Exploring the life stories of HIV/AIDS lay counsellors: From burnout to resilience

by

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DECLARATION

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Exploring the life stories of HIV/AIDS lay counsellors: From burnout to resilience.

I declare that the above thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

(The thesis will not be examined unless this statement has been submitted.)

SIGNATURE

23/02/2022

DATE

DEDICATION

Dedicated to my husband Mr Michael Mthombeni, and my children Nyeleti, Nyiko, Shongile, Nhlanhla, Lwandle and my granddaughter Lulama for the support and encouragement to continue working hard and for lending me their time to achieve my dream. You were kind enough to give me time to study with minimised distractions every day for the duration of my studies.

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ABSTRACT OR SUMMARY

South Africa has one of the largest antiretroviral treatment programmes which demand HIV counselling and testing services. HIV and AIDS lay counsellors have therefore been incorporated into the public health facilities to assist health care professionals with the high workload of HIV counselling and testing. The current study explored the life stories of HIV/AIDS lay counsellors and their move from burnout to resilience. A qualitative approach was used to conduct in-depth interviews with six HIV/AIDS lay counsellors at one of the clinics in the Tshwane area. The aim was to explore the life stories of HIV/AIDS lay counsellors and the extent to which burnout affects them as well as their manifestation of resilience. Factors that contributed to their burnout and their resilience were identified. Although these lay counsellors suffered from some levels of burnout, they were able to cope with their challenges and be resilient despite the challenges they encountered. Suggestions were made to the lay counsellors, managers and the Department of Health to diminish the effects of these challenges. Recommendations for future research were also made.

Keywords: HIV/AIDS lay counsellor; Counselling process; Pre-test counselling; Post-test counselling; PMTCT counselling; Adherence counselling; Burnout; Resilience

CURRICULUM VITAE OF KEIT SHIRINDA-MTHOMBENI

Keit Shirinda-Mthombeni obtained a BA degree (Psychology) at the University of Pretoria in 2001, followed by a BSc degree (Honours) in Psychology at MEDUNSA in 2003. In 2008, she obtained a certificate as a Registered Counsellor with the Health Professions Council of South Africa (HPCSA), and a Master of Social Science in Psychology degree at UNISA in 2014. She is currently pursuing a PhD in Psychology at the University of South Africa, where she explores the life stories of HIV/AIDS lay counsellors in clinics. Upon obtaining a registered counsellor certificate, Keit joined the academic community at the University of South Africa as an academic assistant. She was then appointed as a junior lecturer in the Department of Psychology.

She is currently working as a lecturer, and she has ten years of teaching experience. Amongst the other tuition duties, she has managed to supervise three master's students to completion. Her research interest areas are Social Psychology: Social issues (HIV/AIDS - Psychosocial well-being); Attitude and behaviour change Community Psychology: Women empowerment; Orphans and vulnerable children; Youth empowerment: career guidance, teenage pregnancy/termination of pregnancy (Trauma, support and resilience); Counselling.

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretrovirals
ATTIC	Aids Training, Information and Counselling Centre
AW	Areas of Work life
CDC	Centres for Disease Control and Prevention
CICT	Client-Initiated Counselling and Testing
COR	Conservation of Resources
COVID	Coronavirus Disease
DCM	Demand-Control Model
DoH	Department of Health
ERI	Effort-Reward Imbalance
FBO	Faith-based organisations
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HSS	Health Services Survey
HTC	HIV Testing and Counselling
JDR	Job Demand Resource

MBI	Maslach Burnout Inventory
MEDUNSA	Medical University of Southern Africa
NDoH	National Department of Health
NGO	Non-Governmental Organisation
PEP	Post Exposure Prophylaxis
PICT	Provider Initiated Counselling and Testing
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PPE	Personal Protective Equipment
PTSD	Post-traumatic Stress Disorder
STIs	Sexually Transmitted Diseases
TASO	The Aids Support Organisation
TB	Tuberculosis
TOP	Termination of Pregnancy
UNAIDS	Joint United Nations programme on HIV/AIDS
UNISA	University of South Africa
UTT	Universal Test and Treat programme
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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CHAPTER 1

GENERAL ORIENTATION

1.1 A PERSONAL ACCOUNT

My involvement in the field of HIV/AIDS[1] started at the beginning of 2006 when I was accepted as a lay counsellor at the FF Ribeiro Clinic. I completed my Psychology Honours degree at MEDUNSA (Medical University of Southern Africa) during that time, and I was struggling to find employment due to a lack of experience. Therefore, to improve my curriculum vitae and gain experience, I decided to do volunteer work as a lay counsellor at the clinic's HIV/AIDS section, then called ATTIC (Aids Training, Information and Counselling Centre). The section is currently called Tshwane Aids Unit. Although I had basic information about HIV/AIDS counselling, I was sent on a 10-day course to be trained before I could start working. I was drawn to counselling while doing my Honours degree in Psychology at MEDUNSA; hence, I decided to look for such services at the local clinics. I was fortunate that the FF Ribeiro Clinic offered me the opportunity to do volunteer work, as this enabled me to empower others to participate in combating the spread of the disease.

My main involvement at the clinic was to conduct pre- and post-test counselling. Listening to clients' life stories was stressful and giving a client an HIV-positive result was heart-breaking. The stress was also exacerbated by the increase in the number of clients I had to counsel per day which was twice the number I was supposed to. Sometimes I would sit there depleted after a session wondering, am I meeting the needs of my clients? Although I worked very hard in a very stressful environment, I did not receive any debriefing sessions or much-needed support. My supervisor, a psychologist, was also overloaded with work since all the lay counsellors reported to her whilst she had to do her own work as well. I was only encouraged to join a support group facilitated by the psychologist once a week to learn how to facilitate a support group. There was nothing organised specifically for us as lay counsellors to assist with debriefing. Due to the workload, it was difficult for the lay counsellors to meet to discuss their challenges and support each other. We were just too hard-pressed for time and had to work overtime in order to try to cope with the ever-growing number of people waiting for counselling and testing.

I decided to stop volunteering towards the end of the year. It was not easy to leave the section, but I had to leave because my assignment was fulfilled, and there was no hope for future

[1] Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

employment at all. The demand for counselling was very high since people came to the clinic in numbers for testing every day. The nursing personnel could not handle the flow. Hence, we were also burdened with clients. The section could not absorb us as staff members due to lack of funds to pay us or compensate us with transport money.

I further registered for my MA degree at the University of South Africa (UNISA), where my focus was to look into the psychological challenges of palliative care volunteer caregivers as well as their coping mechanisms. The unpaid workers looked after patients suffering from HIV and AIDS in the community. I found in my research that although volunteer caregivers were satisfied to a certain extent with what they achieved; they also encountered many difficulties. They were often undermined, not appreciated and unsupported by their colleagues, the people they cared for ~~a~~nd their community members. It was also recommended that the volunteer caregivers' psychological, social and financial well-being be taken into consideration in order to maintain them and encourage them to do this very important job. That was a reminder that Africa is completely reliant on volunteers who frequently bear the effect of the AIDS outbreak. Hence, I am deeply interested in finding out what is currently happening with the HIV/AIDS lay counsellors since their challenges are not really different from these volunteer caregivers in my previous study.

I am currently teaching HIV/AIDS modules in the Department of Psychology at UNISA. Due to various challenges that I encountered during my voluntary work as a lay counsellor, I am curious to find out if the situation has changed or not. Hence, I am motivated to explore the life stories of HIV/AIDS lay counsellors in public clinics, the extent of burnout as well as the nature of resilience among them.

1.2 BACKGROUND TO THE STUDY

South Africa is one of several countries that has implemented HIV-prevention programmes into operation in the absence of a cure for HIV. These programmes are run mainly by lay counsellors, who are usually women. They play an important role in motivating clients to test and adhere to their medication after testing positive. The lay counsellors experience severe psychological problems as a result of the societal views of the HIV/AIDS epidemic, as well as the clients who are often upset after receiving their positive HIV test results. Since their roles are enormous and often challenging, many counsellors suffer from burnout. Lay counsellors have a significant function in the field of HIV and AIDS as they provide much-needed counselling to clients, such as pre-test counselling before being tested for HIV. The client should sign a consent form before being tested, and post-test counselling should be provided before the results are disclosed. People who have tested positive for HIV usually react with

shock when they receive their results; hence, it is essential to start with the counselling process.

Lay counsellors also assist in the Prevention of Mother to Child Transmission programme (PMTCT). This programme is available in all public hospitals and clinics. The programme provides services to all pregnant women presenting at public hospitals and clinics for antenatal care. Lay counsellors play an important role in motivating clients to adhere to their medication, encouraging women to comply with taking Nevirapine before the baby is born and bringing the baby for testing after delivery (Malema et al., 2010). Currently, there is no cure for HIV/AIDS, and the disease still carries a stigma in many communities. Few people in the communities have the courage to disclose their HIV status publicly. Therefore, it is necessary to provide counselling before and after a client is tested in order to increase the number of people who take antiretroviral therapy (ART). In South Africa, individual counselling following ART initiation is one of the main strategies for supporting adherence in the public sector (Dewing et al., 2013). ART adherence counselling is a service that encourages clients to deal with their treatment, fix their attention on knowledge about their medication and their personalised medicine programmes, handle any secondary effects and use cues to remind them to take their pills. Clients are also assisted in identifying and addressing barriers to adherence (Dewing et al., 2013; World Health Organization [WHO], 2013).

Peltzer and Davids (2011) indicated that there was constant work-related stress amongst nurses conducting Voluntary Counselling and Testing (VCT) services. They identified psychological and physical stressors among the nurses. Lay counsellors found themselves with the same challenges as those of nurses. They were unable to deal with the complex social, gender, emotional and economic issues for which patients desperately needed support. Many lay counsellors were also required to monitor complex issues outside their scope of practice. Those challenges made the counsellors suffer emotionally, and their job became stressful, leading them to suffer from burnout (Visser & Mabota, 2015).

1.3 PROBLEM STATEMENT

Black et al. (2011) reported that the environment in which lay counsellors usually work does not have a professional body set up to regulate support. The circumstances of their job also put pressure on their private and professional existence. Although they play a crucial role in the health sector, there is little or no plans for skills transfer planning, formal recognition of training, career recognition and opportunities for development. The training that lay counsellors have is incomplete, and they are often not recognised and supported. Despite all these challenges, they still continue to do their work with passion and dedication. They

continue to display determination and genuine compassion for people in their communities infected and affected by HIV/AIDS. They continue to provide their services despite delays in the payments/stipends required to sustain their families (Black et al., 2011). Hence, this study aims to explore the life stories of lay counsellors and the nature of burnout and resilience among them. The study will also make recommendations for future research.

1.4 THEORETICAL FRAMEWORK

Various existing models are used as a theoretical basis for the present research. In this respect, the following models have been identified: the Areas of Work life (AW) Model; the Conservation of Resources (COR) Model; the Demand-Control (DCM) Model; Effort-Reward Imbalance (ERI) Model and the Job Demand Resource Model (JDR) Model. The Areas of Work life (AW) Model, one of the prominent theories of burnout, was proposed by Leiter and Maslach (1999). The central characteristic of the model is the focus on what happens between individuals and their surroundings. The second model, the Conservation of Resources (COR) Model, was developed in 1989 by Hobfoll, one of the leading theories in burnout studies (Hobfoll, 1989). The theory rests firstly on the basic principle that individuals strive to obtain, retain, foster, and protect resources. The third model, the Demand-Control (DCM) Model, also known as the Job Strain Model, was developed by Karasek in 1979. The model states that strain will be higher in jobs characterised by the combination of high job demands, low job control, low social support and such jobs are called high strain jobs (Karasek, 1979).

The fourth model is the Effort-Reward Imbalance (ERI) Model, which emphasises the reward rather than the control structure of work. The ERI Model assumes that job stress is the result of an imbalance between effort and reward (Siegrist, 1996). Effort-reward imbalance is a theoretical model to identify a stressful work environment and explain an imbalance between the amount of effort a person devotes to their work and the rewards they receive (Cooper & Quick, 2017). Lastly, the Job Demand Resource (JDR) Model was developed by Demerouti et al. (2001). The model focuses on the notion that burnout arises when individuals experience continuous job demands and have inadequate resources available to address them. The models are discussed in more detail in the theoretical framework chapter in this study (see Chapter 3).

1.5 PURPOSE AND OBJECTIVES OF THE STUDY

1.5.1 Purpose of the study

The purpose of this study is to explore the life stories of HIV/AIDS lay counsellors and the manner in which burnout affects them and their resilience. It is imperative to explore the factors

contributing to burnout as well as their coping strategies. I aim to develop an understanding of how lay counsellors can be resilient despite the challenges they encounter that lead them to develop some level of burnout.

1.5.2 Objectives of the study

The objectives of this research can be summarised as follows:

- To explore and describe the life stories of HIV/AIDS lay counsellors in the clinics.
- To explore and describe the experiences of lay counsellors during and after the counselling process.
- To identify factors that contribute to burnout among lay counsellors in the clinics.
- To identify aspects that could promote resilience among lay counsellors in the clinics.
- To explore their needs and the psychosocial support system available for lay counsellors in the clinics.
- To make recommendations for improvement based on the findings.

1.6 RESEARCH QUESTIONS

A research question with more than one acceptable answer is formulated, and the question asked will therefore control the way in which the rest of the research process will be carried out.

The primary question

- How can a description of the life stories of HIV/AIDS lay counsellors inform knowledge on:
    a) burnout in HIV/AIDS lay counsellors?
    b) resilience in HIV/AIDS lay counsellors?

The following secondary questions were asked for the present research:

- What are the experiences (life stories) of HIV/AIDS lay counsellors in clinics?
- Do lay counsellors receive any support from their employers? Are there any support systems available for lay counsellors in clinics?
- What are the factors that contribute to burnout among lay counsellors?
- What are the factors that contribute to resilience among lay counsellors?
- Which strategies should be employed to improve the current situation of lay counsellors?

1.7. OPERATIONAL DEFINITIONS

Table 1.1 sets out the key terms that are used in this study

Table 1. 1:

Key terms – operational definitions

Key terms	Operational definitions
HIV/AIDS lay counsellor	An HIV/AIDS lay counsellor is an individual who usually must attend training for 5 to 21 days on how to test and counsel clients at an HIV clinic. The trainee then understands that his/her devotion and respectful attention are necessary to assist clients to decide about taking an HIV test and that they will need counselling before and after the testing (Mwisongo et al., 2015).
Counselling process	The counselling process refers to a planned, private, confidential and cooperative exchange between a skilled individual and a patient or client with the aim of empowering the client to help himself/herself (Mwisongo et al., 2015).
Pre-test counselling	This kind of counselling is offered before the client decides about taking an HIV test. During this period of time, the HIV/AIDS lay counsellor ensures that the counselee makes a well-informed decision about whether to continue with the HIV test or not; then explores the client's existing knowledge of HIV and AIDS and also conducts a risk assessment (Van Dyk, 2016).
Post-test counselling	Post-test counselling is described as the procedure after the test results have been revealed when the HIV/AIDS lay counsellor assists clients to comprehend the consequences and lets them express and adapt to their feelings about being HIV positive or negative (Van Dyk, 2016).
PMTCT counselling	Prevention of mother to child transmission (PMTCT) is the process through which an HIV/AIDS lay counsellor helps the client to understand the transmission of HIV from an HIV-positive woman to her child via the placenta during pregnancy,

Key terms	Operational definitions
	through blood contamination during delivery or through breastfeeding (Van Dyk et al., 2017).
Adherence counselling	This refers to the process through which a counsellor helps the client to understand the importance of adhering to the medication. “Adherence” refers to an active, voluntary, and collaborative involvement of the patient in a mutually acceptable course of behaviour to produce a therapeutic result (Van Dyk et al., 2017).
Burnout	Burnout is defined as a syndrome of physical and emotional exhaustion, the inability to offer psychological support to others, development of a negative self-concept, reduced sense of personal accomplishment, negative job attitudes and feelings of depersonalisation or loss of concern for patients, clients and colleagues (Van Dyk, 2016).
Resilience	Resilience refers to the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability or development. It is also defined as the ability to bounce back from adversity, frustration and misfortune (Ledesma, 2014; Masten, 2014).

1.8 RESEARCH DESIGN

McMillan and Schumacher (2010) indicated that a research design is a strategy used to integrate the different components of the study in a clear and logical way, thereby ensuring to address the research problems and determines how the research will be carried out. David and Sutton (2011) pointed out that qualitative research is associated with induction and exploration in research rather than with the more deductive testing of preconceived theories. I used a qualitative research design in this study in order to obtain an in-depth understanding of the life stories of HIV/AIDS lay counsellors. Importantly, the qualitative design requires the research to be more than a set of worked out formulas; it is concerned with understanding rather than explanation (De Vos et al., 2011).

