a reflection on the session presented.

Summary

In this chapter, the definition of CHWs, including their roles and their part in the primary healthcare system, the challenges they face that negatively influence their emotional well-being was discussed. The personal development intervention was also outlined. CHWs reside in and near resource-limited communities to improve the community's access to primary healthcare. As a result, CHWs serve as a crucial link between the community and these services. The use of CHWs in primary healthcare has been valuable, as they bring improvements in service delivery. However, enormous responsibility has been placed on CHWs, as they are in the frontline of service delivery, although they may not have been trained to do so. The stressors of their work can negatively influence their emotional well-being and mental health. Based on this situation, the Masters Counselling students were tasked to develop and implement an intervention to assist the CHWs in coping with personal and interpersonal challenges, to help them develop their emotional well-being and mental health.

The focus of the current research was to explore the CHWs experiences of the intervention to improve their emotional well-being. The emotional intelligence theory of Bar-On (2010) was used as theoretical framework to develop the intervention and to interpret the data in this research. In the next chapter, a description of the research methodology to evaluate the intervention will be given.

Chapter Three: Research Methodology

This chapter presents a summary of the research process that was used to answer the research questions: How did the CHWs experience the personal development programme presented to them? How did the programme contribute to their emotional well-being? As such, this chapter begins with a discussion on qualitative research methods that was used to carry out the study. The research procedure, which includes the research context, sampling method, data collection and data analysis, is then discussed. This discussion is followed by the strategies that are used to ensure trustworthiness of this study, and lastly, a discussion on the ethical procedures that the study adhered to is elucidated.

Paradigmatic Point of Departure

A qualitative research design is largely a reflective process, in which the researcher interprets the experiences that people have and the meanings they attach to the phenomenon of the study (Creswell & Poth, 2018). Qualitative research focuses on exploring and describing a phenomenon that is either critical or experiential (Creswell, 2014). Experiential research places emphasis on the meanings and perspectives of people who have experienced a phenomenon. As such, this research used an experiential standpoint, as it focused on studying and understanding how the CHWs experienced the personal development programme. An interpretative approach is thus used. An interpretive paradigm is based on the notion that reality consists of people's subjective experience (Denzin & Lincoln, 2005). This paradigm is underpinned by observation and interpretation to create meaning (Carson et al., 2001).

To understand the experiences of the CHWs, phenomenology was used as a theoretical framework to understand the experiences of people and meanings they attach to events and experiences as they live it (Bogdan & Biklen, 2007).

Each individual creates their own meaning through the interaction between internal and external experiences (Bloor & Wood, 2006). Furthermore, a phenomenological approach is appropriate, as it is an interpretive paradigm to understand the experience of people (Giorgi et al., 2017). Thus, it allows for people to define an event by describing how they experienced it.

Research Methods

The methodology can be defined as a logical approach to solving a problem. It involves the process of describing, elucidating, as well as estimating a phenomenon (Goundar, 2012). The aim of a research methodology is to offer a plan on how the research

will be carried out (Goundar, 2012). The qualitative methodology acquires data from participants in their natural settings through methods such as interviews, in order to understand their experiences and make meaning of it (Creswell, 2014; Domegan & Fleming, 2007). The research design and methods used to explore the CHWs experiences of a personal development programme to improve their emotional well-being will be discussed next.

Research Context

This research was done involving CHWs from two clinics in low resourced areas of Gauteng, the smallest province of South Africa, while being the most populous (South African History Online (SAHO), 2021). The specific clinics; Daspoort clinic and Woodlands clinic, also known as Plastic View will be described below.

Daspoort clinic

It is a clinic that functions in collaboration with the University of Pretoria. It is located in Pretoria-West in Gauteng Province, and serves the residents of Daspoort, Malusi and Zama-Zama informal settlements, which are low socio-economic areas. Malusi is a poverty-stricken informal settlement where residents have limited access to basic needs, such as water and electricity (Mahlokwane, 2020). Zama-Zama is also an informal settlement which is poverty-stricken. Many of the people living in Zama Zama are migrants from African countries (Kruidenier, 2017).

Woodlands Clinic

It is located in Pretoria-East, in Gauteng Province. The CHWs reporting to this clinic, work in Plastic View, an informal settlement area, next to a wealthy community and the Moreleta church complex. The majority of residents in Plastic View are non-South African citizens trying to adapt to their new context. The people living in this informal settlement are dealing with extreme poverty, such as housing, sanitation, water and electricity, and many security distresses, such as high levels of crime and xenophobia (Pretoria East Rekord, 2016).

The CHWs who work in these areas try to address the many different needs of these residents. Due to the CHWs being part of these communities, they are also exposed to poor and dangerous conditions, such as being a victim of robbery, violence, or being exposed to poor sanitation and infections, etc. (Pretoria East Rekord, 2016). As a result, their own circumstances can negatively influence their emotional health, and it is amplified by the experiences of other people in the community (Akintola, 2008; Hatzipapas et al., 2017).

Therefore, understanding the CHWs' experiences of a personal development programme to improve their emotional well-being was relevant in view of the concerns they face. The selection of participants in this study is explained in the next section.

Sampling

A population can be referred to as the entire quantity of things, people, and/or events which are observed by a common trait that is of interest to the researcher (Sekaran & Bougie, 2013). The personal development programme initially focused on the CHWs at the Daspoort clinic, however, CHWs from the Woodlands clinic were also included. The roles of the CHWs reporting to these clinics were mainly that of outreach workers. They have contact with community members to be recruited and referred potential patients to the clinics. They also do follow-up visits at the homes of patients to assure that they use chronic medication and that their health improves. The potential participants for this personal development programme, presented by the Masters Counselling students, included the 30 CHWs reporting to the Daspoort clinic in Pretoria-West and the 10 CHWs reporting to Woodlands clinic in Pretoria-East. Because the intervention was not compulsory, a group of 12 CHWs, who report to the Daspoort clinic, participated in the intervention voluntarily. A group of eight CHWs, who report to the Woodlands clinic, also participated. The total number of CHWs that attended the personal development intervention sessions, thus, consisted of a total of 20 CHWs, reporting to both clinics. This is the population of this research.

A sample is a subcategory encompassing characteristics of the population group (Vasileiou et al., 2018). Participants of the research were selected from the 20 CHWs that participated in the intervention. To select the participants of this study, purposive sampling was used. Purposive sampling includes selecting participants who demonstrate features that the research study is interested in (Braun & Clark, 2013). This sampling method was relevant, as the aim of this study was to understand the CHWs experiences of a personal development programme. Thus, the participants were selected based on the following criteria: 1) CHWs working at the Daspoort and Woodlands clinic, 2) that participated in all the sessions of the personal development intervention presented by the Masters Counselling post-graduate students, and 3) being willing to participate in the research study. Furthermore, the samples used in qualitative research favour being small, this is in order to support the depth of analysis which is necessary for this investigation (Vasileiou et al., 2018). The sample was specified as a minimum of six CHWs from the twenty that participated in the intervention sessions, and the interviews continued until saturation of information was reached. As such, eight interviews were conducted.

In order to select the participants for this study, permission was obtained to conduct the study within both clinics (Appendix E and F). The clinic staff and the Masters Counselling students who implemented the development programme assisted the researcher to identify participants for the study. The students informed the CHWs about this study. During the last session of the personal development programme at the Daspoort and Woodlands clinic, the researcher attended the session, in which participant information sheets were distributed. The participant information sheets informed the CHWs about the purpose of the study, the data collection method, as well as the benefits of the research. Moreover, the Masters Counselling students then provided the researcher with the contact details of the CHWs coordinators. The coordinators contacted the CHWs who wished to participate in the interviews a week before the interviews were conducted. The ones who volunteered first were invited to an interview. The interviews were conducted near the end of 2020 after they have participated in the intervention which started in Daspoort before the coronavirus pandemic and continued during the second half of 2020. The data collection methods are discussed in the next section.