Fouché and Schurink (2011) stated that “qualitative research is concerned with understanding and the subjective exploration of reality from the perspective of the insiders” (p. 308). Thus using a quantitative method for this research would have been limiting. The quantitative method would not have addressed the lived experiences of participants as it focuses on true or false, measuring and analysing statistically.

Using a qualitative method allowed me to collect data in the form of spoken language and conduct and study the data in-depth, revealing openness and considerable detail. I also intended to recognise and attempt to comprehend the types of information that emerge from the data (Creswell & Plano Clark, 2017). A qualitative technique appears to maintain the integrity of narrated data.

1.9 SAMPLING METHOD

This study used a goal-directed sampling method which is a procedure for choosing sample members from a population who satisfy certain required characteristics pinpointed as conditions for the target population. Fouché and Schurink (2011) pointed out that the central objective of a goal-directed selection method is to focus on the characteristics of a population that will best enable the researcher to answer the research questions.

Furthermore, goal-directed selection of research participants refers to a way to select a small sample of participants who represent particular events for thorough exploration. Some researchers also see purposive sampling as judgmental sampling as the researcher relies entirely on his or her own conclusion when choosing the target population to participate in the study (Creswell, 2014).

Denzin and Lincoln (2011) stated that the views and knowledge of the researcher involve making conclusions about the selected participants, and the sample members are chosen only based on the researcher's knowledge and judgment. The researcher is steered by essentials that involve the most outstanding characteristics of the population that best assist in achieving the research aims.

They also mentioned that using goal-directed sampling assists the researcher to gather a lot of data out of the appropriately selected participants. Therefore, the selected partakers are expected to comply with the study's criteria (Strydom & Delport, 2011). The research participants for this study will be purposefully selected to seek distinctive and different data. Only individuals working as HIV/AIDS lay counsellors in the clinics and who had been there for at least a year and more were selected for this study.

1.10 DATA COLLECTION

Creswell and Plano Clark (2011) indicated that the collection of data is generally purposive in a qualitative research design as data is gathered and measured in an established systematic fashion that enables the researcher to answer the research questions and evaluate outcomes.

Hence, it is very crucial for the researchers to determine what works for them to answer their research questions.

Therefore, I used semi-structured interviews as a way to gather data for this research. Atkins and Wallace (2012) confirm that interviewing is one of the major data collection methods which are employed in qualitative research. It is a way of getting into individuals' construction of reality, their perceptions, meanings and definitions of situations. The method is flexible as the researcher can adapt and change the questions depending on the participants' answers. Furthermore, the researcher is able to continue with specific attention-grabbing routes through the use of open questions. This allows the participants to talk in some depth, choosing their own words, and the researcher then develops a real sense of the participants' understanding of their situation. (De Vos et al., 2011). When performing this research, I used semi-structured interviews to collect the data. The participants' consent to record the interviews on audiotape during the interviewing process was obtained. During the data collection process, I jotted down some notes. Therefore, immediately after the data collection process, I listened to the recorded interviews and checked the jotted notes and coded them accordingly. The methods that were used for data collection are concisely reviewed below.

1.10.1 Biographical questionnaire

A questionnaire was used to obtain relevant biographical information about the participants. The information allowed me to compare groups of participants. The participants were assured that their responses would remain anonymous. The variables incorporated in the form were age, gender, marital status, educational qualification, the type of training they received to perform their duties and the number of clients the participant sees on a daily basis. I also explored if lay counsellors' stories are different, challenges affect them differently and if they cope differently according to their age, gender, educational qualification and marital status.

1.10.2 Semi-structured interviews

I conducted semi-structured in-depth interviews to augment the information gained through the questionnaire. Through the interviews, I hoped to gain a detailed understanding of the HIV/AIDS lay counsellors' stories and challenges for counselling people living with HIV and AIDS. I also explored the factors contributing to burnout and resilience among HIV/AIDS lay counsellors. An interview schedule was used to provide me with a set of pre-set questions used as a suitable instrument to involve the participants (De Vos et al., 2011). I was guided by the interview schedule rather than be dictated by it.

I decided to use interviews in order to focus on one person and to build rapport easily with the participants. I believed participants would be more willing to discuss personal experiences during an interview and allow me more time to pursue interesting areas (Curtis & Curtis, 2011). The interview schedule consisted of 10 questions used to guide the interviews as mentioned above.

1.11 PILOT STUDY

De Vos et al. (2011) stated that it is valuable to do a small-scale study (a pilot study) as the first step of the entire research protocol in a study. A pilot study is usually undertaken in qualitative research to assist in planning and modification of the main study. A small number of participants sharing the same features with those of the main study are included in the initial study to determine particular tendencies. The main purpose of the pilot study is to determine whether the relevant data could be obtained from the actual participants and to improve the chances of a clear outcome (Strydom & Delport, 2011). After compilation of the interview schedule, three participants were arranged in the recommended organisation to test the interview schedules and the interview questions that did not bring about relevant data were adapted and improved prior to the main enquiry.

1.12 ETHICAL CONSIDERATIONS

Adhering to ethical principles is an imperative component of the research strategy, and they are a set of principles that guide the research designs and practices. They are crucial in the fields that often involve matters that are particularly important for research participants and in areas that could create deliberation (Atkins & Wallace, 2012). Atkins and Wallace (2012) also indicate that research ethics protect the rights of research participants and offer researchers a code of ethical directions. They guide the researcher on how to conduct research in a morally acceptable way. While doing this study, the following ethical standards for research will be taken into consideration: informed consent, permission to tape-record the interviews, confidentiality and anonymity, avoidance of harm to respondents, deception, actions and competence of the researcher, as well as the release of findings.

1.12.1 Informed consent

Creswell (2014) stated that the principle of informed consent requires the researcher to reveal all the facts about a study so that individuals can make a rational decision on whether or not to participate in the study, based on the facts that were given to them. For this reason, I wrote a letter to the manager of the organisation requesting permission to conduct a study on their premises. I, therefore, clearly outlined all the essential facts about the study, such as the

purpose of the study, the processes that would be followed during the study and the possible advantages and disadvantages. For the participants to understand the details of the investigation fully so that they could make a rational decision about their possible participation, I offered correct and comprehensive facts (Strydom & Delport, 2011). Information regarding the use of tape recordings was provided to the participants so that they would not be taken by surprise during the interviews. The participants were requested to give their informed consent by signing a letter to indicate that they agree to participate in the research and thereby also to give permission to audio record the interviews.

1.12.2 Confidentiality

According to Neuman (2011), "confidentiality is the ethical protection for those who are studied by holding research data in confidence or keeping it secret from the public, not releasing information in a way that permits linking specific individuals to specific responses" (p. 139). By keeping their names secret, participants remain unidentified; therefore, their identity is safeguarded from being revealed and remains unknown. I ensured that pseudonyms were used (identifying information not made available) and that personal information was not revealed in the research report.

1.12.3 Avoidance of harm to participants

Strydom and Delport (2011) warned that the research process should not in any way harm the participants, unintended or otherwise. They advised that participants may experience actual damage pertaining to how they are esteemed at work with regard to their work positions. I am, therefore, cognisant of the fact that my participants could develop emotional problems resulting from certain encounters with patients. Thus, I adhered to the ethical principles for social research in order to stay clear of causing any hurt to my participants. I debriefed each participant after every session to ensure that they would not possibly run the risk of emotional damage or hurt due to the research's course of action.

1.12.4 Deception

Curtis and Curtis (2011) mentioned that dishonesty in research often results in participants not being fully informed of the purpose of the study, meaning that they are not given correct information explaining to them what the research will entail and what the aims of the research are. In this case, the researcher misleads the participants to such an extent that if they had been given the correct facts about the study, they might have refused to be part of the study.

Accordingly, I discussed the purpose or nature of the research process and gave participants accurate facts about the course of action that they could expect. I did not deceive or bribe any potential partaker and did not pay anyone; neither did I put force on any person to agree to take part, but I gave them truthful facts about this research.

1.12.5 Actions and competence of the researcher

Researchers should have the expertise to be able to select solutions to problems and their implementation, being truthful and sufficiently competent to undertake the proposed research (Strydom & Delport, 2011). I have completed a master's degree as part of my academic qualifications. I have therefore been exposed to research processes as well as the Code of Ethics (Creswell, 2014) relating to conducting research. I also obtained experience as an HIV/AIDS counsellor, supporting and counselling individuals and groups in an HIV clinic.

1.12.6 Release of findings

Neuman (2011) declared that a research report is a written account used to describe a study that had been carried out and is meant for any interested person (e.g. colleagues, participants of the study). This document can be regarded as the concluding result, describing the research process, the findings and conclusions reached at the end of a long investigative route. She emphasised that the report should be in a format that is accessible and easy to understand. This study's findings will be released in the form of a written thesis and will be submitted to the Department of Psychology of the University of South Africa for degree purposes.

1.13 CHAPTER OUTLINE

Chapter 2: Literature review

The focus in this chapter is on the literature review, which includes an exposition of pertinent, significant notions, a portrayal of the HIV/AIDS lay counsellors, as well as what they encounter nationally and internationally. Theories on how to deal with those challenges and how they apply to the HIV/AIDS lay counsellors, especially in the South African context, are discussed.

Chapter 3: Theoretical framework for the research study

In this chapter, there will be an emphasis on the theoretical structure in which HIV/AIDS lay counsellors are embedded. The relevant frameworks such as the expanded model of burnout and models of resilience are described thoroughly. The frameworks assist in the conceptualisation of this study, and an explanation of how they relate to the study are given.

Chapter 4: Research methodology

This chapter describes the research method used for data collection in detail. The justification of the use of qualitative methods is also described. The chapter also includes details about data collection, sampling, data analysis and ethical considerations to safeguard the ethical rights of the participant.

Chapter 5: The participants' stories

This chapter presents the stories from the participants in detail. Quotations from the interviews will be given in order to get a live and true picture of each participant and what they experience as lay HIV/AIDS counsellors.

Chapter 6: Empirical findings

This chapter discusses the research results. It focuses on the qualitative data collected as well as a presentation and analysis of the empirical research findings. Themes that will be identified from the participants' stories will be presented, and I will focus on the factors that lead to their burnout and resilience, what their needs are and how they cope with their situation at work.

Chapter 7: Conclusions and recommendations

This chapter focuses on the conclusions and recommendations of the study. Conclusions are based on the findings, and recommendations will be made in an attempt to address relevant stakeholders. The strong points and inadequacies of the study will also be pointed out, and I will consider whether the aims/objectives of the study were met.

1.14 CONCLUSION

South Africa is one of the countries with the largest burden of HIV/AIDS in the world. Therefore, as in other developing countries, lay counsellors have been integrated into the formal health care system to fulfil a role in relieving the burden of health care professionals. However, they do not have formal professional or tertiary education. They were previously recognised for their important contribution regarding pre- and post-test counselling. However, with the roll-out of ART, they are playing a crucial role in supporting and expanding the capacity for service delivery. Individual counselling delivered by lay counsellors is one of the main strategies for supporting adherence to their treatment programmes by patients. Lay counsellors carry out their work with a sense of obligation and compassion. However, they often have to deal with problems that make their lives difficult in the process. It seems there is a need for research with the aim to explore what these counsellors experience and how they can be assisted to

cope with the problems they encounter in their work. Research should be conducted to understand the type and degree of their problems as well as their resilience. The present research will address this need.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The World Health Organization (2021) reported that 37.7 million people worldwide have HIV, and over 25.4 million people are in the African region. The burden of the epidemic continues to vary considerably between countries and regions. However, sub-Saharan Africa remains most severely affected. Avert (2020) reported that South Africa has the biggest and most high-profile HIV epidemic in the world, with an estimated 7.7 million people living with HIV in 2018. Although the HIV test is free of charge in the public clinics and hospitals of South Africa, many people are still ignorant of their HIV status. South Africa accounts for a third of all new HIV infections in southern Africa. The report indicates 240,000 new HIV infections and 71,000 South Africans died from AIDS-related illnesses (Avert, 2020). This is a serious challenge to the government and civil society groups, who are trying to reduce the spread of this pandemic and help those affected and infected by it on a daily basis.

South Africa has the world's largest antiretroviral treatment (ART) programme and is making good progress, particularly in regard to testing and viral suppression. In 2018, 90% of people living with HIV were aware of their status, of which 68% were on treatment. Of the individuals who were diagnosed and on treatment, 87% were virally suppressed (Avert, 2020). Hopkins et al. (2018) also highlighted the Universal Test and Treat (UTT) guidelines, which allow for initiation of treatment irrespective of CD4+ count. The report has shown that UTT could lead to substantial reductions in HIV incidence, potentially eliminating it as a public health problem over a period of 15–20 years. Although there is good progress with the ART programme, HIV prevalence remains high, with 20.4% of people living with HIV. However, the prevalence varies distinctly between regions, ranging from 12.6% in Western Cape to 27% in KwaZulu-Natal (HSRC, 2018). The South African National Aids Council (SANAC) (2017) reported that women are more affected by HIV in South Africa than men. In 2017, 26% of women were estimated to be living with HIV, compared to around 15% of men. HIV prevalence among young women is nearly four times greater than among young men (SANAC, 2017). Although there have been some improvements since the roll-out of antiretroviral therapy (ART), people with HIV continue to require care and support.

Research cited by the WHO (2014) indicates that in sub-Saharan Africa, there is a critical shortage of health workers and a large disparity in human resource distribution between urban and rural locations. Other studies in Ethiopia, Swaziland and South Africa have similarly highlighted that the quality of care depends on the training and supervision of lay health care

workers (Assefa et al., 2012; Hanlon et al., 2014). In South Africa, senior nurses in charge of the health facility are often delegated to supervise the lay health care workers. However, Mendenhall et al. (2014) reported that supervision is limited and irregular due to heavy workload and other priorities. Although a number of countries in sub-Saharan Africa have taken steps towards training lay counsellors, improving their recognition, job description and support, progress is very slow. The current challenge of shortages of salaries, lack or reduced donor support, and lack of national prioritisation will threaten the sustainability of this group and the support they provide to the patients (WHO, 2013). The increased number of people in need of HIV testing and the demand for a higher level of access to ART presented new challenges for the South African government. These challenges range from provision of adequate testing kits, access to lay counsellors as well as access to ARTs. Nurses were primarily responsible for providing a range of services such as HIV/AIDS education, counselling, testing and support in hospitals and clinics around the country. However, it became evident that nurses were overwhelmed by the number of people arriving at the clinics as the incidence of the disease increased. The challenge resulted in their need to perform a role beyond simply testing.

The introduction of lay counsellors to reduce the strain of the nurses was a good method of planning for and implementing HIV/AIDS initiatives. Government initiatives such as communication programmes, Prevention of Mother to Child Transmission (PMTCT) programmes, provision of condoms, ART roll-out and the HCT (HIV Counselling and Testing) campaign were implemented (Malema et al., 2010). These programmes contributed to an increase in the pressure on hospitals and clinics to provide counselling and testing services; hence lay counsellors were introduced to relieve the pressure.

South Africa was reported as one of the countries with a critical shortage of health care workers and a large inconsistency in the distribution of human resources between rural and urban locations (WHO, 2014). Research mostly focused on the experiences of HIV counselling and testing counsellors (Petersen et al., 2014), the emotional well-being of HCT counsellors (Visser & Mabota, 2015), the implementation challenges of HCT services, management, remuneration, lack of training and supervision of lay counsellors (Daniels et al., 2010; Peltzer & Davids, 2011; Thurling & Harris, 2012). Few studies evaluated the ability of lay counsellors to implement counselling. Therefore, there was a concern about the quality of counselling delivered by lay counsellors (Dewing et al., 2013). Petersen et al. (2014) indicated that lay counsellors in the South African context could be effective if they are trained and supervised appropriately and Dewing et al. (2013) confirmed this.

However, the few available research findings reveal that many counsellors experience their job as stressful and emotionally draining, leading to occupational burnout. The main causes of stress and burnout among lay counsellors are emotional involvement and internalisation of some of the hardships of their clients, consistent exposure to illness and death, their own personal fears and vulnerability of being infected and being stigmatised, uncertainty and being unprepared for situations that may arise in counselling (Peltzer & Davids, 2011; Visser & Mabota, 2015). However, they continue to serve their clients with love, humility and dedication.