Data Collection Strategies

Semi-structured interviews as data collection strategies are often used in qualitative research (Creswell, 2007). Thus, semi-structured interviews were used as the primary method of data collection. Semi-structured interviews involve the method in which a researcher asks the participants a sequence of pre-set but open-ended questions (Jamshed, 2014). The open-ended questions allow for a discussion with the participants instead of a straightforward question and answer format (Jamshed, 2014). Using semi-structured interviews is suitable for a phenomenological study, as it contributes to the understanding of the experiences of the participants from their own perspectives and the meaning people attach to events (Al Balushi, 2018; Bogdan & Biklen, 2007). Some studies suggest differences in the types of interview, since there is evidence that some phenomenological researchers use structured or semi-structured interviews which can limit openness to a phenomenon which the person themselves should determine (Guerrero-Castañeda et al., 2017). An interview schedule (Appendix B) was developed based on the themes identified in the literature review and the personal development programme. Interviews were conducted in English with CHWs at the clinic where they work. Interviews were about an hour. At the beginning of each interview, the informed consent (Appendix A) form was explained and read to the participants. They were allowed to ask questions to clarify anything they did not understand. Participants who consented were interviewed. The interviews were audio recorded and transcribed verbatim. Notes reflecting upon particular interviews were integrated into the transcripts.

As the interviews were conducted during the coronavirus pandemic building up to the second wave (December 2020), one on one interviews were conducted in a large air vented room with the windows opened. Social distancing was maintained between the participant and researcher at all times. Hand sanitizer was made available before, during, and after the interview in which both the researcher and participants sanitised upon entering and leaving the room. The desk and chairs were also sanitised before and after use. In addition, both the researcher and participant wore a mask at all times. The next section discusses the data analysis procedures.

Data Analysis

A thematic analysis was used to arrange, explain, and interpret the data in order to answer the research question (Braun & Clark, 2006). A thematic analysis is suggested to be compatible with phenomenology, as it focuses on the participants' subjective experiences (Sundler et al., 2019). There is a long tradition of thematic analysis being used in phenomenological research (Sundler et al., 2019). The six steps of thematic analysis outlined by Braun and Clark (2006) were used in this study. These steps involve becoming familiar with the data, creating initial codes, searching, reviewing, and defining themes as well as the write- up procedure.

In the first step, the researcher became familiar with the data by reading and re-reading the interview transcripts. The researcher then began generating initial codes from the transcripts that presented as relevant to the research question. The aim of the initial coding was to label the topics mentioned by the interviewees to describe what was in the data. In the third step of the data analysis process, the researcher examined the codes to identify and create themes within the data. The themes were then reviewed by checking the themes against the dataset. In this step, the themes were refined by being split, combined, or discarded. This step was to make sure the codes were grouped in a meaningful way in relation to the research question and objectives. Thereafter, the researcher provided a detailed analysis of each theme and how it relates to the theory of emotional wellbeing. This was done by describing and interpreting the importance of the findings in relation to what was already known about the research question and explaining new insights that emerged as a result of the research. Lastly, a report was written up which linked linking the analysis and the data extract (Braun & Clarke, 2006). To develop a clear and concise analytic narrative, the trustworthiness of the data is imperative. Thus, the strategies used to ensure trustworthiness of this study is discussed in the next section.

Strategies for Ensuring Trustworthiness of the study

To account for the trustworthiness and quality checks, the criteria by Lincoln and Guba (2005) were used which includes credibility, dependability, and confirmability. Credibility refers to believability of findings, and is enriched by member checking, and control of unwanted influences (Lincoln & Guba, 2005). In other words, credibility addresses the match between the participant's views and the researcher's representation of them (Tobin & Begley, 2006). Thus, for a study to be credible, a co-researcher who co-interprets the data and member checking are ways to increase credibility (Thomas & Magilvy, 2011; Shenton, 2004). A co-coder, external to the study, was requested to co-analyse the data independently. The co-coder was a fellow research student who was qualified to act in this position to ensure that the data was interpreted similarly and no descriptions were lost in translation. The researcher and co-coder discussed their analysis and reached consensus about the interpretation.

To ensure this study was credible, member checking was used to assure that the researcher interprets the participants' experiences as the participants meant it. In addition, I familiarised myself with the culture of the CHWs by visiting the clinics where they work, and attending a session of the personal development programme presented to them. This allowed me to engage with the CHWs who were interested in this study. Lastly, I was able to have discussions with the Masters Counselling students who presented the personal development programme to the CHWs. This added to my understanding of the CHWs and the intervention to be explored.

Dependability determines whether the findings are consistent. To address this, the researcher made sure that the research process was logically and clearly recorded (Tobin & Begley, 2006). Dependability is enriched by audit trails and rich documentation (Lincoln & Guba, 2005). To ensure dependability in this study, I used member checks and peer reviews by using a research colleague to read the study's results and findings. Member-checking was done during the interview by reflecting on how the researcher understood what the participants said. This determines whether the findings are consistent.

Furthermore, an audit trail was developed by containing a transparent document encompassing the interview transcripts, initial codes, themes and the write up was given to the researcher's supervisor. Research audits include a process, in which a researcher provides complete set of notes regarding the research decisions, such as the data collection and the data analysis (LincoIn & Guba, 2005).

Lastly, confirmability refers to establishing that the researcher's interpretations and findings are derived from the data (Tobin & Begley, 2006). Confirmability is achieved by applying reflexivity, which includes acknowledging one's own role in the process of collecting, analysing, and interpreting the data, and including pre-conceived assumptions that one brings to the research. In this study to ensure conformability, the researcher ensured that the interviews, observations, and analytical data are accompanied with reflexive notes (Lincoln & Guba, 2005).

Reflexivity

Language and cultural barriers were especially difficult for me. I learned how easily linguistic and cultural differences can result in misunderstandings or misconceived notions. I tried to address the language barriers by speaking slowly, explaining, rephrasing, and repeating where necessary while talking, to create an environment whereby the participants felt comfortable asking for clarification. I also discovered that language may not be the only barrier. Cultural barriers might include nonverbal cues, such as gestures, and symbols, which have various connotations depending on the culture. As such, I attempted to be particularly aware of these complexities when interacting with the participants.

In addition, as our educational experiences were different, I learned to recognize that I was in a position of influence. As a result, I was continually questioning my behaviour as I was afraid of appearing as superior when I had to re-explain questions to them. As a result, I became apologetic and automatically rephrased the questions that I had initially planned. I understood when they could not answer in English, as they did not know how to answer it in English. Furthermore, I constantly reflected on my role as the researcher when writing about the experiences of the participants. Since I was conducting a qualitative study based on perceptions, I had to remember to remain as near as possible to reflect the participants' experiences. I had to be mindful that the stories of some participants had been overlooked and ignored before. As a result, I had to proceed cautiously when discussing these experiences so that if they read them, they will not be withdrawn from sharing their experiences in the future, and would trust those who would present interventions to them.

Furthermore, I began to challenge my preconceptions about working in communities and with healthcare workers. I had an impression that healthcare workers had an obligation to support patients no matter the cost, that their patient is their responsibility. However, listening to the participant's stories made me to reconsider my previous assumptions, and accept that they can only do so much to help patients if they don't help themselves. It made me realize that CHWs require care as well, as providing care to people with limited resources is difficult. It also encouraged me to recognize that many people expect too much

from CHWs without realizing that they are doing their best every day. Overall, this study will not only help with prospective interventions, but it has also helped me in forming new perspectives and refining old ones, as I have learned a great deal from the participants' experiences.