Peltzer and Davids (2011) found that 78% of lay counsellors in their study experienced high levels of job stress and that 31% felt emotionally drained by their work. At the same time, almost two-thirds experienced high levels of job satisfaction. Peltzer et al. (2012) found that 20% of HIV lay counsellors experience symptoms of post-traumatic stress disorder (PTSD) much worse than the average population, whereas Breuer et al. (2012) indicated that 20.5% of the counsellors were HIV-positive, which could affect their emotional well-being. According to Breuer et al. (2012), 49% of lay counsellors were unsatisfied with their work environment. Hence, the main purpose of this research is to explore the life stories of lay counsellors by exploring the factors that contribute to burnout and resilience among them.

This chapter presents an outline of HIV/AIDS counselling in South Africa as well as the requirements in the Standards for Counselling and Training Guidelines (DoH, 2015), especially in the selection and training procedures of counsellors. The chapter further discusses different challenges faced by lay counsellors, their coping strategies and resilience.

2.2 AN OVERVIEW OF HIV/AIDS COUNSELLING IN SOUTH AFRICA

HIV Counselling and Testing (HCT) has been said to be a key intervention in preventing new infections and reducing the impact of HIV/AIDS on individuals, families, communities and society (Mwisongo et al., 2015). Grabbe et al. (2010) also highlighted that counselling and testing remain key components of HIV/AIDS prevention as they provide an entry point into prevention, care, treatment and support services. The South African HCT has experienced rapid growth since its inception in 2000. The South African government launched the HCT campaign, and over 13 million people were tested for HIV by the end of 2011 (UNAIDS, 2013). Although there has been considerable success in making HCT accessible in South Africa, a shortage of trained HIV counsellors restricts the provision of HIV services, particularly in resource-limited settings (Mwisongo et al., 2015).

The programmes were expanded in 2004 to include Voluntary Counselling and Testing (VCT) and non-medical sites in community settings. Lay counsellors and professional nurses ran the VCT in public health facilities. The main function of lay counsellors was to deliver pre-and

post-test counselling whilst professional nurses conducted the rapid test (Dlamini, 2016). Pre-test counselling aims to give individuals relevant HIV information by assessing HIV knowledge, correcting misconceptions about HIV as well as reviewing the client's risk reduction options in order to motivate behaviour change. Post-test counselling assesses the client's readiness to receive their HIV results, discusses the meaning of test results and assesses the impact of the results on the client (Njeru et al., 2011; Van Dyk et al., 2017).

In 2010 the first HCT policy guidelines were published, officially expanding the then VCT to include Client-Initiated Counselling and Testing (CICT) and Provider Initiated Counselling and Testing (PICT). Provider Initiated Counselling and Testing (PICT) refers to HIV counselling and testing, which are routinely offered by health care providers to persons attending health care facilities as a standard component of medical care, whereas CICT refers to services provided within health facilities for clients who present specifically for HCT services (Van Dyk et al., 2017). Provider Initiated Counselling and Testing (PICT) was mandated to be implemented in all public health facilities and HCT through community-based health services, stand-alone, mobile services, workplace services, home-based and patient guide models.

2.3 NATIONAL GUIDELINES AND MINIMUM STANDARDS

South African HCT Policy guidelines have always been based on international standards, including those developed by the World Health Organization (WHO), UNAIDS, as well as the Centres for Disease Control and Prevention [CDC] (Mohlabane et al., 2015). However, in 2000, the Department of Health (DoH) adopted a brief for HIV and AIDS Policy Guidelines as well as the Minimum Standards for Counselling and Training Guidelines, which outline the selection and training procedures of counsellors. In 2003, the DoH developed guidelines in order to provide continued guidance on HCT implementation. These guidelines constitute the South African National Voluntary Counselling and Testing (VCT) as well as the HIV-Prevention and Care Strategy, and they catered for both the public and private sectors and addressed issues around counselling and testing in the context of HIV/AIDS prevention and care interventions (DoH, 2015).

The National Guidelines and Minimum Standards for VCT were standardised to ensure the effective delivery of quality services countrywide. Furthermore, they provided an approach for the implementation of VCT services in health and non-health facilities and built on the experiences accumulated during the previous utilising documented practices from South Africa and other countries. The conditions under which people undergo HIV counselling and testing must be anchored in an approach that protects their human rights and pays due respect to ethical principles (DoH, 2015). Hence, Van Dyk et al. (2017) cited that lay counsellors may

perform the pre-and post-counselling process and only refer the client if there are cases beyond their scope of practice.

2.3.1 The TASO model of HIV/AIDS counselling services

The Aids Support Organisation (TASO) is one of the largest non-government organisations in Uganda established by people who were directly or indirectly affected by HIV/AIDS. Although the model was regarded as the first African strategy in the fight against HIV/AIDS, it has become a model for benchmarking to community-based organisations in several other countries, including South Africa (Isaacs, 2014). It was founded in 1987 to provide patient support and serve the needs of people living with HIV/AIDS through counselling, social support, medical and nursing care for opportunistic infections. The Aids Support Organisation (TASO) also started an Antiretroviral Therapy Programme in 2004 to contribute to fulfilling its mission that seeks to improve the quality of life of persons, families and communities infected or affected by HIV and AIDS. In 2015, the organisation implemented annual routine viral load monitoring as part of its ART programme (Okoboi et al., 2016).

Okoboi et al. (2016) indicated that through counselling, medical care and material support to clients and their families, TASO had effected change in people's attitudes, knowledge and lifestyles. It has responded effectively to the HIV/AIDS challenges and in changing communities' attitudes towards stigmatisation. Challenging stigma collectively exceeded individual experiences and united people living with HIV in the process of social renegotiation to achieve change. Groups of people living with HIV provided peer support and improved the confidence of their members, which ultimately reduced self-stigma and improved their ability to deal with external stigma when it was encountered (Mwai et al., 2013). The Aids Support Organisation (TASO) has demonstrated a strong capacity to overcome major problems that challenge AIDS care in most places, revealing one's HIV status to relevant others, accepting People Living with HIV and Aids (PLWHA) in the family and community, seeking early treatment, and combining prevention and care (Okoboi et al., 2016). The current predominant counselling models, such as the Egan model in South Africa and the TASO model in Uganda, are seen as less structured to effect any behavioural change compared to the Risk Reduction Model used in many other parts of the world (Van Rooyen, 2013).

2.4 TRAINING AND RECRUITMENT OF HIV/AIDS LAY COUNSELLORS

When HIV/AIDS counselling was introduced in the 1990s, only professional counsellors and people living with HIV performed the service. At present, the national HCT policy guidelines stipulate that all service providers should be trained according to the National Minimum Standards for Counselling and Testing. Lay counsellors are trained before they resume work,

although their training varies in length and content, depending on the training organisation (Mwisongo et al., 2015). After recruiting HIV/AIDS lay counsellors, they are subjected to training as required by the NDoH that certifies them as trained and registered HIV/AIDS lay counsellors. The attitude towards HIV/AIDS and those infected and affected are critically important to the NDoH in selecting, recruiting, training and appointing lay counsellors (Isaacs, 2014).

The NDoH highlighted that lay counsellors need ongoing mentoring and supportive supervision by a nurse in charge and a counselling supervisor, as well as a clear description of duties. There should be clear criteria for selecting lay counsellors and a specific pre-service training curriculum. The lay counsellors' status needs to be consolidated with a career path and a reliable system for payment, time off and benefits. Table 2.1 presents the current status of the role of lay counsellors in hospitals, clinics and in the community (NDoH, 2010).

Although there was a call for lay counsellors to take over the non-clinical tasks to keep the facilities efficiently functioning while nurses are free to get on with nursing, the lay counsellors' limitations must be kept in mind. The NDoH further highlighted that some tasks should not be shifted to them because quality should not be compromised, and lay counsellors should be monitored (NDoH, 2010).

Table 2. 1

The role of lay counsellors and involvement in People Living with HIV and AIDS (PLWHAs) (adapted from NDoH, 2010).

Role of lay counsellors	
Facility level (clinic or hospital)	**Community-level**
General clinic support HIV testing and counselling (HTC) TB education and adherence counselling Support session, treatment literacy, empowerment of PLWHAs ART preparation and adherence counselling	General awareness-raising Outreach with nurses Exploring "out of clinic" tasks

Schneider and Lehmann (2010) indicated that lay counsellor training in South Africa has its roots in a slightly different tradition. It emerged from a professional base of psychology in counselling and testing centres where counsellors are trained in a client-centred approach to

counselling. This approach emphasises the centrality of the counsellor-counselee relationship and aims to develop counsellors who respect the position of those they counsel without imposing their own values. However, in practice, a mixture of client-centred and more directive health advising counselling techniques tend to be used

In a report by the NDoH, peer to peer counselling improved treatment literacy for HIV and had a good impact on patient self-management (empowerment) and adherence. In a study evaluating the standard of care during ART adherence counselling in the Western Cape, South Africa, it was established that while lay counsellors described their counselling approach as having the Egan's client-centred principle, the actual observations of the counselling sessions did not evidence the practice (Dewing et al., 2014). It is recommended that they use the Risk Reduction Counselling Model, which consists of brief, collaborative, patient-centred discussions between a trained lay counsellor and the HIV patient during routine clinical visits. The counsellor uses motivational interviewing techniques to assess the patient's sexual risk behaviour and then negotiates an individually tailored and achievable behavioural change goal with the patient for the next visit in the Risk Reduction Model (Cornman et al., 2011).

However, whilst there have been efforts to train counsellors to use the Risk Reduction Model in the South African context, it has not been widely implemented (Van Rooyen, 2013). In contrast to other types of lay work, counselling is a predominantly facility-based activity in South Africa, while home-based care has become more general in focus. HIV counselling has tended to remain a specialised core function in the health system, and lay counsellors constitute roughly 10% of the total. Lay counsellors express a higher degree of professional efficacy than home-based carers do, although they experience a lack of recognition from other health professionals (Mwai et al., 2013). Their contribution to managing HIV/AIDS is valuable even though the health authorities do not recognise their importance (Mkhabele & Peu, 2016).

Black et al. (2011) indicated that lay counsellors perform Prevention of Mother to Child Transmission services and ART. However, access to these services is contingent on diagnosing HIV infection. This is a role commonly performed by lay counsellors through provider-initiated testing and counselling. Lay counsellors also prepare patients for ART and provide counselling on adherence to ART regimens and infant feeding options.

Employment and remuneration arrangements for lay counsellors in South Africa are characterised by the payment of stipends rather than formal employment contracts. However, lay counsellors express dissatisfaction due to late remuneration of stipends or even non-payment (Mkhabele & Peu, 2016). This arrangement of payment of stipends is probably due to the cadre being relatively recent, with a rapidly evolving scope of work. Moreover, the NDoH

commonly contracts with intermediary non-governmental organisations (NGOs) to manage and pay lay counsellors. Late payment and poor working conditions are reportedly frequent, and ambiguity in employment status limits the counsellor's protection under labour law (Black et al., 2011).

2.5 CHALLENGES FACED BY HIV/AIDS LAY COUNSELLORS

This section intends to place the focus on the different types of psychosocial challenges faced by HIV/AIDS lay counsellors and how these challenges could expose them to physical, mental and emotional exhaustion. A number of challenges facing lay counsellors were reported; they lack nationally recognised training, experience poor recognition, low remuneration and little supervision, lack of social support and poor involvement in decision making (Mwai et al., 2013). Various structural challenges they face were also reported, including lack of a designated counselling space, privacy, recognition and career structure (Peltzer & Davids, 2011).

Van Dyk et al. (2017) pointed out that working with HIV/AIDS care places a serious challenge on counsellors because they often work under difficult circumstances. She highlighted that the nature of HIV infection and AIDS requires not only physical care but also psychological, emotional, and spiritual care. She further indicated that ARTs also brought their own challenges since people need care for longer and assistance with side effects and adherence to the treatment (Van Dyk et al., 2017). Peu et al. (2014) mentioned that lack of resources becomes a serious concern as it contributes towards inadequate and ineffective service delivery. The shortage of resources such as testing kits and treatment affect the management, care and support of HIV/AIDS individuals.

Mwisongo et al. (2015) found that lay counsellors work under stressful working conditions, heavy patient workload and staff shortages. They work an average of 33 hours per week, with a minimum of 7 and a maximum of 70. An average of 20 hours was spent on HIV counselling and testing per week, with a minimum of 2 and a maximum of 40 hours. It was further reported that they counsel an average of 12 clients per day and testing from 9 to 25 clients on a busy day. Many of the lay counsellors also performed other duties apart from HIV counselling such as HIV testing, ART adherence counselling, PMTCT services and coordinating support groups.

Haffejee et al. (2010), in their study evaluating VCT services for mineworkers, established that counselling was also poorly and inconsistently provided in this context. They found that due to lack of training, counsellors failed to pay attention to symptoms of mental illness, although patients testing HIV-positive are highly likely to suffer mental distress. Similarly, Mohlabane et

al. (2015) found that counsellors were inadequately equipped with counselling skills in their training; hence they failed to address the window period in their pre-test counselling.

The emotional dissatisfaction of lay counsellors was also highlighted, and it was exacerbated by a poor work environment, such as inadequate infrastructure, which impedes privacy and confidentiality practices during counselling sessions (Mwisongo et al., 2015). In a study conducted in Cape Town, counsellors reported that they lacked designated counselling space and privacy, as they shared space with other health care workers in the health facility (Christofides & Jewkes, 2010). They further noted that because of inadequate facilities and high patient loads, counselling services were usually rushed to accommodate other services. Lack of privacy poses a serious challenge as it disrupts confidentiality and contributes to making counselling sessions less effective. Lack of confidentiality may discourage the clients from seeking assistance in the health facility in future (Christofides & Jewkes, 2010).

It can be expected that the stressful nature of their work has lay counsellors run the risk of cultivating burnout. The high emotional burdens combined with the high workloads call for immense energy, resilience and endurance. Mwai et al. (2013) highlighted that due to the exceeding demands of HIV/AIDS care and counselling, lay counsellors might not be able to successfully cope or find meaning and benefit in their work situation. Therefore, there is a need for clearly defined roles and responsibilities as well as supervision of lay counsellors. There should also be a coordinated approach to optimise their performance through quality management strategies to help them cope with stress and prevent burnout (Van Dyk et al., 2017). Before I discuss burnout faced by lay counsellors, it is crucial to look at the concepts of stress, depression and compassion fatigue. Although these concepts are not the focus of this study; it is however, important to differentiate between them. These concepts overlap significantly, and this may lead to theoretical confusion. The differences between these concepts have been highlighted below to provide conceptual clarity.

2.5.1 Stress, depression, and compassion fatigue

The literature gives numerous reasons why individuals working in human service professions frequently burn out. Therefore, before discussing the concept of burnout, it is important to differentiate between the following concepts:

2.5.1.1 Stress

Van Dyk et al. (2017) define stress as a “state of physical, mental or emotional tension or strain resulting from adverse or difficult circumstances” (p. 628). It can be classified as acute or chronic. Acute stress is the response to an immediate threat, generally known as the fight

or flight response, and chronic stress is defined as extended, intensive stress. A certain amount of stress is necessary for an individual to function effectively. However, too much stress can have a negative impact on the individual's life, work and relationships (Van Dyk et al., 2017). According to Van Dyk et al. (2017), stress hormones respond to the intensity of the threat and usually normalise once the threat subsides. However, if the stress remains and the individual experiences further difficulties, it is likely to cause severe physical and psychological disturbances.

Stressors can either be external or internal; hence, Renzenbrink (2011) defined occupational stress as the perception of being unable to cope with an internal or external expectation or demand in the workplace. Different people experience stress differently, and it can be either enjoyable or distasteful. The difference between burnout and stress is that burnout can result in stress, but those suffering from stress do not automatically experience burnout.

2.5.1.2 Depression

Bianchi et al. (2013) indicate that there are similarities between depression and burnout; however, they also differ in some aspects. According to the *Diagnostic and Statistical Manual of Mental Disorders* [5th ed., also called the DSM-5] (American Psychiatric Association, 2013), a depressive episode must last at least two weeks. The individual must experience at least four of the following symptoms associated with depression: "changes in sleeping patterns, loss in weight, change in activity levels, lack of energy, feelings of guilt, poor decision making, and recurring thoughts of death and suicide".

The difference between burnout and depression is that burnout is not classified as a mental disorder, whereas depression is categorised as a mental disorder in the DSM-5. According to Vachon (2011) and Van Dyk et al. (2017), burnout is characterised by symptoms such as discontent with one's personal achievement, job disappointment, emotional fatigue, feelings of depersonalisation, negative job attitude, and it is context-related (usually work-related), whereas depression is persistent, interfering with all aspects of the person's life. Burnout and depression show similarities where individuals experiencing burnout may display depressive symptoms (Bianchi et al., 2013).

2.5.1.3 Compassion fatigue

Slocum-Gori et al. (2013) define compassion fatigue as the emotional cost of caring for others, the normal reactions and emotions that occur when a person learns of a traumatising event experienced by a significant other. It has been portrayed as a stress response that emerges suddenly and without warning and includes feelings of powerlessness, helplessness,

vulnerability, feeling of loneliness, absence from supporters and confusion (Potter et al., 2010). Compassion fatigue is a form of secondary traumatic stress that transpires whenever a person discovers or observes a traumatising event that involves a significant other. Like burnout, compassion fatigue was primarily conceptualised as a response to the stress of interpersonal interactions. However, unlike burnout, compassion fatigue was viewed as a response to working with traumatised individuals (Thompson et al., 2014). Van Dyk et al. (2017) indicate that compassion fatigue is also called “vicarious traumatisation” or “secondary traumatisation” (p. 629), which means that an individual is experiencing emotional strain due to his/her exposure to the suffering of others.

The difference between burnout and compassion fatigue is that burnout emerges over a long time of exposure to stress, whereas compassion fatigue has a more rapid onset, and it has a faster recovery if recognised and managed early (Van Dyk et al., 2017). Although compassion fatigue and burnout differ, as indicated above, they are similar in that they both can cause a counsellor to become unable to sustain meaningful relationships (Craig & Sprang, 2010).

2.5.2 Burnout

Plieger et al. (2015) reported that burnout was mentioned first in the 1970s. However, there is still no undisputed definition for this construct. Moreover, there is even no agreement whether burnout can be seen as a distinct syndrome apart from depression. Burnout was initially thought to emerge in socially oriented professions, which require working or helping people. However, the term was broadened and extended to include occupational groups (Plieger et al., 2015). Although there are different conceptualisations of burnout, one characteristic all definitions have in common is the exhaustion of the organism that is caused by work stress. Burnout is a universal phenomenon and affects people working in diverse professions.

Ahola et al. (2014) highlighted that burnout is a process in which the psychological resources of an individual are gradually depleted as a consequence of prolonged stress at work. A mismatch between the expectations and the resources of an individual on the one hand and the job demands, job resources, and possibilities in the job on the other may lead to burnout. They further indicated that high workload, as well as lack of participation and social support at work, increases the risk of burnout (Ahola et al., 2014). Skovholt and Trotter-Mathison (2014) described burnout as “a haemorrhaging of the self” (p. 145).

Thompson et al. (2014) indicated that extensive research led to burnout being defined as a psychological syndrome that helps in response to chronic emotional and interpersonal stress and is characterised by three features: emotional exhaustion, depersonalisation, and feelings of ineffectiveness or lack of personal accomplishment. According to Maslach and Leiter

(2016a), emotional exhaustion can be described as a feeling of being burdened with emotions and worn out by interactions with others. It occurs when a person becomes too emotionally involved and stretches him or herself too far to meet work-related demands.

Depersonalisation is characterised by negative, detached, cynical or even inhumane attitudes and behaviours towards the recipients of services. Individuals having a sense of depersonalisation are at risk of losing passion for their work and compassion for the clients. Reduced personal achievement involves a tendency to feel useless in one's work that may leads to feelings of incompetence (inability to perform one's job effectively) and failure. Emotionally demanding situations lead to individuals experiencing symptoms of physical exhaustion, being helpless and hopeless, discouraged and having low self-esteem and a negative attitude towards interpersonal relationships and life itself (Leiter & Maslach, 2016).

Edelwich and Brodsky (1980) propose four stages to describe the process of burnout as experienced by some individuals, as indicated in Figure 2.1.

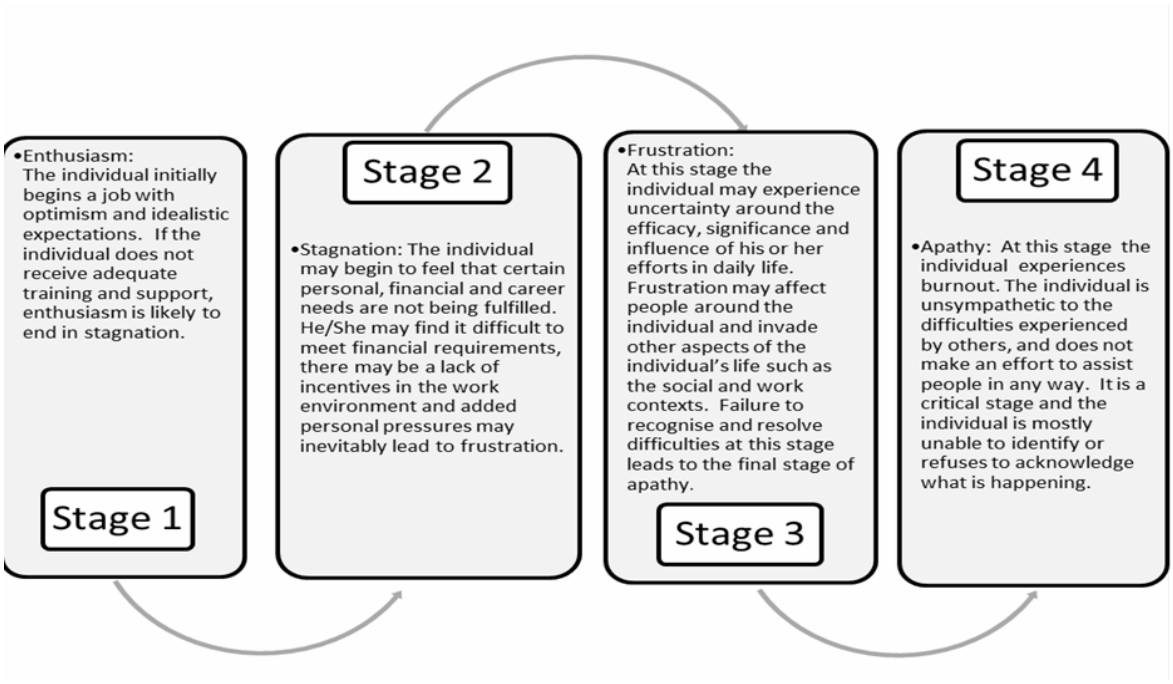

Figure 2. 1. **Stages in the process of burnout (adapted from Edelwich & Brodsky, 1980).**

Emotionally demanding situations tend to be long term and often leads to burnout that manifests as physical, mental and emotional exhaustion. However, understanding how contextual factors may contribute to burnout can help address a continuing challenge for

counsellors: protecting their own well-being while providing care to individuals (Thompson et al., 2014).

According to Cordes and Dougherty (1993), burnout is a complex and multifaceted concept comprising physical, interpersonal, behavioural and attitudinal sections, as shown in Figure 2.2. This figure presents some of the most predominant signs of burnout. Although not all symptoms are experienced by lay counsellors, many are apparent in those suffering from burnout.

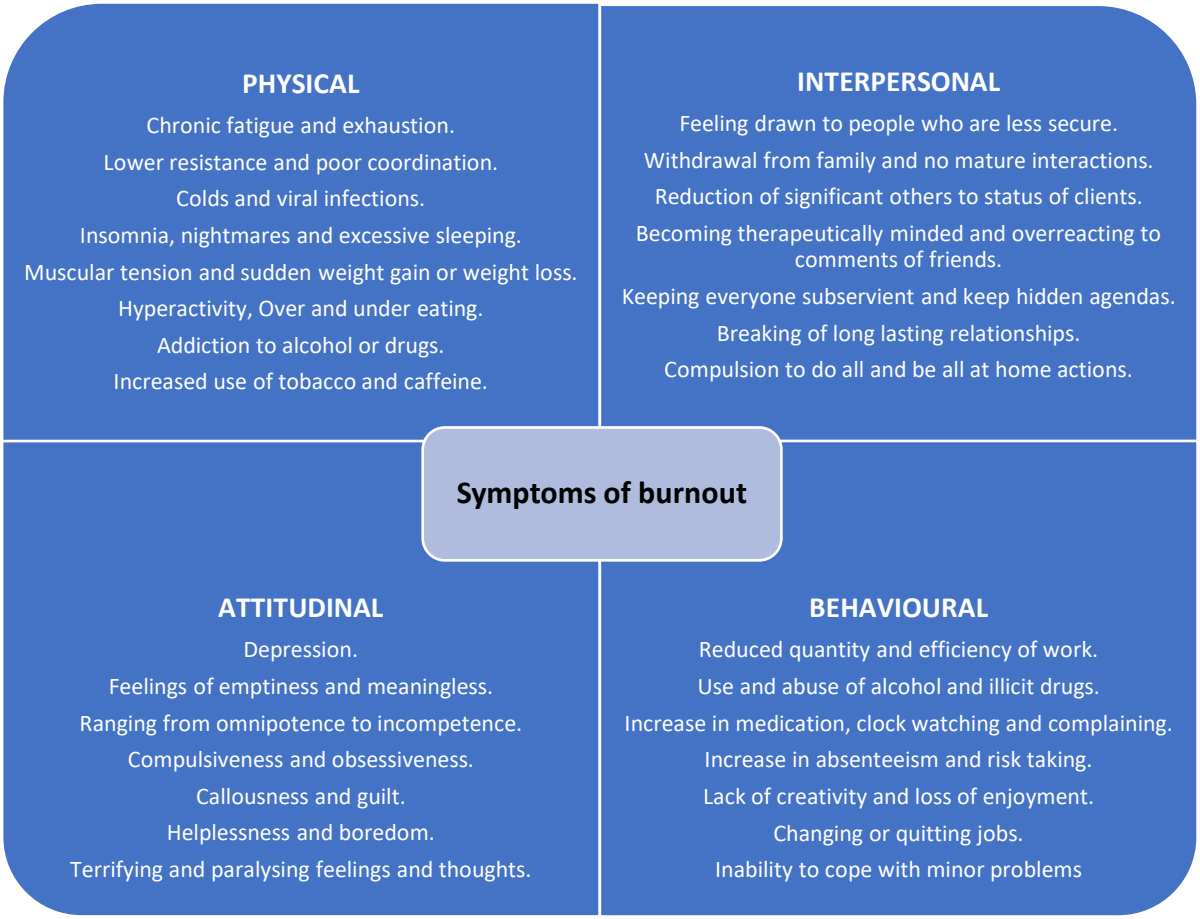

Figure 2. 2. **Symptoms of burnout (adapted from Cordes & Dougherty, 1993).**

According to Murgatroyd (1985), burnout cannot be predicted; therefore, it is not completely foreseeable. Lay counsellors can, in their years of employment, suffer mental, emotional and physical fatigue and lose interest in their work. This leads them to feel they are being undervalued in the workplace resulting in them becoming ineffective and dissatisfied. Early detection of burnout and doing something about it would significantly improve the relationship between individuals and their work. However, early recognition has been proven to be difficult.

Bakker and Costa (2014) indicated that there are different causes of burnout, and they divided the causes into two categories: situational factors and individual factors. Situational factors include job demands and lack of job resources. Job demands are aspects of the job that require sustained effort associated with physiological and psychological costs, such as increased heart rate and fatigue. Such symptoms may set the ground for the experience of burnout because job demands lead employees to feel exhausted and to distance themselves from work psychologically. Role ambiguity, role conflict, role stress, stressful events, workload, and work pressure are among the most important job demands that cause burnout (Alarcon, 2011).

According to Bakker and Costa (2014), both socioeconomic status and personality variables have been analysed as creating a predisposition to suffer from burnout symptoms. Mann (2012) also highlighted that personality characteristics play a role in predicting burnout. He indicated that certain individuals might be more capable of adapting to stressful conditions and returning quickly to their original levels of well-being than others.

2.6 COPING STRATEGIES USED BY LAY COUNSELLORS

2.6.1 Coping

According to Lazarus (1991), coping is defined as a “person’s continuously changing cognitive and behavioural efforts used to manage specific external or internal demands that are considered as being beyond the resources of a person” (p. 112). Individuals must learn to cope with stress in order to continue functioning in an adaptive way. They should employ various types of coping strategies in order to manage the overwhelming feelings associated with burnout. Lazarus and Folkman (1984) examined the process of coping in terms of cognitive appraisal in which the individual and the environment relate in a dynamic, transactional process. They proposed that the two styles involved with an individual's coping are either problem- or emotion-focused.

2.6.1.1 Coping mechanisms

According to Thoits (2011), coping strategies are methods individuals often use in the face of minor or major stress, trauma and natural changes to help manage painful emotions that they experience in life. Individuals employ various types of coping strategies in order to manage the overwhelming feelings associated with burnout. Thompson et al. (2014) found those lay counsellors who employ active or direct coping strategies rather than passive, avoidant, or helpless strategies generally display lower levels of burnout. However, those who employed emotion-oriented strategies or passively concentrated on emotions induced by stressful

circumstances experience a lower perception of personal accomplishment and an overall higher level of burnout (Mann, 2012). For example, maladaptive coping was a significant predictor of burnout, indicating that individuals endorsing substance use, denial, distraction, and self-blame, used coping strategies that were more vulnerable to burnout (Thompson et al., 2014).

Specific passive coping mechanisms such as "keeping stress to oneself" and "going on as if nothing happened" have also been found to be related to higher levels of burnout. When considering gender differences in coping efficacy, studies revealed cognitive coping skills as more effective in women and problem-solving coping skills as more beneficial in assisting men in managing stress and symptoms of burnout. Other findings suggest that those with increased access to coping resources and flexibility in what coping strategies to use given a particular circumstance correlate with lower levels of burnout (Mann, 2012).

Thompson et al. (2014) highlighted that adaptive strategies like self-care and career-sustaining behaviours had been the main constructs examined in the literature. Therefore, it would be crucial to explore the use of both adaptive and maladaptive coping strategies in order to provide a richer picture of the ways in which counsellors respond to the stresses they encounter, not just the positive or beneficial ways. Wherever coping mechanisms are absent, lay counsellors will fall prey to burnout. They should employ suitable strategies because if they become hopeless and discouraged by the negative impact of their work, other colleagues around them will be affected, resulting in them losing their passion and eventually quitting their job.

2.6.2 Support systems for HIV/AIDS lay counsellors.

Van Dyk et al. (2017) highlighted that volunteer workers in the HIV/AIDS field could not cope with the difficulties encountered while doing their job unless they received individual and organisational assistance. They should know where to find assistance and how to care for themselves in order to give quality time to those in their care. Therefore, different support systems to assist lay counsellors are discussed below.

2.6.2.1 Social support

The concept of social support has been conceptualised in various ways by different authors. It has been defined by Cassel (1974) as corrective feedback from significant others guiding a person toward desirable and anticipated consequences. Cobb (1976) defined social support as information leading a person to believe that he/she is cared for, loved, valued and esteemed or is a member of a network of communication and mutual obligations. According to House

(1981), social support is an interpersonal transaction that involves one or more of the following: emotional concern, which involves caring, trust and empathy; instrumental aid, which involves the provision of financial aid and material resources; informational support, which involves help in defining, understanding, and coping with problematic events; and appraisal support which involves information that helps an individual evaluate personal performance.

Singh et al. (2011) define social support as "helpful functions performed by significant others such as family members, friends, co-workers and neighbours, thereby enhancing the individual's physical and psychological well-being" (p. 843). Implicit here is the idea that the individual is part of a reliable alliance in which there is a genuine concern for his/her well-being and in which certain people and resources would be available if needed. Van Dyk et al. (2017) indicate that a social support system relieves stress, loneliness, depression, anxiety and it strengthens the sense of self-worth, trust and life direction.

Peltzer and Davids (2011) found that lay counsellors receive emotional support from the nursing sister in charge when they receive cases beyond their scope of practice. Others reported that they approach various avenues such as dealing with the problem on their own, going to church, sharing with a close friend and peer support activities. When counsellors have other individuals they can rely on, they are psychologically better able to handle job stress as well as the everyday challenges of living. However, decreased social support in the family and work environments is related to an increase in psychological problems. Since counsellors work in a stressful environment on a daily basis, they are just as much in need of relief, support and debriefing as it is offered to clients.