Ethical Considerations

Approval

In order to conduct this study, ethical approval was obtained from the Humanities Faculty Research Ethics committee (Appendix C) and the Health Sciences Faculty Research Ethics committee (Appendix D) of University of Pretoria. Following approval from the University of Pretoria, permission from both clinics, Daspoort and Woodlands, was granted through the coordinators of the clinics. All participants provided informed consent before they voluntary participated in the interviews.

Informed consent

In this research, ethical considerations, such as informed consent, confidentiality, and protection of participants was strictly adhered to. The informed consent procedure was carried out by discussing the consent form with the participants before the interviews took place. This was to ensure that the participants are completely aware of the purpose and procedures of this study. The participants signed the informed consent form if they agreed with its contents. The consent form consisted of information regarding the aims and nature of the study, how the results will be disseminated, and the data storage procedures. It also included information concerning the participants' rights. The participants were informed that participation is voluntary, and they may withdraw from the study at any stage. Furthermore, the participants were assured that their responses were kept confidential. The results of the study were not associated with the identity of the participants. Each participant was assigned a number which was used for their information and results collected in the study. The participant's confidentiality was valued and no information that revealed their identity was released or distributed.

Storage of research data

During the study, all the audio-recordings and transcriptions that were used were stored on a passcode protected computer that only the researcher's supervisor and researcher had access to. The researcher's reflective and field notes were also stored with the audio-recordings and transcriptions. As discussed in the participant information sheet and consent forms, the data was safely stored in the Department of Psychology at University

of Pretoria, for reuse and archiving for a period of 15 years until 2035. During this time, other researchers may have access to the transcripts for further use.

Possible risks

Any participant who experienced some discomfort due to sharing personal experiences in the interview was referred to a counsellor. No remuneration was offered for participation in this study.

Adverse situations

During an interview, one of the participants conveyed that confidentiality was breached, by one of the students, when facilitating the intervention. As such, this situation was addressed immediately by the supervisor, student and participant, as it breached ethical behaviour. In addition, this presented as a challenge for the researcher as the participant was hesitant to provide personal details during her interview.

Summary

The chapter provided an outline of the research methodology to explore the CHWs' experiences of the personal development programme they participated in. The research followed a qualitative design using a phenomenological framework, which allowed the CHWs to provide their descriptive accounts of their experiences of the personal development programme. Semi-structured interviews were used to interview the participants individually. The interview transcripts were then analyzed using a thematic analysis. Furthermore, strategies used to ensure trustworthiness of the study were also elucidated. Lastly, the ethical procedures that the study adhered to were explicated. In the next chapter, the findings of the study are presented.

Chapter Four: Findings

The study's findings are presented in this chapter. An overview of the characteristics of the CHWs who participated in the study is given. Following that, a summary table is provided, which includes all of the themes and sub-themes that emerged during the analysis. Finally, each theme is expanded upon by including excerpts from participants' interviews.

The participants

The participants in this study were given numbers in order to retain confidentiality and anonymity of their identity, as previously outlined, such as Participant 1, Participant 2…Participant 8. Participant 1 to Participant 5 reported to the Daspoort clinic, where they worked in the Daspoort, Zama-Zama, and Melusi communities. The remainder of the participants (Participant 6 to Participant 8) reported to the Woodlands clinic, where they worked with the Plastic View community. The participants consisted of two males and six females, and were aged from mid-twenties to fifties.

Findings

A total of five main themes and ten sub-themes were identified after analysing the interviews conducted with eight participants. Some themes were developed through an inductive approach, while the rest were developed through a deductive approach, moving from broad generalisations to specific ones. During the process, there were themes that were merged as they seemed to link together. This was done through continuous revision of the data. These themes are presented in tabular format (see Table 1 below), which offers a summary of the CHWs' experiences of the personal development intervention to improve their emotional well-being. Succeeding the table, the descriptions of each theme, including its sub-themes are given.

Table 1

Summary Table of Themes and Sub-themes Regarding the CHWs Experience of a Personal Development Programme to Improve Their Emotional Well-being

Main Themes	Sub-themes
Theme 1: Problems and challenges in their community work	1.1 Work stressors 1.2 Coronavirus
Theme 2: Intrapersonal skills	2.1 Emotional regulation

Theme 3: Interpersonal skills	3.1 Listening and empathy 3.2 Communication and assertiveness 3.3 Conflict management 3.4 Interpersonal boundaries
Theme 4: Relationship with environment/work situation	4.1 Stress management 4.2 Dealing with demands from work 4.3 How to deal with problems in the community
Theme 5: Future interventions	

Theme 1: Problems and challenges in their community work

This theme refers to challenges the CHWs experience in their work and how it negatively influences their well-being. Two sub-themes are presented from this theme, namely work stressors and Coronavirus. The sub-themes are discussed below.

Sub-theme 1.1: Work stressors

The first sub-theme revealed that the participant's emotional well-being was negatively influenced by their patients' problems, painful situations, and poverty. The theme focuses on how the CHWs' work in the community affected them emotionally.

> *"…some don't understand our work. So, some they are demanding too much for us beyond what we can help them with"* (Participant 6)

The participants become emotional when confronted with poverty and the dependency of their patients and their families on material help.

> *"But every Monday, like this Monday, I saw them over there asking just for a pap. That one, instant one. It's painful. Like when you take yourself in their socks, it's worse, yeah. It makes me sometimes emotionally. I wish like, I was having like, too much money, you know these people who are winning the lotto. They're not doing, they have the money, but it's like for me, I'll do something"* (Participant 1)

> *"Some of the households that I was working with, some of them died due to COVID. So even approaching that family, knowing that this guy died, and then he was the breadwinner and he was depending on that person. Sometimes you feel like I can help*

more but unfortunately I can't. So like, when I… always when I pass that household, I feel like emotional because now they're suffering because someone they was depending on is dead" (Participant 4)

In addition, the patients had the tendency to expect the assistance of CHWs for material goods, and these CHWs often feel hopeless when they cannot help:

"So if you don't have something to give them, like food parcels, then it's a bit painful because it's like they are… you're their hope that they might get bread, maybe veggies or something but then we had a problem of giving out vouchers. Even if it was not enough, but then they could get the 2kg mealie meal and soya, and fish oil. But then, we made a big difference, even if we didn't cover up all of the people but some that we know that they're lacking, it did a big difference" (Participant 5)

This reflects the participants' experience of their work situation. The problems of their patients, such as dealing with the disabling effect of severe poverty influenced the participants well-being negatively. They expressed that their patients do not understand the limitations of their roles. This presents a challenge to the participants.

Additionally, dealing with traumatic situations of their patients, such as a child being raped presents as a work stressor for CHWs:

"Yeah, sometimes, if you are helping someone, for example, I help another small girl who was raped. So it was very emotional. Like, I can see that she's not staying with her parents, so that thing makes me feel somehow…" (Participant 7)

Moreover, the participants indicated that when their patients are rude to them, it contributes to their distress. Participant 1 indicated that an adverse situation arose at the clinic with a person who was rude towards her. This adverse situation had a negative influence on her emotional well-being:

"One of the patients come here and I was screening the person. I couldn't hear what he was saying. And I was asking, I can't hear, please, I beg your pardon. He said "Oh my god". I was like wow, and he started to raise that F word for me, twice. Like I felt like down, like I was like this (hand gesture). I couldn't do anything, late when I'm home is when I told my family, do you know somebody said to me, called to me this, that, F words" (Participant 1)

It is reflected that this situation took a toll on the participant's emotional well-being, as she brought this situation from her professional life into her personal life. This is an example of the negative influence of spill-over.