2.6.2.2 Organisational support

According to Van Dyk et al. (2017), lay counsellors must have personal and organisational support for managing stress. Mwisongo et al. (2015) indicated that counsellor support and supervision is important, as it helps to reduce stress and thereby strengthen the quality of counselling procedures. HIV/AIDS lay counsellors are constantly dealing with psychosocial situations of clients on a daily basis, and it is therefore up to them to determine their strengths and weaknesses and to accept that they are only human. HIV/AIDS lay counsellors must then realise they are unable to be a solution to every problem the client encounters (UNAIDS, 2013); hence, they need supervision and mentoring by their seniors.

Mwisongo et al. (2015) also found that the majority of lay counsellors in their study were comfortable with the amount of supervision they received. However, a number of other studies indicated a lack of supervision and mentoring, lack of commitment and cooperation (Peltzer & Davids, 2011). When employees are well mentored and supervised, they become committed

to their job; they are willing to put in the effort to make it a success. It is more likely that they will work together with others, and a growing sense of loyalty and trust develops eventually with commitment and cooperation.

2.6.2.3 Support groups and staff clinic

Support groups offer individuals interactions with fellow people who may have had similar experiences and understand each other. Dageid (2014) indicated that getting together in a group with individuals having the same problems has members gaining knowledge from one another while sharing their emotions, individual incidents, fears and troubles. The main goal of a support group is to improve the individual's decision-making capacity and coping rather than to change the participant's behaviour as in group therapy. Being part of a support group could reduce isolation, promote acceptance, improve self-confidence, encourage new friendships and networks, and assist in disclosure

Kave et al. (2019) emphasised that support groups are an advocacy and networking tool for individuals to make their health-related needs, challenges, and concerns known, thereby maintaining a close relationship with their fellow support group members and their facilitators. Support groups provide valuable social and emotional support and may well improve coping, well-being and mental health. It is therefore imperative for lay counsellors to attend support groups in order to deal with their problems effectively. The NDoH highlighted that many health care workers already experience burnout, whereas others are HIV infected. They often struggle with stigma, fail to access treatment earlier and die of AIDS. Hence, staff clinics' support systems were introduced to combat staff burnout and avert deaths due to HIV/AIDS as well as to achieve essential widespread access to ART. Lay counsellors should be encouraged to attend or visit the staff clinics in order to receive convenient, confidential and holistic care (NDoH, 2010).

2.6.2.4 Spirituality and religion

Delgado-Guay (2014) defined spirituality as a way individuals seek and express meaning and purpose and how they experience their connectedness to the moment, self, others, nature, and the significant or sacred. They also mentioned religiosity as a distinct construct from spirituality. Spirituality can be seen as a dimension of personhood, an important element that is connected to seeking meaning, purpose, and divine existence in life, whereas religion is a construct of human making that enables the conceptualisation and expression of spirituality.

The individual's larger community can also be thought of as a potential support system. People belong to many organisations in the communities (neighbourhood, religious, and extended

family) that can identify those who require support and channel resources to them. Having a spiritual connection or religious affiliation offers a wonderful source of support when an individual is facing challenges. Spirituality can offer a sense of hope and purpose in counsellors' lives and help them find greater strength and resilience. Counsellors can also connect with other individuals with similar beliefs (Taylor et al., 2015).

2.6.2.5 Relaxation training, healthy lifestyle and biofeedback

According to Roberts (1985), the individual's ability to relax is influenced by activity in the hormone system and the autonomic nervous system, neither of which is normally under direct voluntary control. Kumar and Jim (2010) indicated that individuals could use relaxation methods to handle tension and prevent burnout. Relaxation and leisure is another approach that individuals use to cope with stress. Biofeedback was introduced to control stress; however, it did not prove to be the cure-all as it was expected (Roberts, 1985).

Biofeedback is a technique used to help people whose internal biological responses have surged out of control. Biofeedback devices (in the form of a watch one wears on the arm, such as a "fitbit") measure a variety of physical responses such as muscle tone, perspiration, skin temperature and brain waves. The device then gives the individual immediate information, or feedback, about subtle changes in these responses, changes of which the individual is not usually aware. With this feedback, subjects can learn relaxation techniques and see how they affect their physical responses (Roberts, 1985). It may be helpful to add biofeedback as one component of a multidimensional therapy package through which people learn to relax in the face of stress. Health care workers in the HIV/AIDS field should be encouraged to live a healthy lifestyle in order to manage their well-being. According to Weaver (2010), health means a state of physical, mental and social well-being, which means that one is physically, mentally and spiritually well. Health is an equilibrium that an individual has established within himself, family, community and environment. It is a state that allows the individual to adequately cope with the daily life by having a healthy way of life that is essential to ward off the development of burnout.

2.6.3 Resilience

Ledesma (2014) defined resilience as the ability to bounce back from adversity, frustration and misfortune. According to Masten (2014), resilience refers to the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability or development. However, Grant and Kinman (2013) believe that resilience is not just resistance to adversity but the ability to recover from adversity, react appropriately as well as the ability to grow and develop under difficult conditions. He further mentioned that when defining

resilience, it is important to distinguish it from related concepts such as invulnerability, stress resistance adaptive behaviours and mental toughness. According to Truffino (2010), invulnerability refers to absolute resistance to the negative impact of an adverse situation. The concept has been often linked to resilience; however, some authors believe that resilience is not necessarily absolute resilience but rather recovery. Stress resistance refers to recovery after an adverse event, whereas resilience refers to better skills and growth after the trauma. Adaptive behaviours are necessary for facing emotional, cognitive and social situations but are not enough in defining resilience. The last concept that is closely related to resilience is mental toughness, and it refers to any set of positive attributes that helps a person cope with difficult situations (Truffino, 2010).

McCann et al. (2013) emphasised that the negative stress outcome can impact the individual's ability to care effectively for others. It is therefore important to adopt a preventative approach. They indicated that developing and fostering resilient environments is emerging as a way to reduce negative and increase positive outcomes of stress in health professionals. They further identified studies that aimed at ascertaining the characteristics associated with resilience in counsellors. They found that self-compassion is one of the characteristics that is associated with resilience in counsellors. Self-compassion involves understanding one's own suffering, experiencing feelings of caring, kindness, non-judgement towards oneself, and recognising that struggles and triumphs are part of ordinary human experiences (McCann et al., 2013).

Patsiopoulos and Buchanan (2011) investigated how counsellors practice self-compassion, and they identified three main themes. The first one is counsellor stance in a session that includes acceptance, not knowing, attending compassionately to inner dialogue, mindfulness of present experience and being genuine. Second, the workplace relational way of being includes participating in a compassionate and caring work team as well as speaking the truth to self and others. The last one is finding a balance through self-care strategies. Their participants also reported a number of benefits in relation to the practice of self-compassion. These benefits include an improved overall sense of well-being, job satisfaction, creativity, balance, openness, groundedness and a spiritual sense of connectedness. Furthermore, it was reported that self-compassion helps in lowering unrealistic expectations, developing more effective boundaries, finding balance between client needs and counsellor needs, self-correct when necessary and engaging in more proactive, preventative self-care (Patsiopoulos & Buchanan, 2011).

2.7 CONCLUSION

When considering the existing research on lay counsellors, it becomes clear that these counsellors play an important role in HCT provision in South Africa. However, their role is challenged by a lack of standardised training in counselling and testing designated working space to maintain privacy and confidentiality as well as specific counselling skills for marginal groups. There is evidence that lay counsellors are overburdened with HCT work due to staff shortages (Mwisongo et al., 2015). The researchers also highlighted that poor remuneration, recognition by fellow permanently positioned health workers, low morale, and motivation affected lay counsellors' performance (Mwisongo et al., 2015).

It is important for counsellors to be supplied with enough space allowing them privacy and confidentiality to do their work effectively.

Although early detection of burnout is difficult, it would be crucial to look out for role ambiguity, role conflict, role stress, stressful events, workload, and work pressure since they are among the most important job demands that cause burnout in lay counsellors. Therefore, it would also be crucial to explore the coping strategies of lay counsellors because when coping mechanisms are absent, lay counsellors will fall prey to burnout.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

This chapter focuses on the theoretical framework of the research giving special attention to burnout and resilience amongst health care workers in the HIV/AIDS field. Leiter et al. (2014) indicated that recent work on burnout has begun to develop new theoretical contexts that more clearly integrate both individual and situational factors, rather than seeing them in separate standings. Since the beginning of the 21st century, psychologists have expanded their understanding of burnout by extending their attention to burnout's positive antithesis (e.g. engagement, resilience, thriving) rather than focusing only on the negative ones. It is evident that although some professionals reported being burnt out and quitting their positions, others continue to do their jobs. The question of how these professionals who experience burnout survive, manage and thrive despite their exhaustion and what resources enable them to do so, has not been given much attention in the literature.

Therefore, to understand the process of moving from burnout to resilience amongst health care workers, several factors that should be taken into consideration have been emphasised. There is a general agreement that engagement with work, job crafting, and effective coping represent a productive and fulfilling state (Leiter & Bakker, 2010).

3.2 BURNOUT

There has been a great interest in the study of burnout over the past thirty years. The term burnout has been used in different ways, and it has many definitions. First, I will give a brief history of the development of the concept of burnout and thereafter provide different definitions and models of burnout.

3.2.1 Introduction: A brief history of burnout

The earliest publications about burnout were made by Freudenberger and Maslach in the mid-1970s (Maslach & Jackson, 1981). The initial contribution was to describe the phenomenon, give it a name and demonstrate that it was not an unusual response. Furthermore, it was recognised as an occupational threat for various people-oriented professions such as human services, education and health care. Hence, their research focused particularly on the experience of people working in human services and health care occupations. The main aim of their study was to provide support and services to those who experienced emotional and interpersonal stressors (Maslach & Leiter, 2016b). During this early phase of studying the

phenomenon of burnout, many descriptions were based on observations, interviews, case studies and personal experience. There was a scarcity of research looking into the features, triggers and experiences of burnout. However, it was referred to in popular psychology.

The initial researchers originated from social and clinical psychology, and relevant ideas were established from these fields. The social-psychological viewpoint emphasises concepts involving interpersonal relationships. These include detached concern, dehumanisation in self-defence and an attribution process. The concepts of motivation and emotion, particularly coping with emotions, were also included. The clinical viewpoint also focused on motivation and emotions but then outlined these in terms of psychological disorders (e.g. depression). The industrial organisational psychology viewpoint emphasised work attitudes and behaviours. During this point around the 1970s, burnout was conceptualised as a form of job stress. However, the focus was on the organisational context rather than on the physical characteristics of the stress experienced by an individual.

The period after the 1980s experienced a growing emphasis on burnout in the helping professions. It is, however, fascinating to be aware that in this period, the early concepts were derived from what they observed in people-oriented human services but expanded their observations to other occupations such as police officers, correctional officers, and librarians. During this period, the emphasis was primarily on the working environment and not so much on different kinds of the phenomenon that the researcher is trying to measure in some way (Maslach & Jackson, 1984). This focus should not be surprising because scholars became interested in positive psychology during that time with its concepts of fulfilment experienced at work, tensions encountered on the job and relations with colleagues and equals. They were also interested in concepts designed to bring focus and meaning to work. (Maslach & Leiter, 2016b). Whereas the 1980s experienced an expansion of the explanation for burnout and a selective emphasis on occupations aiming at helping people, the 1990s experienced continuous research and the incorporation of other vocations or careers, which was called the expansion phase. In this period, there developed an increasing insight that burnout is not found only in people working in the helping professions, but that it also exists in a broader range of professions. Hence, an increased influence of occupational and organisational psychology was experienced during this phase, focusing on how approaches to work and performance at work can be influenced. The emphasis on the environment of the organisation increased, and there was less prominence given to the psychological features of tension which led to viewing burnout as a type of job stress.

Maslach and Leiter (2016b) indicated that after the year 2000, they noticed a growth in positive psychology as an opposite to burnout, and the focus was on work fulfilment and commitment.

Exciting developments led to the identification of engagement as the opposite of burnout, and that included the development of measuring instruments for burnout.

Since the characteristics of burnout became clearly identified, the following stage was to develop a measuring instrument that could evaluate them. During this time, psychometric research was conducted to develop a method that will measure the burnout experience based on these exploratory works. Several measures were proposed based on different assumptions about burnout. However, many of them depended on the face validity of the measurement items. The first burnout measure developed from the psychometric research was the Maslach Burnout Inventory (MBI). The MBI was designed specifically to assess the three dimensions of the burnout experience that developed from the earlier qualitative research. These basic dimensions are the following: First, exhaustion which is also described as exhaustion, loss of energy, depletion, debilitation and fatigue. The second dimension refers to feelings of cynicism and detachment from the job and is also described as depersonalisation, negative attitudes, detached concern, irritability, loss of idealism, and withdrawal. The third dimension involves a sense of professional inefficacy, lack of accomplishment, reduced productivity or capability, low morale, and an inability to cope (Maslach & Leiter, 2016a).

The MBI has been translated and validated in many languages, and it has been considered the standard tool for research in this field. Further developments in the conceptualisation of burnout appeared after the original release of the MBI. The scale was used by researchers, adapted or unchanged, with occupational groups other than human service providers (Maslach & Jackson, 1984). Due to the different conceptualisations of burnout, changes and modification of burnout measures have been made over the years. For example, the MBI-Health Services Survey (MBI-HSS) was designed to measure burnout as an occupational problem for people providing human and health care services. Individuals working in educational situations developed a second version for use, and they named it the MBI-Educators Survey (MBI-ES). The labels for the three dimensions in both the HSS and ES forms reflected the focus on occupations where workers networked broadly with other people. They interacted extensively with people such as students, clients and patients, indicating the emotional exhaustion, depersonalisation, and reduced personal accomplishment dimensions. There was an increasing interest in burnout within occupations that were not clearly people-oriented. This led to the development of a third, general version of the MBI, which was named the MBI-General Survey (MBI-GS). At this point, the three components of the burnout construct were conceptualised in slightly broader terms focusing on the job and not on the personal relationships that may be part of that job. Therefore, the MBI-GS assesses the same three dimensions as the original measure, using slightly revised items, and maintains a

consistent factor structure across a variety of occupations. Maslach and Leiter (2016b) emphasised that the difference between measures that assess several dimensions of burnout and those that assess the sole dimension of exhaustion still continues.

Bakker and Costa (2014) found that employees who are at risk of burnout are those who are chronically exhausted and hold a negative, cynical attitude towards work. The employees also show impaired job performance and may face serious health problems over the course of time (Bakker et al., 2014). Previous burnout research suggests that the syndrome has structural causes in the work environment, particularly high job demands and low job resources (Alarcon, 2011). Apparently, work engagement and burnout symptoms respectively promote or hinder one's performance, organisational commitment and well-being (Upadyaya et al., 2016).

Other related factors that researchers emphasised are, for example, individual factors. According to Swider and Zimmerman (2010), individual factors such as neuroticism and perfectionism play a significant role in the development of burnout. These characteristics influence individuals to cope incorrectly with their high job demands in the workplace. Neuroticism is defined as a tendency towards anxiety, hostility, depression, self-consciousness, vulnerability and other negative feelings; neurotic individuals are emotionally unstable, respond worse to stressors and are more prone to psychological distress. Perfectionism is characterised by an individual striving for flawlessness and setting high-performance standards. In its maladaptive form, it drives an individual to attempt to achieve unrealistic goals, often leading to depression. Perfectionism appears to be associated with a Type-A behaviour consisting of competition, self-criticism, hostility, impatience, an excessive need for control, which eventually leads to burnout. They further indicated that individuals who are burnt out cope with stressful events in a passive and defensive way. In contrast, individuals who practice active and confrontive coping are associated with less burnout. Confrontive coping is related to the dimension of efficacy which refers to the ability of an individual to produce the desired outcome. Therefore, to comprehend the concept of burnout, we also need to know how other scholars defined the term – the discussion follows in the next section.

3.2.2 Defining burnout

Freudenberger (1974), a famous innovator of burnout research, described burnout as a condition of extreme fatigue caused by continuing tension at work that has not been managed effectively. It is caused by being overly committed and working too passionately without taking one's own needs into consideration. The keywords in this definition of burnout include extreme fatigue (exhaustion) and commitment.

According to Freudenberger and Richelson (1980), burnout is “a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward” (p. 13).

Beemsterboer and Baum (1984) defined burnout as a progressive loss of idealism, energy and purpose usually experienced by people in the helping professions because of the nature of their work. Malakh-Pines et al. (1988) define burnout as “a state of physical, emotional and mental exhaustion caused by a long-term involvement in situations that are emotionally demanding” (p. 9). They further indicated that burnout is the result of repeated emotional pressure associated with an intense involvement with people over a long period of time. These intense involvements are particularly prevalent in health and social service occupations where professionals are employed to take care of other individuals’ psychological, social and physical problems.

Tracy (2000) defined burnout as general exhaustion from the pressures of work because of a complicated interaction between personal and employment features. It occurs when you feel emotionally drained, overwhelmed and unable to meet constant demands.

In addition to this, Halbesleben and Buckley (2004) considered burnout as a form of emotional, mental and physical work tension resulting from a significant build-up of work-related stress. Furthermore, according to Lee et al. (2010), the term “burnout” refers to a process in which everyday stresses and anxieties that are not addressed gradually overpower the caregiver. The stressors undermine the caregiver’s mental and physical health so that eventually, caregiving and personal relationships become a challenge.

The most commonly used definition is that of Maslach and Jackson (1981): “Burnout is a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind. A key aspect of the burnout syndrome is increased feelings of emotional exhaustion” (p. 99). They continue to highlight another two characteristics following exhaustion, namely negative and pessimistic attitudes towards the people they work with and the tendency to be displeased with their own achievements with regard to their work with clients. In a later article Maslach and Leiter (2016a) define burnout as “a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job” (p. 103). All the definitions are followed by a brief description of the three key aspects (exhaustion, depersonalisation and reduced personal accomplishment). They further emphasise that the three-dimensional model emphasises that stress takes place in a social environment and encompasses the individual’s conception of him or herself and of other people. That raised an argument on whether burnout involves only that which is highlighted,

or it can be explained through additional factors. There was also a belief during the 1980s that burnout occurs only in workers from the human services.

However, Maslach emphasised that burnout is not necessarily restricted to the human services professions, but it appears to be specific to the work domain, in the sense that its origins lie in the job situation. She pointed out that the phenomenon might be found in occupations other than human services, and it is her work that greatly influenced contemporary thinking on burnout (Maslach & Schaufeli, 2017).

Manzano-García and Ayala-Calvo (2013) commented that researchers have never defined the term burnout unanimously. Terms such as "burned out syndrome", "burnout due to work pressure", "professional wearing out syndrome", "professional exhaustion syndrome", and "psychological fatigue", among others, have all been used to describe the same concept. They indicated that initially, professionals focused particularly on the practical aspect, ignoring the conceptualisation of the term, and that made it difficult to establish a more precise definition thereof. The definitions mentioned above differ in terms of scope and precision; however, each contributed to the understanding of burnout in a unique way.

Therefore, a conclusion drawn from the historical review of the burnout concept is that the definitions are corresponding rather than disagreeing; and can be divided into two groups depending on whether the phenomenon is considered as a state or as a process (Manzano-García & Ayala-Calvo, 2013). Maslach and Jackson (1981) provide a view of burnout as a state which indicates a three-dimensional syndrome characterised by emotional exhaustion, depersonalisation, and reduced personal accomplishment, whereas Cherniss (1980) put forward the view of burnout as a process which is discussed below (see section 3.2.3.1).

Despite many diverse perspectives or views on a definitional level, the different definitions discussed share certain similarities regarding the key features of the phenomenon. First, a predominance of dispirited symptoms such as mental exhaustion, fatigue and depression. Second, the accent is on mental and behavioural symptoms rather than on physical symptoms, although some authors mention atypical physical complaints as well. Third, burnout symptoms are work-related. Fourth, the symptoms manifest themselves in "normal" persons who did not suffer from psychopathology before. Fifth, decreased effectiveness and work performance occur because of negative attitudes and behaviours (Maslach & Schaufeli, 2017).

The definition that is used for this study is the tripartite definition by Maslach (1982) that is accepted across the literature as the most complete compared to others. This definition describes burnout as a psychological syndrome of emotional, physical and mental exhaustion,

depersonalisation and reduced personal achievement that can occur among individuals who work in the helping professions. This definition is relevant to this study as it highlights burnout as a condition of emotional and physical fatigue, known to cause the absence of commitment to the work, loss of self-caring and self-depreciation – these are signs that are usually experienced by health care professionals suffering from burnout and is therefore also applicable to HIV/AIDS lay counsellors.

3.2.3 Models of burnout

Researchers proposed different theoretical models that attempt to describe the burnout phenomenon. Initially, many of these models were based on the idea that the syndrome is sequential and on the understanding that burnout is a response to chronic work stress. The main theories in such models originate from social psychology and industrial psychology (Manzano-García & Ayala-Calvo, 2013). Models differ about the sequence of stages in the development of burnout as in the following examples:

Maslach (1982) focused on the relationship between the three dimensions of burnout, which were often described in sequential stages. The model highlights different sequential progression in which the occurrence of one dimension advances the development of the other. According to this model, exhaustion is assumed to develop first in response to work demands and overload; the second stage is that of depersonalisation, as people try to cope by withdrawal and negative, cynical reactions follow; if this continues, the third stage of reduced personal accomplishment follows, when people begin to experience inefficacy and failure (Maslach, 1982; Maslach & Leiter, 2016a).

Another approach, also with the view of stages that follow from one to the next, was the phase model, in which the three burnout dimensions were described in the reverse order. The dimensions were divided into high and low scores, and all the possible groupings of the three dimensions resulted in eight phases of burnout. In this model, depersonalisation (cynicism) is the first phase of burnout, followed by inefficacy and finally by exhaustion (Golembiewski & Munzenrider, 1988).

Some of the models described below describe sequential stages, and others do not. The discussions below give various views on burnout. First, some models that mainly describe imbalances between job demands and individuals' resources are discussed. The model used for this study is then discussed in more detail.

3.2.3.1 The transactional model of burnout

Cherniss (1980) developed the transactional model of burnout based on annotations made of specialists in mental health services and some of the primary helping professions. She defined burnout as a process in which professionals who were dedicated before withdrawing from their work in reaction to work tension and the individual stress experienced while working. The model proposes a first stage of an imbalance between work demands and individual resources (job stressors), a second stage of an emotional response of exhaustion and anxiety (individual strain), and a third stage of changes in attitudes and behaviour, such as greater cynicism (defensive coping) (Cherniss, 1980).

3.2.3.2 The Areas of Work life (AW) Model

In 1997, Leiter and Maslach formulated a model that focuses on the degree of match, or mismatch, between the person and six domains of his/her job environment. One new aspect of this approach is that the mismatch focus is on the enduring working relationship people have with their job. Mismatches arise when the process of establishing a psychological contract leaves critical issues unresolved or when the working relationship changes to something that a worker finds unacceptable. Second, whereas prior models of job-person fit predict that such fit produces certain outcomes, this new model hypothesises that burnout is an important mediator of this causal link. In other words, the mismatches lead to burnout, which in turn leads to various outcomes (Leiter & Maslach, 1999).

Leiter and Maslach (1999) propounded the Areas of Work life (AW) Model as one of the well-known theories of burnout. The model is also known as the Person-Within Context Theory. The essential characteristic of the theory is the focus on the interplay between the individual and his/her environment. It is different from the Imbalance Model, which focuses on work tensions resulting from individual-work disparities and finds the causes of these imbalances. Leiter and Maslach (1999) argued that burnout occurs when there is a disparity between the individual and his/her surroundings. According to their theory, the person relates to six aspects of the work, which consist of workload, control, reward, community, fairness, and values. They argue that stress and burnout can occur in any sphere, commencing with stress and, after that, burnout. They concur that imbalances in the six areas indicate the intensity of burnout that the person suffers from and how his/her work performance and welfare is influenced. It then brings about that that the higher the mismatch between the person and the six areas, the greater the burnout experienced and vice versa. The six domains by Maslach and Leiter are described in Table 3.1.

Table 3. 1

Six domains of burnout (adapted from Leiter & Maslach, 1999).

Dimension	Description
1. Workload	A mismatch in workload is generally found as excessive overload, where too many demands exhaust an individual's energy to the extent that recovery becomes impossible. A workload mismatch may also result from the wrong kind of work, and it adds to burnout by reducing the ability of workers to take on the job's requirements. Generally, workload is mostly associated with the exhaustion part of burnout.
2. Control	A mismatch in control often indicates that individuals have insufficient control over the resources that are required to do their work; lack of control when employees do not have resources available to generate valuable results. Lack of control is generally related to the reduced personal accomplishment aspect of burnout.
3. Reward	A mismatch that involves lack of social rewards, such as when an individual's hard work is ignored and not appreciated by others, for example, insufficient financial rewards, people not receiving the benefits suitable to their achievements. Lack of reward is closely linked to feelings of inefficacy.
4. Community	A mismatch occurs when people lose a sense of good relationship with others in the workplace. People succeed in community and function best when they share comfort and humour with people they like and respect. However, continuing and unresolved conflict with others in the community results in constant feelings of frustration, hostility and reduces the chances of social support.
5. Fairness	A mismatch between the person and the job occurs when an individual does not receive fairness in the workplace. The concept refers to the degree to which workers evaluate the management to be impartial and just in their decisions. Unfairness occurs when there is inequality of workload or pay and when assessments and promotions are handled inappropriately. Unfairness is generally associated with a deep sense of cynicism about the workplace.
6. Values	Values involve principles and encouragements that primarily attract people to their work and therefore connect the worker with his/her place of work. A mismatch occurs when there is a conflict between values. In some instances,

Dimension	Description
	people might feel coerced by their duty to practice things that are unethical and not in accord with their own values.

Exploring these domains would support the viewpoint that burnout occurs in these areas. The model seems to be applicable in different situations. The theory also recognises that there can be individual variances in the connection between the individual and his/her milieu. There also seems to be experiential confirmation for the theory in both cross-sectional and longitudinal studies (Schaufeli et al., 2008). Research on this model began to clarify the relationship between these six areas, as well as their connectedness to the three dimensions of burnout. The mismatches in these six critical areas of organisational life provide a conceptual framework for the predicaments that interrupt the relationships that individuals develop with their work. This approach emphasises the importance of observing an individual in a particular context in terms of his/her fit with the key domains of work life.

More recently, Maslach and Leiter (2016b) propounded burnout models that have been based on theories about job stress and the notion of imbalances leading to strain. Examples of these models are discussed below, namely the Conservation of Resources Model, the Demand-Control Model, the Effort-Reward Imbalance Model and the Job Demand Resource Model. The fundamental assumption of these models is that an individual develops job strain when the job demands exceed the coping resources that are required to deal with them (Maslach & Leiter, 2016b).

3.2.3.3 The Conservation of Resources (COR) Model

Hobfoll developed the Conservation of Resources (COR) Model in 1989. This is one of the principal theories in burnout studies (Hobfoll, 1989). The COR theory was reinforced when research interest shifted towards work engagement and vigour as the positive counterparts of burnout and away from deficit and pathology models. The theory rests firstly on the basic principle that individuals strive to obtain, retain, foster, and protect resources. The model follows a basic motivational theory assuming that burnout arises because of persistent threats to available resources (Hobfoll & Freedy, 2017). The basic principle of this model is that when individuals perceive that the resources of their values are threatened, they strive to maintain those resources. The loss of resources or even the impending loss of resources may aggravate burnout. Following this principle, the process of resource loss, gain, and protection is seen as significant in explaining burnout and work engagement.

Resources are those personal energies and characteristics, objects and conditions valued by individuals or that serve as means for attaining other objects, personal characteristics, conditions or energies. These resources include social support, job enhancement opportunities, degree of participation in decision making, being psychologically well or having an optimistic personality, level of autonomy, and established behaviour outcome contingencies (Chirico, 2016). This was confirmed in a study by Mwai and colleagues where they found that in lay counsellors, the following contribute to burnout: No nationally recognised training, poor recognition, poor communication, low remuneration and supervision, lack of social support and poor involvement in decision making (Mwai et al., 2013).

According to Chirico (2016), the central element of burnout and work engagement is the affective component resulting from processes that centre on peoples' basic energetic resources, more specifically emotional toughness, reasoning and physical strength. Burnout viewed this way is the end state of a long-term process of resource loss that gradually develops over time, depleting energetic resources. The idea was also emphasised by Alarcon et al. (2011), who stated that burnout is a psychological phenomenon of prolonged exhaustion and disinterest.

Therefore, we can see that the main view of the COR theory is that burnout is the loss of resources over time. Resources lost may be physical health, time, self-esteem or social support. The loss of resources leads to maladaptive coping strategies that further increase resource loss, causing individuals to "burnout". The opposite is engagement, which is conceptualised as a positive, persistent and affective-motivational state of fulfilment in individuals who are reacting to challenging circumstances. The engaged individual creates more resources in the environment and may invest in the resources in social support, physical fitness and may experience an increase in positive emotions. The abundance of these resources leads to increased productive coping (Alarcon et al., 2011).

3.2.3.4 The Demand-Control Model (DCM)

The Demand-Control Model (DCM) is also known as the Job Strain Model, and it was developed by Karasek (1979). The main assumption of the Job Strain Model is that a combination of a situation of high demands, low control and low social support is viewed as stressful for a worker (Chirico, 2016). The model states that strain will be higher in jobs characterised by the combination of high job demands, low job control, and low social support – such jobs are called high strain jobs. This model highlights that those who experience high demands at work with little control are more likely than other employees to feel stressed. According to this model, those who experience low demands with a high amount of control

should be those who are the least stressed. For example, Mwisongo et al. (2015) found that HIV/AIDS lay counsellors work under stressful working conditions, heavy patient workload and staff shortages which they cannot control. These researchers indicated that many lay counsellors also performed other duties apart from HIV counselling, which led to a tremendous strain in their lives.

In contrast, task enjoyment, learning and personal growth will be highest in jobs characterised by the combination of high job demands and high job control. Although such occupations are intensively challenging, employees with good decision making can use all their available skills, which enable them to cope with the high demands and solve problems. The model attained a prominent position in the literature; however, its experiential evidence is diverse (Bakker & Demerouti, 2014). The effects of job demand and job control on employee well-being have been found in research done by De Lange et al. (2003) as well as Van der Doef and Maes (1999). Many studies failed to produce the interaction effects proposed by the DCM, and therefore, the model was not applied in this study due to the lack of empirical evidence in the research literature.

3.2.3.5 The Effort-Reward Imbalance Model (ERI)

This model emphasises the reward rather than the control structure of work. The ERI Model assumes that job stress is the result of an imbalance between effort (job demands and motivation to meet these demands) and reward (in terms of financial reward, promotions). The basic assumption is that a lack of reciprocity between effort and reward (for example, high effort and low reward conditions) will lead to stress reactions. Mkhabele and Peu (2016) found that counsellors' express dissatisfaction due to late remuneration or even non-payment of stipends, as well as poor working conditions and ambiguity in employment status. This job insecurity leads to stress, increased levels of burnout and decreased levels of work engagement in lay counsellors and other employees.

Furthermore, even when employees are working very hard but have a demanding and unstable job without any promotions, there will be a stressful imbalance. The combination of high effort and low reward at work was found to be a high-risk factor for burnout (Chirico, 2016). The ERI introduces a personal component in the model, namely overcommitment. Overcommitment is defined as behaviours, attitudes, and emotions reflecting excessive striving in combination with a strong desire for approval. According to the ERI model, overcommitment may be related to an individual's need for approval and an inability to withdraw from work. This can cause too many attempts of not being rewarded, which will hamper feelings of wellness in an individual. A meta-analysis of high-quality prospective

studies of workers' perception of their work environment provides strong and dependable evidence that combinations of high demands and low decision latitude, and high efforts and low rewards, are prospective risk factors for common mental health disorders (Stansfeld & Candy, 2006).

3.2.3.6 The Job Demand Resource Model (JDR)

It was imperative to discuss the developmental models of the demands and resources imbalances above as they are some of the models that have emerged recently. The models are constructed on the theories about job stress and the idea of imbalance that leads to job strain. The models were discussed to bring a broader overview of existing models and even some insights that can be of value. However, these models focus on one side because they are either positioned within the job stress tradition or motivational tradition. Hence, the models are not applied in this study since they usually do not address both these processes that actually occur concurrently. The nature of jobs is currently changing, but the above-mentioned existing models do not consider this volatility. These models limited their theoretical progress and practical usefulness because they were generalised and oversimplified (Demerouti & Bakker, 2011). However, the theoretical basis of these models and their associated weaknesses provided a platform for the development of the new model, which is the Job Demand Resource Model (JDR). Therefore, the JDR Model is applicable to this study because it does not restrict itself to specific job demands or resources.