Lastly, another work stressor that negatively influenced the participants' personal life is the worry about their own financial situation. One participant experienced stress and worry, as the date that they receive their stipend was changed. As such, this had an impact on his personal life, as he did not know how he would send money home. This negatively influenced his emotional well-being:

> *"It is so challenging, like, like before, we know that we get salary on 25th. Now, everything is changed. So I'm still busy playing it in my mind, how am I going to deal with the money? How am I going to send the money home? How am I going to send the money like, it is not going to be 25th or the end of the month, it is going to be the beginning of the month"* (Participant 8)

Another aspect that presents as a challenge to CHWs in their work is when their patients do not adhere to treatment:

> *"So, that thing it makes me worry because I first educate this patient and tell him this diet, you must follow this diet because you inject yourself while I teach this patient to… how to inject, how to use the insulin, when he must use it and the measurement and I educate this person, but at last I found the person not follow up the diet, eating the vegs or eating… putting the salt, too much salt. So that thing, it worries me"* (Participant 2)

Sub-theme 1.2: Coronavirus

This sub-theme refers to conditions associated with the coronavirus pandemic that changed the participants work. It includes the way in which the pandemic presented challenges to the participants personally, and how it negatively influenced their emotional well-being.

Seven out of the eight participants expressed that the coronavirus pandemic changed the nature of the work they do. They explained that the pandemic made their work more difficult, specifically because of the community members' financial hardship, and that it was difficult to continue with their regular work:

> *"Well, it has changed a lot. But then it's more difficult because of… since the pandemic, things have been rough in the community, lack of fundings, lack of finding a*

job and then, some people are being retrenched at work. So it's a stress. And then, when you come there, when you do your work, there is a question about food securities" (Participant 5)

CHWs could not attend to their regular patients with chronic diseases, as they had to shift their attention to focus on screening for coronavirus :

"We couldn't go to the patients like before, to check for TB and HIV patients like before, you see. So that COVID-19 is like all of people they forget about… about all the diseases that we have, the chronic people that we have. Even our government, I think they forgot about that because they focusing on COVID-19" (Participant 3)

In addition, due to changing the way the participants provide care, their patients changed their responses towards them, adding to the difficulty of their work:

"Yeah, many challenges. Like we have to go to the village and screen people and other people don't like do that thing, they don't like it at all" (Participant 7)

For the participants personally, their work has become more time consuming and difficult. The participants expressed that they have to work overtime, and have to continously worry about their safety and protection from the virus. As such, they have to wear protective gear all the time. This negatively influences their emotional well-being, as it adds to their stress, fear, and worry:

"So it was very challenging and you have to distance yourself even though you have to help someone. You have to think before helping her, you have to go back to fetch some gloves, some masks so that you can be able to be safe" (Participant 7)

"During that time, we are always working overtime. And, the fact that we don't get anything for working overtime and working in the season of COVID-19" (Participant 6)

"I'm no longer going to their household, we only go to the household that we know at times. We don't just go to any household. Like we choose the households, and before it was just going to any household" (Participant 4)

Moreover, the pandemic has not only negatively influenced the nature of their work, but also negatively influenced their personal life and emotional well-being. They are in the frontline of having to screen people for the coronavirus. They fear for their own safety, as some of them and their families may have comorbities, which place them at risk of getting the coronavirus:

"I was scared, very scared. I'm asthmatic and some (points to sinus)... you know. Okay, I took, they said those who are having symptoms- no not having symptoms... like you know when you are asthmatic, I can't remember they call it something. Yeah, I stayed home for a while, it was during March. I came back, like April, month end April... So from that time it was COVID. I was still, I was scared- worst part was working outside during that cold" (Participant 1)

"We are living in fear, like every person you come across with, if they… let's say, maybe you are in the household, and then the person is coughing, you're no longer feeling comfortable because now my mind is always on COVID because it killed so many people" (Participant 4)

Some participants expressed that the coronavirus pandemic did not negatively influence their work so much, it only added to their workload. They still do all their regular work as before the pandemic, with the addition of doing coronavirus screening:

"It doesn't necessarily change the nature of my work, because we had been always, even now, helping people. If the child is burned, or somebody have got the wound, we are still helping them. We are still in contact with people. Yeah, the only difference is that when we're doing COVID screening" (Participant 6)

The analysis revealed that majority of the participants had a positive experience of the personal development programme. They linked this positive experience to how much knowledge they gained from the intervention, which they can impart to others:

"My experience, I think I have gained a lot of knowledge and experiences that I took home. And my neighbours, it helped, it helped me a lot. The experience that I have" (Participant 3)

The majority of participants found the personal development programme to have covered almost all of the topics they needed information on. The topic that the participants experienced as the most helpful was information on the topic of substance abuse. They said:

"Everything was good. I didn't realise, because everything was so good" (Participant 4)

"No, I did enjoy everything" (Participant 7)

"No, there was no negative thing" (Participant 1)

A discussion on the next main theme, intrapersonal skills, follows.

Theme 2: Intrapersonal skills

This theme encompasses the personal skills the participants gained from the intervention. The most prominent skill gained was emotional regulation which is discussed below.

Sub-theme 2.1: Emotional regulation

All participants expressed that learning to calm down helped them regulate their emotions, in their personal and professional life. They learned to become aware of their feelings, and to calm down- to think before they act. They learned not to take things personally or to overeact, which would otherwise negatively influence their emotional well-being:

> *"I am very calm like in every situation, I'm very calm. Because I've learnt that calming down is the best thing. I'm always, even though sometimes when they are having disagreement, I'm always calm, I will just speak whenever I get that chance to speak not when they speak and then I'll say… I speak with them. No, I'm calm. I've learned that by calming down is the best"* (Participant 4)

> *"In my community, it helped me to always keep myself calm, not to overreact, not to bust, not to shout because even if you shout, it won't help you in any way. Just to keep yourself calm, analyse the situation. Yeah"* (Participant 5)

Most of the participants used this newly developed skill to cope with tough situations at work and to deal with difficult patients:

> *"I didn't expect something like that and then I was emotional. Yeah, but I calmed down and didn't say anything. When I was like, asking for peace and then my peace came back and I was carrying on with my job"* (Participant 1)

These participants learned to deal with their own emotions when working in a way that would not have an adverse influence on their emotional well-being:

> *"Professionally, they taught us how to go to people and how to treat them. But by myself, they taught me that if I have something like, that hurt me, I have to calm down before I can respond to that person"* (Participant 7)

> *"It helped me because we are stressed with COVID, because it's the new thing. But the fact that I was taught how to deal with my emotions to deal with the emotions of my patients, my clients, had helped me a lot"* (Participant 6)

Engaging in these learned healthy behaviours and coping skills from the intervention positively assisted the participants.

Another skill they developed is identification and awareness of a situation, which allows them to understand the situation and respond in a way that benefits both themselves and their patients:

> *"I've learned that it's, it's important to analyse the situation, keep yourself calm, and then tackle the situation. You don't have to shout, swear at everybody, you see, those characters that are not helping to resolve the problem. But if you manage your conflict, then I think you have a better way of addressing the situation, you have a better way of finding a solution and not burst"* (Participant 5)

Moreover, the participants expressed that the programme assisted them in facing the challenges of the pandemic. Some of these participants indicated that the programme reminded them to take care of themselves and their health:

> *"Like when they did tell us, you must keep these things, you must sanitise every time. Your mask be on, that one is the most important thing. Yeah and we must take care of ourselves, yeah. I think it was the most, even now I'm still doing it for asthma, sometimes because of the weather, and I'll be having the sanitizer"* (Participant 1)

The next main theme is presented below.

Theme 3: Interpersonal skills

As the participants reflected on the programme, they conveyed an improvement in their knowledge and skills to improve their interpersonal relationships, personal and professional relationships. Four sub-themes emerged from this theme namely; listening and empathy, communication and assertiveness; conflict management, and interpersonal boundaries.

Sub-theme 3.1: Listening and empathy

The participants expressed that learning to listen before speaking prevented conflict, and contributed to better communication. This helped them to better help their patients, by listening to their problems and understanding them. This also taught the participants sensitivity for their patients, which contributed to the participants having empathy.

> *"So whenever I approach a person, I just look how they talk to me, then I will, if that person is too high, I will just be low, until like they understand that this person is not*

fighting, he just want to talk to me, you see. Because in the field, we meet like people with stresses, some of them like, they're drunkards, like you just have to understand the situation… the person you are approaching, after greeting, just listen how they greet you, then you'll see that here I have to approach this person in this manner" (Participant 4)

This participant reflected that he had learned to take a calm position when the patient is emotionally aroused in a negative way.

"I was that kind of person, I don't give a damn, you see. But now after the intervention, I saw that's not the life I must live. They helped me like I just have… sometimes, it is not good to say I don't give a damn. Just listen to what other people are saying before you can react and then feel... put yourself in their shoes before you can react" (Participant 4)

In addition, listening taught the participants to acknowledge that their role is to help people, and it is important for them not to judge their patients. The participants learned to accept people and their patients for the way they are:

"here at work, we work with different people, they have different mind-sets. So you just have to adapt. And like, you don't have to judge any person, you have to allow the person to express their own feelings without hoping if you want right answer, and then you think that that person will give the right answer. No, it doesn't work like that, because of… we don't have the same mind-set. We might agree to disagree. And then it told me, that that's fine" (Participant 5)

It also appeared that many of the participants' behaviour changed when they learned more skills. They could use these skills with their colleagues, their patients and at home in their personal lives:

"Like before, I was loud, …if you just start like a little fight. I can just be high, but right I can't… I listen first, before I talk" (Participant 3)

"What changes… at home I wasn't listening. If they talked to me, I was always arguing with them. So after this session, it taught me to listen to others. Yes" (Participant 3)

Sub-theme 3.2: Communication and assertiveness

Communication played a huge role in the participants' professional life. Using the knowledge of communication, the participants found that it made their work environment peaceful, as it is was easier to work with their collegues and their patients. The intervention

contributed to their assertiveness, expressing how they feel and problem-solving abilities to prevent conflict in their professional roles, and allowed them to help more patients.

> *"I've learned that the difference that I've made is communication. I think communication is key. If you communicate… if you have a problem, then you communicate about it. I think it's worth it, than to bottle things up in your mind and not talking about it"* (Participant 5)

In addition, the participants learned how to communicate and work within a team to help patients, instead of shouldering the burdens by themselves:

> *"I can sit with my colleagues and talk and tell them about this patient, then we discuss about this person, then we see how can we solve this problem"* (Participant 2)

Furthermore, by learning to be assertive, the participants kept their boundaries, not to be exploited by their patients:

> *"…So my work is easier now because of that, because I just tell them that no, I'm sorry, can you please call an ambulance. I give them the number of the ambulance or can you please hire your own transport because the ambulances are scarce nowadays"* (Participant 7)

This seemed to have made their life and work easier.

In addition, learning to communicate allowed the participants to resolve conflicts by not allowing gossiping behind ones back and to create boundaries. This was reflected when a participant used the skills she acquired, from the programme, to resolve a conflict with a colleague.

Sub-theme 3.3: Conflict management

In addition to the other interpersonal skills, conflict management was another skill that proved useful to these participants, as majority of participants experienced conflicts at work and in their personal life. The participants used to respond to conflict in ways that would aggrevate the conflict, which would have a negative influence on their emotional well-being. The interpersonal skills they learned through the intervention, such as communication and calming down, helped them to better manage conflicts at home and in their work place:

> *"That conflict management, I learned a lot, because conflict is not good. And if there is a conflict at work, it can break your work, it can also break your relationship, you can't*

work, you can't be happy. If there is a conflict at work, please just confront the person, then you sit and discuss about it. So that you can do the work" (Participant 2)

"Like I've said, I've changed my pattern of resolving things. So now I do things in a different way like instead of busting, you calm down. Instead of not talking about something that's bothering you, now I speak up so that there can be in solution" (Participant 5)

Sub-theme 3.4: Interpersonal Boundaries

Boundary setting seemed to play the biggest role in the participants' experience of the programme. This interpersonal skill had value in their professional and personal life. The knowledge they gained about boundary setting also played a role in the knowledge they gained from the other topics. The participants incorportated boundaries with intrapersonal skills, such as calming down, other interpersonal skills, such as listening before speaking and communication, and their relationship with the environment, such as dealing with daily pressures and gender-based violence.

Setting boundaries had an important positive influence on their professional life. They learned to keep their emotions and personal life separate from their work, putting limitations on what they can discuss with their colleagues. In addition, the participants set boundaries based on the context which determined what behaviour is appropriate:

"At my colleagues, like… when I'm at work there's something that I don't do that here. I know that I'm at work, I don't do these things. And, then at the household, I know that here, I do this, and I don't do this. At home, I know that I do this. And I know that I'm a community health worker, I don't have to do this and this and this at the community" (Participant 3)

The participants also established boundaries with their patients by putting limitations on how much help they can provide for their patients. This revealed to have a positive influence on their emotional well-being, as they were not going beyond what they can provide and get exploited by patients. They also acknowledged their patients' painful situations but tried not to get involved personally, and put limitations on their workling hours. This increased their quality of life, as they were able to rest and take care of their own health without having to wake up during odd hours to help patients.

"so I'm able to say no, if I'm not supposed to help that person, or he or she wanted me to do something that I won't be able to help her with or him with. So I'm able to set boundaries based on the situation" (Participant 6)

Furthermore, learning to set boundaries allowed the participants to gain a voice and to speak up for their needs. With this voice, it allowed them to enforce clinic rules with their patients, what they can help clients with, and to set boundaries based on the time they are available to their patients:

> *"So I tell her or him that next time you come to clinic at half past seven, not half past ten or half past eleven. If she or he said he's a new patient, is not a new patient, and he knows exactly that the clinic is open at half past seven, say no sorry, come next week or go to Pretorious Park because we can't help you at this time, yet you know that the clinic is opened at half past seven"* (Participant 6)

> *"sometimes the leaders will knock at my door at half past eleven so that I have to help the patient, that is not the safe… the right and the safe time, at that time. Yeah"* (Participant 6)

Learning to establish healthy boundaries allowed the participants to provide help to their patients while setting boundaries for themselves. Establishing boundaries taught the participants to not take things personally and not to try and go beyond what they can do, as this negatively influences their emotional well-being by creating more stress.

The fourth main theme is presented below as follows.