The JDR Model is used in this study because it is recognised by many researchers (such as Bakker et al., 2010; Clausen et al., 2012; Demerouti & Bakker, 2011; Nahrgang et al., 2011) as one of the leading job stress models. It is a principal model which combines the positive and negative outcomes of employee health and well-being into one comprehensive model. The model focuses on the idea that burnout develops when individuals experience continuous job demands and have inadequate resources to address them. The ERI Model discussed earlier assumes that employee health and well-being result from a balance between positive (resources) and negative (demands) job characteristics. The JDR Model differs slightly from this view because it does not restrict itself to specific job demands or resources. It assumes that any demand and any resource may affect employee health and well-being. Hence, its scope is more comprehensive than the other models as it includes all job demands and job resources. The model is also more flexible and can be used in different work settings. The model is significant to this study because it also represents a way of thinking about how job characteristics and personal characteristics may influence employee health, well-being and motivation (Schaufeli & Taris, 2014). This is crucial in understanding how job characteristics

and personal characteristics of lay counsellors can influence/encourage them to move from the experiences of burnout to resilience.

The JDR Model was first published (developed) by Demerouti et al. (2001) in an attempt to understand the background of burnout. The model has been used to predict job burnout, organisational commitment, work enjoyment, connectedness and work engagement. In addition, the model has been used to predict the consequences of these experiences, including sickness, absenteeism, turnover and job performance (Bakker & Demerouti, 2014). According to the JDR Model, all working environments or job characteristics can be demonstrated using two different categories, which are job demands and job resources. Job demands refer to those physical, psychological, social or organisational aspects of the job that require sustained physical and psychological effort and are therefore associated with certain physiological and psychological costs (Bakker & Demerouti, 2014). For example, lay counsellors may experience high work pressure and emotionally demanding interactions with clients. These kinds of demands are what they must cope with due to the exceeding demands of HIV/AIDS care and counselling. Lay counsellors might not be able to successfully cope or find meaning and benefit in their work situation. A lack of resources may make it difficult to meet job demands, which further leads to withdrawal behaviour, and the long-term consequence of this withdrawal is disengagement from work (Mwai et al., 2013).

In 2004 Schaufeli and Bakker revised the original JDR Model by adding work engagement as a new construct (Schaufeli & Bakker, 2004). This can be seen in Figure 3.1, showing burnout and work engagement as mediators of the relationship between job demands and health problems, job resources and turnover intention.

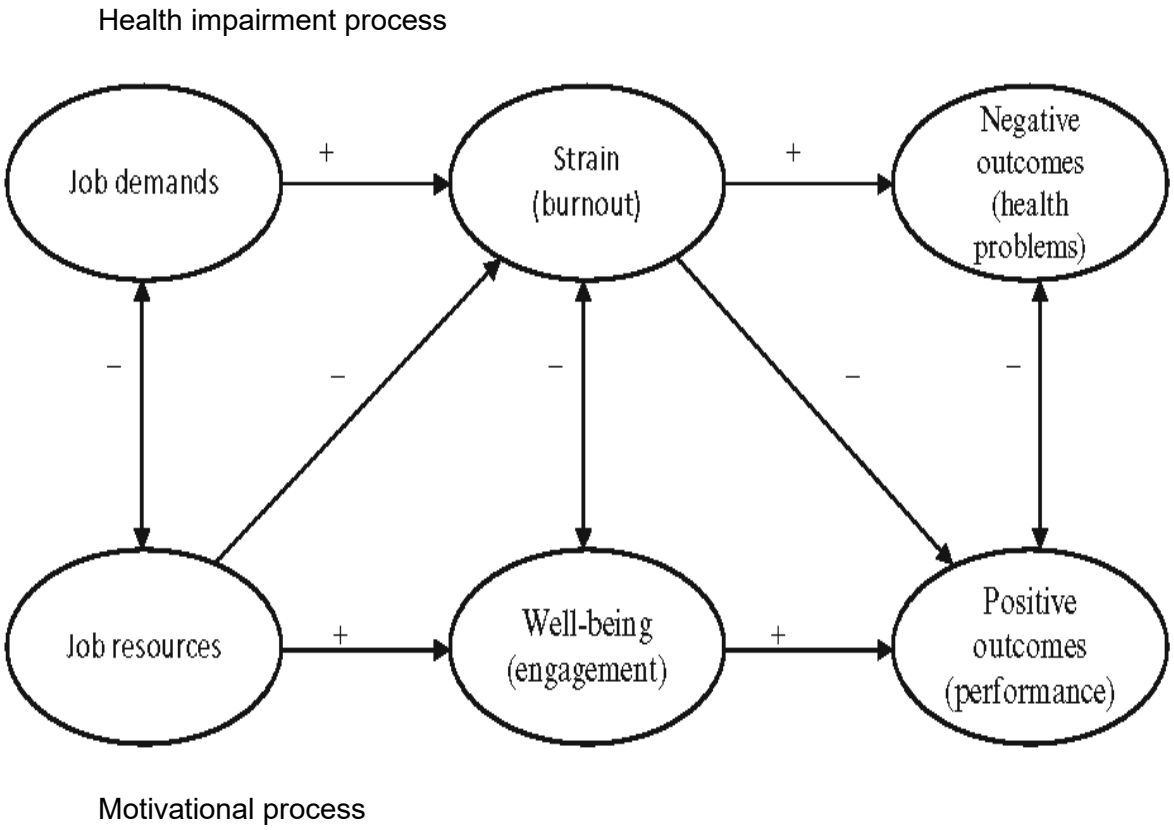

Figure 3. 1. **The revised version of the JDR Model (Schaufeli & Taris, 2014, p. 46).**

The revised model includes work engagement in addition to burnout, and that provided a positive psychological turn to the JDR Model. The reviewed model did not only attempt to explain a negative psychological state (burnout) but also its positive matching part (work engagement). Work engagement refers to a positive, fulfilling, work-related state of mind that is characterised by vigour, dedication and absorption. This construct will be discussed in detail below.

The revised model assumes that burnout results from high job demands and poor job resources. Burnout is expected to facilitate the relationship between job demands and employee health and well-being through the regular draining of mental resources (burnout). This is the health impairment process of the revised JDR Model. Similarly, a motivational process is activated when the job resources are very high. The revised model emphasises the inherently motivational qualities of job resources. Job resources play a motivational role because they encourage the individual's willingness to put in more effort, thereby reducing job demands and fostering goal attainment (Schaufeli & Taris, 2014).

Job resources are important because they contribute to an individual's ability to achieve work goals effectively. They also play a fundamental motivational role because they satisfy an

individual's basic needs for independence, relatedness and competence. Schaufeli and Taris (2014) indicated that feedback from the employer to the employee might encourage learning and increase the willingness to perform exceptionally. Involving the employees in decision making and social support satisfy their needs for autonomy and relatedness, respectively. In both cases, job resources produce a satisfying positive work-related state of mind (work engagement), either through the achievement of work goals or the satisfaction of basic needs. In turn, this affective-motivational state encourages an employee to be more committed and perform well in the organisation. Therefore, engagement is assumed to mediate the relationship between job resources and organisational outcomes (Schaufeli & Taris, 2014). The model's respective constructs are discussed below.

Work engagement

Kahn (1990) introduced the concept of engagement. He conceptualised it as the "harnessing of organisation members' personalities to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performances" (Kahn, 1990, p. 694). Engaged employees have a sense of energetic and effective connection with their work, unlike those who suffer from burnout. They perceive their work as challenging instead of viewing it as stressful and demanding. Work engagement is defined as a persistent, positive affective-motivational state of fulfilment that is characterised by the three components of vigour, dedication and absorption (Bakker et al., 2014). They further described vigour as characterised by high levels of energy and mental resilience, the willingness to invest effort in one's work, and perseverance even in the face of difficulties. Dedication refers to being strongly involved in one's work and experiencing a sense of significance, enthusiasm, and challenge. Absorption is characterised by being fully concentrated and happily engrossed in one's work, whereby time passes quickly. Therefore, work engagement is characterised by a high level of energy and strong identification with one's work, whereas burnout is characterised by the opposite, which is a low level of energy and poor identification with one's work (Demerouti-et al., 2010).

Engaged employees are active workers who show determination, confidence and they are content with their work. Although engaged workers also experience fatigue, they persist in the face of difficulty and experience satisfaction (Bakker, 2011). The JDR Model clearly explains the different interactions between job resources and demands and the accompanying outcomes. Low job demands paired with low job resources are likely to result in apathy. High job demands associated with low resources will possibly result in burnout, while the opposite, namely low job demands and high resources, will lead to low strain and high motivation;

therefore, the outcome will be boredom. Engagement is the result of both high job demand and resources.

Job performance

Nell (2015) believed that job performance has an influence on job crafting behaviour because it is assumed to be an outcome of work engagement. There is no agreement upon the definition of performance; however, over the years, many definitions focused on behavioural content, organisational environments, motivational antecedents, organisational consequences and personality factors. Motowidlo and Van Scotter (1994, as cited in Nell, 2015) indicated that performance could be divided into groups which are tasks and contextual performance. Task performance refers to the required skills with which a specified task should be completed, and it includes the accomplishment of core, practical, in-role duties and tasks that differentiate one job from another. Task performance is determined by an individual's knowledge and skills that are required to accomplish a job. Contextual performance refers to any positive behaviour that goes above and beyond what is expected of employees in terms of actual job and task requirements, and it is determined by factors situated within an individual's personality structure. Hence, the JDR Model focuses on work engagement as the primary antecedent of job performance (Bing et al., 2011).

Job demands

Bakker and Demerouti (2014) highlighted that job demands fulfil a regulating role in the JDR Model – they control the relationships between resources and engagement. The JDR Model assumes that job demands can exceed resources (including job and personal resources). This occurs when employees' job demands are high, and the resources necessary to adequately deal with job demands are not available. Therefore, when job demands are high, additional effort must be applied to achieve the work goals and prevent decreasing performance. However, this comes with more physical and psychological costs, such as fatigue and irritability (Bakker, 2011). Job demands and their related consequences may bring about the health impairment process, as identified by Demerouti and Bakker (2011). Employees may recover from putting pressure on themselves by taking regular breaks, exchanging tasks or performing fewer demanding activities. However, when recovery is inadequate or insufficient, the employee may relapse and result in a state of continuous activation leading to physical and mental exhaustion (Schaufeli & Taris, 2014). Demerouti and Bakker (2011) indicated that when job demands *meet* job resources, it initiates the motivational *process* that encourages the growth, learning, and development of employees. This occurs when adequate resources are available to deal with high demands. Bakker (2011)

states that job resources become more important when job demands are high. This implies that employees only utilise their available resources when job demands are high. Demerouti and Bakker (2011) further indicated job resources could exceed job demands. This implies that without any job demands, work has the potential of becoming boring, dull, and unchallenging (Bakker, 2011). Employees might feel that they do not contribute to a bigger meaningful whole, their efforts are minimal, and that others can cope without them.

Job resources

Job resources refer to the physical, physiological, social or organisational aspects of the job that are functional in achieving work goals, reducing job demands and improving personal growth. The associated psychological and physiological costs stimulate personal growth, learning and development (Bakker & Demerouti, 2014). Some examples of job resources have been identified, such as feedback, job control, autonomy, social coaching, professional development and social support. Job resources can play intrinsic and extrinsic motivational roles because they satisfy basic needs and create an environment for positive energy, which can be used for goal attainment and work task completion (Bakker et al., 2011).

Bakker and Demerouti (2014) indicated that job demands and resources are the triggers of two independent processes, which are a health impairment process and a motivational process. Too high job demands are generally the most important predictors of outcomes such as exhaustion, psychosomatic health complaints and repetitive strain injury, whereas job resources are generally the most important predictors of work enjoyment, motivation and engagement. Lack of resources was linked to disengagement. The reasons for these unique effects are that job demands needs effort and consume energy resources, whereas job resources fulfil basic psychological need like autonomy, relatedness and competence (Nahrgang et al., 2011).

Personal resources

Van den Heuvel et al. (2010) indicated that interest in personal resources originated in stress and coping research and have been described as aspects of the self that are generally linked to resiliency. The early and revised version of the JDR Model only considered characteristics of the work environment. However, since most psychological approaches assume that human behaviour results from an interaction between personal and environmental factors, personal resources were integrated into the model. The inclusion of the personal resources component is one of the distinctive elements that make the JDR Model complete and more unique. The model is more comprehensive in explaining work-related health and well-being when compared to previous job stress models (Bakker, 2011).

Personal resources are positive self-evaluations that are linked to resiliency. It refers to the individual's sense of their ability to control and influence their environment successfully. It has been argued that such positive self-evaluations predict goal-setting, motivation, performance, job and life satisfaction and other desirable outcomes (Schaufeli & Taris, 2014). The reason for this is that the higher an individual's personal resources, the more positive the person's self-regard and the more goal self-concordance is expected to be experienced. Individuals with goal self-concordance are intrinsically motivated to pursue their goals, and as a result, they show higher performance and satisfaction outcomes (Van den Heuvel et al., 2010). Personal resources combined with job resources encourage personal growth and facilitate an individual's ability to organise other available resources more effectively. Personal resources may also influence perceptions of the changing work environment (Bakker, 2011). Resilient employees are more likely to perceive a new requirement as a challenge, while less resilient employees experience changed requirements as demanding. In recent years the concept of psychological resilience has emerged as a personality trait that is protective against burnout. The concept resilience is discussed below.

3.3 RESILIENCE

3.3.1 Introduction

Research in this area has increased substantially over the past decades. The concept is now receiving increasing interest, especially from those involved with policy and practice in relation to its potential impact on health, well-being and quality of life. This interest is due to a move away from "deficit" models of illness and psychopathology, as resilience theory focuses on understanding healthy development despite the risk and on strengths rather than weaknesses (Windle, 2011). According to Schetter and Dolbier (2011), there is a wealth of research on resilience but no general consensus regarding its conceptualisation. Some describe resilience as attaining eventual favourable outcomes following exposure to adversity. Others describe it as specific relatively short-term responses characterised by a return to homeostasis after initial disruption due to a stressor, and still, others refer to resilience as resources that enable the individual to withstand or recover from major stressors (Schetter & Dolbier, 2011).

Resilience research originated in two fields: traumatology (looking at adults) and developmental psychology. In developmental psychology, researchers aimed to identify personal qualities (e.g. self-esteem) differentiating children who had adapted positively to socioeconomic disadvantage, abuse or neglect and catastrophic life events from children showing comparatively poorer outcomes. In the ensuing years, the concept of resilience

moved from research on children to other populations, including adults, older adults and ethnically diverse populations. Early resilience research with adults focused on identifying what led some individuals to avoid traumatic stress (Scoloveno, 2016).

Research on resilience often tries to explore whether resilience becomes apparent in successful recovery from massive stress or in the process of overcoming difficulty, or whether it is strengthened through stress (Elisei et al., 2013). However, Rutter (2012) believes that there is extensive evidence to prove that in certain circumstances, the experience of stress or difficulty has a stimulating effect on individuals, thereby supporting their resilience to stress in the future. He further indicated that studies of resilience focus on exposure to extreme adversity, whereas positive psychology focuses on all individuals and not only those who have experienced adversities. Resilience researchers have considered both the presence of knowledge, coping strategies, as well as the evasion of psychopathology when individuals are exposed to severe or chronic stressors (Rutter, 2012).

The concept of resilience was adopted by medical and social sciences on the wave of interest in resilience and positive growth, and it has been used in the fields of psychiatry, health psychology, crisis intervention and positive psychology for more than 50 years (Luthar et al., 2014). Resilience encompasses the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development. It is applicable to a broad range of systems ranging from children, families, institutions and societies (Masten, 2014). Yates et al. (2015) are of the view that resilience also carries a connotation of positive developmental adaptations despite exposure to clear threats or adversity. Therefore, identifying processes of resilience requires clear operational definitions of both adversity and positive adaptation or competence. Furthermore, contemporary models of resilience explicitly recognise that adversity and competence, as well as the process that underlie them, may vary across levels of analysis within and across cultures.

Brendtro et al. (2014) indicate that the understanding of resilience furnished by positive psychology is well reflected by a model called the Circle of Courage, which assumes that healthy development in individuals has visible manifestations. The development of the four components of resilience elucidated on by the Circle of Courage (that is Attachment, Autonomy, Achievement and Altruism) occurs when the following universal needs are met: Belonging, which requires opportunities to build trusting bonds; Mastery, which entails opportunities to explore, learn and develop abilities and talents; Independence which requires growth in self-regulation and the ability to cope with challenges and make responsible decisions as well as Generosity, which entails empathy, prosocial values and altruistic behaviour (Brendtro et al., 2014).