Theme 4: Relationship with environment/work situation

This theme refers to the knowledge and tools the participants gained to improve work with their patients and coping effectively with the daily demands and pressures of life,and their surrounding environment. Three sub-themes emerged from this theme, namely; stress management, dealing with demands from work, and how to deal with problems in the community. These sub-themes are discussed below:

4.1 Stress management

The participants expressed that they experience distress on a daily basis due their patients expectations, the coronavirus pandemic, and the small stipend they receive which they use to provide for their families. This stress not only has a negative influence on the participants' emotional well-being but also decreases their quality of life, and the quality of service they provide at work. As a result, the intervention provided ways for participants to manage distress by coping with personal demands and demands of professional work. This revealed to be beneficial to the participants, as they practice meditation and relaxation by taking time out when feeling stressed instead of continuing to engage in work:

"Yeah, the programme taught us how to manage the stress. They taught us how to relax so that the stress can go away, like in the quiet places. And they show us how to do it, like you have to relax, close your eyes, whatever. They taught us those things" (Participant 7)

"Yeah, it was very helpful because I was able to share with other people the experience of my work, where I work here at Woodland village, because it's so stressful for the fact that the people who are living there, some don't understand our work" (Participant 6)

The participants' personal life and experiences within their families and at home also contributed to their experience of distress. They often responded negatively to their family members when facing an adverse situation or they would continue to help their families at the expense of experiencing negative emotions. They have learned how to address stressful situations:

"like, before I told you about stress, I know how to manage stress. Like, if I had too much in my mind, I can just sit down and relax, and then close my eyes. Like my mind" (Participant 3)

From these excerpts, it can be seen that the programme helped by providing skills participants can use on a daily basis within their professional and personal life to manage stress. Implementing these skills has not only created a healthier environment in their work situation and personal life but positively influenced their emotional well-being, and allowed them to understand their own behaviours:

"personally, like I said, I was relieved emotionally, seeing that there is… for somebody who can come and then we can share with her or him, yeah, your challenges. And, apart from that, giving me skills, how to deal with stress and certain emotions" (Participant 6)

Sub-theme 4.2: Dealing with demands from work

Gaining knowledge on coping methods taught the participants how to better cope with situations that impacted them at work and in their personal life. They learned how to deal with some of the demands of patients in their work and to set boundaries between themselves and their patients, making it easier not to take the demands of work personally:

"Because they told us sometimes, you going to meet people like this, but you mustn't take it personally. Because it's there, there's nothing we can do. We are trying, but there's nothing we can do more" (Participant 1)

Moreover, working in a team allowed them to deal with the demands of work by not shouldering the burdening by themselves to relieve some work stress.

"At my work place, I was that kind of person say I do my own things at my own time. It's when I do my work, I will do my work, no one can tell me anything as long as they're not my supervisor or not my chief leader. But now like, if we're strategizing, I just say, okay this is gonna be good. If I don't think it is good, I give them my inputs, let's do this or like that" (Participant 4)

Sub-theme 4.3: How to deal with problems in the community

The participants gained more knowledge and additional tools to identify and be aware of key issues in their communities and in their families, namely; gender-based violence and drug abuse. One participant described that she became aware of the emotions of a family member that experienced gender based violence but pretended that everything is fine. Based on what she has learned she wants to provide help:

"It helped me to identify my sister in law, but because she is scared, maybe her husband... she cannot do anything. Everything to her is fine even though she's broken every day. Me, myself, I can't do anything because she's allowing the husband to do whatever. You know, when she's with us, she will say hello smiling, but she's smiling her (points to face) but inside her (points to heart) she's not smiling" (Participant 1)

It is evident that the participant has developed the skill of identifying and being aware of gender-based violence from the knowledge she gained. While at the same time, she is exercising the skill of setting boundaries by not going beyond the help that she can provide.

The facilitators of the intervention helped them deal with tough situations at work to recognise gender based violence:

"*When a man hits you, it is not a love. So that's where I give them advice"* (Participant 3*)*

The last main theme regarding future interventions is eludicated next.

Theme 5: Future Interventions

Lastly, this theme refers to what the participants would want to experience from an intervention if future interventions have to be presented again, including topics that should be presented.

The participants expressed the need to learn more topics like gender-based violence, stress management, controlling emotions, boundary setting, and the coronavirus. They expressed that they learned about these topics in this interventions but did not know how to apply the knowledge they gained. It would be beneficial for future interventions to focus on teaching CHWs how to apply the skills they learned:

> *"Maybe giving us more skills on how to deal with stress and certain emotions"* (Participant 6)

The intervention did not help them with their very personal problems. They request that future interventions should focus soley on influencing their personal well-being positively, perhaps individual sessions with CHWs:

> *"I think, they did all what I need. The only thing is that, other things are very personal, so it's like we can have someone who is like, who can come for our personal things at home, you see"* (Participant 7)

Furthermore, the participants felt that if facilitators would provide future interventions to community members, it would benefit them to work with community members who are their patients. Then their patients would be aware of certain topics, so that they would be willing to talk about it. This would then ease the CHWs' work:

> *"but if you can at least convince 25 people and say they will be talking about like stress management or those kinds of things, they will say okay these people will come and help us, then the minute you approach them, you will talk to them. And then maybe we can ask them what topic can we deal with the following week or for the following month, then they will tell you and you come and talk about this topic, you see, then the community will benefit"* (Participant 4)

> *"…especially gender-based violence. I think that if they can touch more on that and make awareness because GBV is a real problem in our community. People live in silence, they don't talk"* (Participant 5)

The analysis of this theme helped focus the recommendations, presented in the next chapter, for future programmes to positively influence the emotional well-being of CHWs in this and in other areas.

Summary

This chapter began with an overview of the participants in this research. This was subsequently followed by a summary table presenting the themes. Thereafter, the five main themes alongside the sub-themes were discussed. The main themes were namely; (1) problems and challenges in their community work, (2) intrapersonal skills, (3) interpersonal skills, (4) relationship with environment/work situation, and (5) future interventions . In the next chapter, this study is concluded by a discussion of the results, an explication on the conclusion and limitations of this study, and recommendations for future research.

Chapter Five: Discussion, Conclusion, Limitations and Recommendations

The general aim of this study was to explore the CHWs' experiences of a personal development programme to improve their emotional well-being. This chapter focuses on the discussion of the results and conclusion of this research. The limitations of the study will be followed by the recommendations for future research.

Discussion

In the interviews, the participants expressed a variety of professional challenges they experienced. Many of these challenges were highlighted in the literature, and are thus, experienced by CHWs in other areas and capacities. The research highlighted the participants' experiences outside of the work context and how these experiences negatively influenced their emotional well-being.

Bar-On's (2010) model of emotional intelligence was used to interpret the CHWs' reflections on how they benefitted from the intervention. The findings will be discussed according to how they benefitted in terms of (a) intrapersonal well-being, (b) interpersonal well-being, and (c) coping effectively with daily demands, as each area highlights different aspects of their experiences.

Intrapersonal well-being

Bar-On's model on intrapersonal well-being includes the ability of being aware of oneself, including one's strengths and weaknesses and being able to express oneself (Bar-On, 2010). In other words, well-being includes being aware of one's own and others' emotions, needs and feelings, and the ability to manage and cope with these emotions in different contexts (Bar-On, 2010).

Intrapersonal well-being was displayed through the analysis, as participants moved from displaying adverse emotions in situations at work and at home, to displaying appropriate emotions and behaviours, determined by specific situations they were in. In addition, many of the participants expressed how they displayed emotional regulation, as the intervention taught them how to stay calm and control their emotions.

Furthermore, the participants learned to be sensitive to their patients' feelings and needs. Learning how to be sensitive to others allowed the participants to control their emotions and stay calm, as they understood that the feelings of their patients were not something to take personally. This skill seemed to have improved their own emotional well-being, as they learned that they need not take responsibility for the emotions of their

patients. This is in line with previous research by Karimi et al. (2013) that indicated health workers with a higher ability to regulate emotions displayed better well-being.

Interpersonal well-being

This aspect of Bar-On's (2010) model includes one's ability to have skills that allow them to have a clear understanding of the feelings and requirements of others and allows one to create and maintain productive and rewarding relationships.

From the analysis of data, it was understood that the participants' emotional well-being was negatively influenced by painful situations and relationships that they encounter at work with their colleagues and patients, and at home with their families. The participants measured their own value by how much help they can provide to their patients (Visser & Mabota, 2015). As such, this can be very detrimental to their emotional well-being, as sometimes there is nothing more they can do to provide help than they already have done. However, after the intervention, some of the participants mentioned that they moved from having some adverse experiences in their profession and personal life, to having more positive, healthy, and balanced experiences in their relationships. They could implement boundaries on various levels, they learned to listen before they react to deal with conflicts and painful situations, and they learned to communicate more assertively and honestly in difficult situations. These skills could improve the services they provide and their own experience of their work situation. This is in consensus with a study by Watson et al. (2018) that suggests interventions focused on improving and developing personal resources is associated with positive well-being.

Furthermore, these skills can appear to result in rewarding relationships that allow them to understand their patients and be sensitive towards them. In this way, they can provide appropriate services, and feel a sense of accomplishment in their work (as found by Akintola (2010), Ramukumba (2019) and Visser and Mabota (2015)).

Coping effectively with daily demands

This aspect of Bar-On (2010)'s model encompasses how one successfully copes with stress, demands of daily life and their environment, and being able to make effective decisions so that one can lead a positive life. In addition, Bar-On (2010) states that an individual who is able to control their emotions, will be able to effectively cope with stress.

From the analysis of the interviews, it is evident that the participants gained a number of skills and knowledge, which assisted them in coping effectively with daily demands. One of the key topics the participants gained knowledge on was stress management. These

participants appear to display emotional regulation and stress management techniques, and reported that by exercising these practices, they found themselves less stressed, and it eased their relationships at work. This is evidenced by a study using Bar-On's (2010) model which used stress management techniques to help health workers against psychological stress and helped to manage stress relating to their workload (Newton et al., 2016).

Setting boundaries helped the participants in their work by keeping their emotions and personal life separate from their work, putting limitations on what they can discuss with their colleagues, and limitations on how much help they can provide for their patients. It also allowed them to have a calm work environment, as they were not going beyond their limits and getting exploited by their patients. This provided a better quality of life, as they were able to relax and take care of their own health without having to wake up during odd hours for patients. This is in consensus with Mental Health America (2020), that states establising boundaries can prevent exhaustion and conflict in individuals.

Furthermore, the coronavirus panademic negatively influenced the participants' emotional well-being, as the pandemic not only changed the nature of their work but also the way they provide help to their patients. Their workload increased drastically, as they had to care for their regular patients and do screening to identify possible coronavirus patients. However, the participants indicated that the programme assisted them in coping with the challenges of the pandemic, and improved their emotional well-being by providing them with steps to follow which reduced their stress significantly. A study by Sølvold et al. (2021) evidenced this by suggesting that strategies, such as preventive and protective steps, relaxation and stress managemt techniques, and enhancing interpersonal skills can assist health workers with the demands of the coronavirus pandemic.

Conclusion

Five themes were developed from this study, which reflected the CHWs experiences of a personal development programme to improve their emotional well-being. It was reflected that problems and challenges in their community work, encompassed the work stressors that the CHWs experience, including not taking treatment and the coronavirus pandemic. Evidently, these identified stressors operated in negative ways by corroding the CHWs emotional well-being.

CHWs gained knowledge on topics through their experience of the intervention and could strengthen their interpersonal relationships. This contributed to their positive experience. Moreover, the CHWs gained personal skills, especially emotional regulation

which could assist them in developing healthy behaviour and displaying healthy emotions (Bar-On, 2010).

Acquiring skills to cope with daily demands assisted the CHWs in reducing work and personal stress, as well as coping with the challenges of the pandemic. Furthermore, the CHWs expressed the need to or learn how to apply skills and that similar interventions should be presented to community members. These recommendations will be discussed in the section on recommendations below.

The results of the study show that CHWs reported some improved emotional well-being on a personal and a professional level. Despite living and working in areas with high levels of crime and violence and had limited resources, the CHWs developed knowledge and skills that allowed them to continue to provide care but not at the expense of their own emotional well-being. They used these skills by also spreading it in their community, with their neighbours, family and patients.

In addition, much of the CHWs improved emotional well-being was attributed to establishing boundaries, which allowed them to gain a voice and speak up for themselves. They, thus, actively participated in improving their emotional well-being, by participating in acquiring knowledge that would benefit them, and recognising that they want to improve the quality of their lives. Furthermore, the current study showed that it is significant to provide CHWs with intervention programmes that can assist them with the tools needed to improve their emotional well-being.

Limitations

The researcher experienced some barriers in implementing the research.

Language barriers presented a limitation for the researcher. Although the researcher ensured that only the participants who could articulate themselves in English would participate, English is not the participants' first language. As a result, it is possible that some of the meaning and essence of their experiences could have been lost through their expression in English. In addition, the language barrier sometimes stemmed thin descriptions or no elaborations from the participants.

The development and implementation of the intervention (which was the background but not part of this research) was disrupted by the coronavirus pandemic and lockdown. The needs assessment at Daspoort clinic was done before the outbreak of the pandemic, but the implementation was disrupted by the lockdown period. Three sessions were presented virtually by two students on campus while the group of CHWs gathered at the clinic. This

was not an ideal situation. Low attendance of the Daspoort CHWs resulted in the students reaching out to CHWs at Woodlands clinic. The intervention content was developed based on the expressed needs of the CHWs that report to the two clinics involved. The programmes were, thus, not the same, and the programme implemented among the CHWs reporting to Woodlands clinic was much shorter than the programme implemented at the Daspoort clinic. Although participants from both clinics benefitted, it cannot be concluded that CHWs benefitted in the same way from the two interventions.

Recommendations

The current study revealed the significance of how CHWs could be assisted to receive new knowledge, information, and skills, which could increase their quality of life and the service they provide to communities. Based on the findings of this study, the following recommendations are made:

- It may be beneficial to provide interventions that focus on how CHWs could apply the knowledge they have gained in their own lives and in their work situation. It seems as if some of them still experience difficulty with the application of skills.
- The participants seemed to want more focus on gaining knowledge to deal with the challenges of the pandemic. Interventions that focus primarily on coping with the pandemic could be considered.
- Furthermore, the participants indicated that it would benefit them and the community if interventions such as these, focusing on emotional content, would be presented to groups of community members. Community awareness of emotional reactions, and coping with personal and interpersonal challenges could improve the health of community members. The CHWs, thus, alerted us of the emotional needs of community members that need to be addressed. The recommendation is that CHWs be empowered to present such interventions in the community they work in, such as coping with stress, awareness of what to do if confronted with gender-based violence. In this way, they can start to address some of the emotional needs of patients that negatively influence community health. This can extend the role of CHWs, so that they have a wider scope of work to address more of the health needs in communities.

These recommendations can be helpful to health workers who work closely with CHWs and improve the scope of work of CHWs in communities. Future research on this topic is also encouraged in different areas and contexts in South Africa, to explicate the significance of providing programmes to improve the emotional well-being of CHWs.

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UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Humanities 100.
1919 - 2019
Department of Psychology

APPENDIX A

PARTICIPANT INFORMATION AND INFORMED CONSENT FORM

STUDY TITLE: Community health workers experiences of a personal development programme to improve their emotional well-being.

PRINCIPLE INVESTIGATOR: Yasirah Adam Abdoola (Masters Research Psychology student)

SUPERVISOR: Professor. Maretha Visser

INSTITUTION: University of Pretoria

CONTACT DETAILS:

Yasirah Adam Abdoola (Researcher): 071 354 5377 or ysirah@gmail.com

Prof. Maretha Visser (Supervisor): on 012 420 2549 or maretha.visser@up.ac.za

Dear Prospective Participant

Dear Mr./ Ms. _____

1. INTRODUCTION

You are invited to participate in a research study. I, the researcher, am a student conducting research as part of the requirements for a Master's degree in Research Psychology at the University of Pretoria. The research is under the supervision of Professor Maretha Visser in the Department of Psychology at the University of Pretoria. The information presented in this form is to help you in deciding if you would like to participate in this research. Participation is voluntary and you should only agree to participate once you fully understand what is involved. Should you have any questions about the research, please contact me (the researcher) or my supervisor.

2. NATURE AND PURPOSE OF THE STUDY

This study aims to explore the ways in which the personal development programme you participated in during 2020 improved your emotional well-being. You will be asked questions regarding your emotional well-being and the intervention sessions, presented by the Masters

Counselling students in 2020, which you have participated in. The information acquired will be used to improve the development of similar interventions for community health workers to cope with challenges they experience.

3. EXPLANATION OF PROCEDURES AND EXPECTATIONS OF PARTICIPANTS

As part of the research you will participate in an interview that will be approximately one hour. The interview will take place in a private and comfortable setting at the clinic. The interview will be audio recorded and the recording will be transcribed. Follow-up interviews may also take place.

4. POSSIBLE RISKS AND DISCOMFORTS INVOLVED

There are minimal risks anticipated in taking part in this study. Participants may experience some emotional discomfort due to sharing of personal experiences. Should participants have any negative experience, they will be referred to Dr Ellenore Meyer, who agreed to provide support without compensation.

5. POSSIBLE BENEFITS OF THIS STUDY

There is not direct benefit from this study for the interviewees. However, the results will help to benefit other community health workers who face challenges at their job that influence their emotional well-being.

6. COMPENSATION

The participant will not be paid to participant in this study. There are not costs involved to participate in this study.

7. RIGHTS AS A RESEARCH PARTICIPANT

Participation is voluntary. You are entitled to withdraw from the study at any time without providing reasons. This withdrawal will not have any negative ramifications for you. Furthermore, you are not obliged to answer questions or disclose information that you do not wish to.

8. ETHICS APPROVAL

Ethics Approval was granted for this study by the Research Ethics Committee of the Faculty of Humanities and Health Sciences at the University of Pretoria. This will be made available by the researcher on request.

9. INFORMATION

You are encouraged to ask any questions that you may have with regard to this research study at any given time. Should you at any period of time feel uncomfortable, unhappy, or concerned about the research, please contact me on 071 354 5377 or ysirah@gmail.com or my supervisor (Prof. Visser) at the University of Pretoria on 012 420 2549 or maretha.visser@up.ac.za.

10. CONFIDENTIALITY

Your identity will be kept confidential. Your name will not be attached to any of the results of the study. The transcript of the audio recording will be kept on a password protected electronic devise in the research archive of the Department of Psychology for the next 15 years. Thereafter it will be destroyed.

11. CONSENT TO PARTICIPATE IN THIS STUDY:

I understand that:

1. The researcher is a student conducting research as part of the requirements for a Master's degree in Research Psychology at the University of Pretoria. The researcher may be contacted on 071 354 5377 or ysirah@gmail.com. The research is under the supervision of Professor Maretha Visser of the Department of Psychology of the University of Pretoria who may be contacted on 012 420 2549 or maretha.visser@up.ac.za.
2. The information collected during the study will not be linked to my identity and I give permission to the researcher of this study to access the information.
3. The data will be securely stored at the Department of Psychology for a period of 15 years for archiving and reuse.
4. The results and findings of this research will be used in research outputs such as the researcher's Master's mini-dissertation, publications, and conferences presentations.
5. The interviews will be conducted in English.
6. The research is conducted to gain knowledge regarding the experiences of community health workers of a personal development programme. It is not carried out for remuneration purposes.
7. My participation will involve attending an audio-recorded interview session in which I will discuss my experiences of a personal development programme delivered by post graduate students.
8. I understand that participation in the study is voluntary and that I am free to withdraw from the study at any time without prejudice and having to provide reasons.
9. I have read and understood the information sheet presented to me.

10. I have asked the researcher questions regarding anything that I did not understand on the information sheet presented to me.
11. I have had an opportunity to ask the researcher questions where I needed clarity.
12. I have received a signed copy of this consent form agreement.

Participant's name Date

_____ _____

Participant's signature Date

_____ _____

Researcher's name Date

_____ _____

Researcher's signature Date

APPENDIX B

INTERVIEW GUIDE

1. What was your experience of the personal development intervention presented by post-graduate students?
2. How has the personal development programme helped you personally and professionally?
   Probe:
   a. What have you learned about boundaries in relationships? How do you implement that in your work in the community?
   b. What were the limitation? What else would you have liked to be covered in the programme?

   For Daspoort:
   a. What have you learned about conflict management?
   b. Or gender-based violence?
   c. How does that help you in your work in the community?
3. How has the coronavirus pandemic changed the nature of your work?
   Probe:
   a. How has the programme helped you to face the challenges of coronavirus?
4. How has the nature of your work influenced you emotionally?

   Probe:
   a. If so, how?
   b. How has the personal development programme helped you with the challenges of these emotions?

APPENDIX C

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

19 September 2021

Dear Ms Y Adam Abdoola

Project Title:	Community health workers' experiences of a personal development programme to improve their emotional well-being.
Researcher:	Ms Y Adam Abdoola
Supervisor(s):	Prof MJ Visser
Department:	Psychology
Reference number:	16030852 (HUM038/1020)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 19 September 2021. 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 the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely,

Prof Karen Harris
Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

APPENDIX D

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

18 March 2021

Endorsement Notice

Ethics Reference No: HUM038/1020
Title: Community health workers' experiences of a personal development programme to improve their emotional well-being.

Dear Ms Y Adam Abdoola

The **New Application** as described in your documents specified in your cover letter dated 2021-01-26 received on 2021-03-18 was approved by the Faculty of Health Sciences Research Ethics Committee on 2021-03-17 as resolved by its quorate meeting.

Please note the following about your ethics approval:
- Please remember to use your protocol number HUM038/1020 on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Professor Werdie (CW) Van Staden
MBChB MMed(Psych) MD FCPsych(SA) FTCL UPLM
Chairperson: *Faculty of Health Sciences Research Ethics Committee*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

APPENDIX E

Dear Retha Erasmus
Plastic view/Woodlands clinic
retha.erasmus@moreleta.co.za

Permission to do research

The MA Counselling Psychology students presented sessions for personal development of the Community Health Workers (CHWs) of Plastic view / Woodlands clinic, during the second half of 2020. This was done under my supervision. After the intervention we intend to interview three or four of the CHWs to understand their experiences while participating in the personal development sessions. This is done to evaluate the effectiveness of the sessions to address the challenges they experience in their work situation and to plan ahead to address their additional needs.

A MA Research Psychology student Yasirah Adam Abdoola intend to do her mini-dissertation on the evaluation of these sessions under my supervision. To apply for ethical clearance for her research, she needs your permission to do this research with the CHWs who participated in the personal development sessions. In her research she will ask three or four of them to volunteer for the interviews. The proposal for this research has already been approved by the Department of Psychology and is attached here.

We will appreciate your permission to do this research.

Regards

Prof MJ Visser
Department of Psychology
Maretha.visser@up.ac.za

I hereby give permission to MA Research Psychology student Yasirah Adam Abdoola to do her research at the Woodlane Village Clinic.

Retha Erasmus
Clinic Coordinator and Executive Director of LIFT Community Development.
Mobile Phone 0797305985, email retha@moreleta.co.za
08/12/2020

APPENDIX F

Dear Yasirah Adam Abdoala

I have reviewed your request regarding your research . Am pleased to support your research .

Your request to use Daspoort Poli Clinic CHW as a research site is granted .

We look forward to working with you

Sincerely

Dr Gerhard Botha

31/08/2021