Yates et al. (2015) describe resilience as the most appropriately conceptualised developmental process or a dynamic capacity rather than viewing it as a static outcome. The concept of resilience has changed from a negative approach of the absence of psychopathology to a positive focus on competence and adaptive behaviour. Therefore, to understand positive functioning, researchers must specifically assess positive assets, resources and outcomes. Graber et al. (2015) argue that the absence of psychopathology does not necessarily indicate that a person is thriving, and they indicated that resilience is a personality trait permitting positive outcomes under extreme hardship.

Psychological resilience is a developmental and psychosocial process through which individuals exposed to sustained adversity or potentially traumatic events experience positive psychological adaptation over time (Graber et al., 2015). Resilience is also a dynamic process, where interaction occurs with the environment by negotiating and managing resources in response to the stressor (Treglown et al., 2016)

Sikorska (2017) emphasised that the concept of resilience has many similarities to the positive psychology approach. Positive psychology offers a positive outlook on human capability by providing terms such as the strength of character, gifts, or virtue. According to positive psychology, healthy living is determined not only by the absence of disease but also by subjective well-being. One of the virtues that particularly correlate with resilience is courage, the term being defined as emotional strength and determination to achieve goals. The concept encompasses four strengths: perseverance or the ability to achieve one's goals; bravery or resistance to anxiety or difficulties; honesty or being authentic and genuine; and vitality or the ability to feel excitement and vigour (Sikorska, 2017). Although it is accepted that resilience can be seen as part of positive psychology and consists of many virtues stressed by positive psychology, it is still not clearly defined since it involves many factors and has developed in diverse disciplines. It is therefore important to look at definitions of resilience to identify their differences. Some definitions are briefly discussed below.

3.3.2 Defining resilience

The concept resilience has been used in many ways, and researchers used the term to refer to outcomes resulting from stressful situations. In 2010, Cabanyes declared that when defining resilience, it is important to distinguish it from related concepts such as invulnerability, stress resistance, adaptive behaviours and mental toughness. He indicated that invulnerability refers to absolute resistance to the negative impact of adverse situations. He was further of the opinion that resilience, as opposed to vulnerability, covers all areas of personal competence, for example, emotional, cognitive and social competencies. Although adaptive behaviours are

necessary for facing difficult/adverse situations, they are not enough to define resilience. In addition, mental toughness is another concept that is closely related to resilience, and it refers more to stress resistance than to its management. From his research, Cabanyes (2010) subsequently defines individuals with resilience as having a relatively good psychological outcome despite suffering from risk experiences. It is not immunity to trauma but rather the ability to grow and develop under difficult conditions.

Resilience has been researched by many disciplines in the past years and each discipline has its own definition of the concept. For example, the developmental psychopathology field defines resilience as the ability to cope with challenges and threats while maintaining an internal and integrated sense of self (Garmezy & Masten, 1986). The epidemiology field defines resilience as the ability to survive stress and rise above difficulty (Rutter, 1987). The psychiatry field defines resilience as a psychological and biological strength that humans use to master change successfully (Flach, 1988). In contrast, the nursing field defined resilience as the ability to revive power to respond to the internal or external environment for survival, growth or development (Scott-Jones, 1991). The field of change management defines resilience as the ability to demonstrate both strength and flexibility during the change process while displaying minimal dysfunctional behaviour (Conner, 1993). In the field of medicine, resilience is defined as the ability to recognise pain, acknowledge its purpose, tolerate it for a while until things begin to normalise (O'Leary & Ickovics, 1995).

The social sciences generally define resilience as the ability to recover from negative life experiences and become stronger while overcoming them (Henderson & Milstein, 1996). In the field of psychology, resilience is defined as the ability to bounce back and withstand hardship by remaining oneself (Prilleltensky et al., 2001).

Zautra et al. (2010) advanced the study of resilience by defining resilience as involving three distinguishable but frequently overlapping components. The first component refers to recovery, which is returning to baseline functioning following a major stressor, consistent with a homeostatic approach. The second component suggests sustainability which refers to the capacity to continue forward during stressors and maintain functioning without any disruption. The third term indicates growth which refers to enhanced adaptation beyond original levels of functioning.

Schetter and Dolbier (2011) defined resilience as the process that involves an ability to endure and cope with recurrent demands and maintain healthy functioning in different areas of life. In 2013 Werner indicated that the field of developmental psychology defines resilience as the ability to endure or effectively cope with hardship (Werner, 2013). Resilience is defined

as the “act of rebounding or springing back” (Resilience, n.d., para. 1). Harper (2012) also referred to coping with hardship and defined resilience as an ability to respond to harsh conditions and cope with adversity. According to Masten (2014), resilience is “the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development” (p. 10).

The term resilience has also been frequently linked to recovery – some authors believe that resilience is not necessarily absolute resistance but rather recovery. Harper and Speed (2012) point out that it is important to differentiate between recovery shortly following an adverse event and the later development of better skills and growth after the trauma. They define the first response as resistance to stress and the second as resilience (Harper & Speed, 2012).

Wright and Masten (2015) emphasised that definitions of resilience always consider both the nature of the threat to adaptation and the way individuals adapt to the environment after exposure to the threat. Threats to adaptation are typically characterised by different terms such as risk, adversity, and stressful life events. Positive adaptation is also defined and assessed in different ways, including the absence of psychopathology, success in developmental tasks, subjective well-being, and relational capability (Wright & Masten, 2015). Even though the commonality of all definitions is the ability to recover from an altered state, they do not explain the mechanisms through which resilience occurs.

Although different definitions have been discussed above, I have decided to use the psychological definition by Prilleltensky et al. (2001), which states that resilience is the ability to rebound and to endure hardship by remaining resilient even in times of difficulty and remaining true to oneself. This definition is used for this study as it seems to resonate with the HIV/AIDS lay counsellor’s plight.

3.3.3 Models of resilience

Charmaz (2014) indicated that to be applied to a research study, the chosen theory must accentuate the purpose and importance of the study. Hence, to give a broad overview of the concept of resilience, a few models of resilience that could be applied to HIV counsellors’ situations are discussed below.

Ledesma (2014) identifies the following three models of resilience: the Protective Factor Model, the Cumulative and the Challenge Model. However, some researchers have used different terms for these models that basically describe the same mechanisms for the effect of stress on the quality of adaptation (Ledesma, 2014). These models are used in this study to examine and identify factors that influence HIV/AIDS lay counsellors’ resilience. Although

different terms/names have been used to describe these three models of resilience, the following terms will be used in this study: the Protective Factor Model, the Compensatory Model and the Challenge Model.

3.3.3.1 The protective factor model

The protective factor model refers to processes in which promotive factors control the negative effects of risks that can result in negative outcomes. The model indicates that there is an interaction between protection and risk factors, which reduces the probability of a negative outcome and lessens the effects of exposure to risk (Ledesma, 2014). Counsellors' strong spiritual base appears to mitigate against vicarious traumatisation. Their spirituality provides them with a source of support and hope. Positive emotions such as these can be useful in counteracting negative experiences and provide protection against stress (Chance, 2012). For example, when HIV/AIDS counsellors use prayer to deal with their problems, it reduces the risk of burnout, and it is protective in the sense that it gives them strength and determination to assist their clients effectively and produces good outcomes (Valjee & Van Dyk, 2014).

According to Zimmerman et al. (2013), the term "protective factors" had originally only been used to describe beneficial effects in the presence of risk conditions, but not in their absence. They argued that for protective factors to be meaningful, they must be defined by an interactive process in which exposure to the protective factor modifies or subdues the effects of the risk factor on the outcome. They further highlighted that access to a protective factor should have beneficial effects on those exposed to the risk factor but should not benefit those not exposed to the risk factor. Hence, there should be an interactive relationship between the protective factor, the risk exposure and the outcome (Zimmerman et al., 2013).

Ungar et al. (2013) underlined that this model of resilience fosters positive outcomes and healthy personality characteristics despite unfavourable or adverse life circumstances. They indicated that different protective processes influence resilience differently depending on the individual's exposure to risk. They further emphasised that protective processes are valued and made available differently in different contexts and cultures.

In the case of lay counsellors working in the HIV/AIDS field, they often experience isolation, stigma associated with HIV/AIDS care and discrimination which can seriously impact their quality of life. The situation deprives them of much-needed support, and it also contributes to emotional exhaustion, occupational stress and burnout (Van Dyk et al., 2017). Although they face those challenges, they will manage to restore their self-esteem, continue doing their job and assist the client to receive a positive outcome. Peltzer and Davids (2011) studied lay counsellors' experiences of delivering HIV counselling in public health facilities and found that

counsellors often have a poor working environment, too many clients, inadequate facilities to assist the clients, lack of supervision and feedback on their job performance, and must also accomplish other unforeseen practical roles. Yet, besides all the problems, they would gain personal strength and continue doing their job. Chance (2012) found that counsellors positively value their life experience as an aspect of maintaining resilience in their workplace. They indicate that the ability to draw on life experience was an integral part of maintaining well-being and resilience.

3.3.3.2 The compensatory model

The compensatory model describes a process in which the contributing factors counteract exposure to risk. The model identifies resilience as a factor that neutralises exposure to risks. It best explains a situation where resilience operates in the opposite direction to a risk factor. The resilience factor has a direct effect on the outcome, one that is independent of the effect of the risk factor (Ledesma, 2014). For example, asking the help of God through prayer, the support of colleagues and doing physical exercise are directly associated with a lower risk of stress and burnout in HIV/AIDS counsellors when facing challenges (Van Dyk et al., 2017).

Religion has been important in determining how people have responded to the disease since the beginning of the HIV epidemic (Muñoz-Laboy et al., 2011). HIV/AIDS counsellors usually use devotions, asking God's help to handle difficult situations, cope with tension and counteract burnout. When praying, one's views about a state of affairs can change to see a problematic situation more positively (Root & Van Wyngaard, 2011). Research by Wener (2016) about evaluating resilience in youth identified four central characteristics that characterise youth as resilient. They are the following: an active approach towards problem-solving; a tendency to perceive experiences in a positive light even when they were suffering; the ability to gain positive attention from others as well as a strong dependence on faith to maintain a positive view of life.

3.3.3.3 The challenge model

The challenge model of resilience suggests that low levels of risk exposure may have a beneficial effect, providing a chance to practice problem-solving skills and mobilise resources. The risk exposure must be challenging enough to help individuals develop mechanisms to overcome its effects, but not so taxing that it overwhelms their efforts to cope. In this model, exposure to both low and high levels of a risk factor is associated with negative outcomes, but moderate levels of the risk are related to less negative outcomes (Zimmerman et al., 2013). Therefore, individuals exposed to moderate levels of risk may be confronted with enough of

the risk factor to learn how to overcome adversity, but they are not exposed to so much of it that overcoming it is impossible. An interesting finding from the study by Valjee and Van Dyk (2014) was that HIV/AIDS counsellors who had a heavier workload were exposed to high levels of risk as they were required to care for more clients leading to severe strain. They were, therefore, unable to cope with the challenge; hence they used avoidance as their coping strategy. However, those with fewer clients were associated with moderate levels of risk, and consequently, they did not have so much pressure (Valjee & Van Dyk, 2014). From a developmental psychology perspective, the challenge model can be considered as a model of immunisation, preparing the developing individual to overcome significant risks in the future (Zimmerman et al., 2013).

Richardson (2002, as cited in Fletcher & Sarkar, 2013) provided an interesting application of the challenge model of resilience. He indicated that resilient reintegration is the most positive outcome of a process involving an individual's reaction to some stress and adversity. He further highlighted that resilient reintegration occurs when one experiences some insight or growth because of disruption and experiences it as a challenge to cope with the situation. It results in the identification and strengthening of resilient qualities. Individuals are genetically predisposed with more potential to confront challenges than they are conscious of; therefore, a disruptive process is a means to access this potential for resilience.

3.3.4 Concepts related to resilience

There are many concepts that are assumed to be related to resilience. However, only two concepts, namely thriving and hardiness, are discussed for the purposes of this study.

3.3.4.1 Thriving

Recent studies have started to focus on thriving as one of the concepts related to resilience. Thriving developed from the scientific study on vulnerability and coping models. The concept is grounded on an individual's positive change resulting from experiences of hardship (Ledesma, 2014). The concept of thriving has been a central theme in centuries of literature, poetry and personal narratives. Hence, the study of thriving and its application to the field of science, medicine and psychology can improve our understanding of well-being and provide important opportunities for prevention and intervention (Ickovics & Park, 1998). The term has received much attention in the fields of social and behavioural psychology in the last decade.

Thriving is defined as the effective mobilisation of individual and social resources in response to a threat, leading to positive mental, physical and social outcomes (Ickovics & Park, 1998). However, Carver (1998) defined thriving as a reduced reactivity to succeeding stressors and

faster recovery from subsequent stressors. Although the later definitions vary, it is clear that thriving is characterised by growth experience after enduring hardships and as such, the individual demonstrates strengthened resilience after adversity. This view is communicated by Saakvitne et al. (1998), who said: “people are capable of changing traumatic experiences to gain wisdom, personal growth, positive personality changes or more meaningful and productive lives” (p. 282).

Patterson and Kelleher (2005) highlighted that thriving is mainly determined by an individual’s resilience capacity. Highly resilient people thrive in situations that other people fail to manage. To thrive means to gain strength from hardship without becoming depressed. However, despite individual uniqueness in responding to difficult situations, all highly resilient people have strength and skills that enable them to maintain their resiliency with very little fluctuation. Personal values, efficacy and energy, are identified as the three energy sources that explain resilience capacity and help determine an individual’s response to hardship (Patterson & Kelleher, 2005). Therefore, as individuals grow from hardship, their resilience capacity is expanded through strengthening these energy sources and which provide more energy for them to face the future (Ledesma, 2014).

Counsellors working in the HIV/AIDS field are always confronted with heavy job demands, high expectations, hazards and risks that constantly interrupt their psychological well-being. According to Maslach et al. (2001), a mismatch between workload and the employee’s ability is usually found as excessive overload. The simple formula that too many demands exhaust an individual’s energy to the extent that recovery becomes difficult explains the idea. A workload mismatch may also result from the wrong type of job; for example, when people lack the skills for a certain type of work, even when it is required in reasonable quantities, it may be a challenge. This was confirmed in Chance’s (2012) study, where they found that counsellors were forced to do jobs for which they were not fully equipped which led to role discomfort. High expectations lead people to work too hard and put enormous pressure on themselves. The pressure leads to exhaustion and eventual cynicism when the high effort does not produce the expected outcomes. However, under such stressful working conditions, it is the counsellors’ responsibility to exercise self-care; by practising resiliency skills that enable them to thrive in situations that wear them down (Van Dyk, 2016).

Another mismatch between the organisation and employee occurs when a person loses a sense of positive connection with management in the workplace. Many counsellors feel that they are not appreciated or supported by their organisations and do not have sufficient managerial support (Chance, 2012). People thrive in communities/organisations and function best when they share praise, comfort, happiness, and humour with people they like and

respect. In addition to emotional exchange and instrumental assistance, this kind of social support reaffirms a person's membership in a group with a shared sense of values. Therefore, counsellors must use both emotion-focused and problem-solving coping strategies to thrive in such situations (Van Dyk et al., 2017).

3.3.4.2 Hardiness

Hardiness emerges as a pattern of attitudes and strategies that together facilitate turning stressful circumstances from potential disasters into growth opportunities (Maddi, 2013). Florian et al. (1995) define hardiness as a constellation of personality characteristics that function as a resistance resource in the encounter with stressful life events, whereas Maddi (2013) defines hardiness as having a sense of control over one's environment. It embraces an individual's ability to behave positively even in difficult situations. Bonnano (2012) identifies the following three dimensions of hardiness: being committed to finding a meaningful purpose in life, the belief that one can influence one's surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences.

Personality theorists and researchers have paid special attention to hardiness as an inner resource that may moderate or diminish the effects of stress on physical and mental health. This is so because hardiness is considered a personality trait that helps to buffer exposure to extreme stress (Florian et al., 1995). Individuals who have this personality trait are able to evaluate possibly stressful situations as less threatening and minimise distress. They are also more confident and are able to use coping mechanisms and social support more effectively (Bonanno, 2012). O'Leary (1998) states that literature discussing the concepts of resilience focuses more on the internal and external factors that contribute to an individual's ability to thrive. Internal variables in resiliency are defined as self-factors, personality factors or individual resources and external variables are demarcated as relationships and social support. He also indicates that factors that significantly impact how a person interprets and manages the crisis at hand are hardiness, coping ability, a sense of coherence, the use of personal, cognitive resources, and self-efficacy (O'Leary, 1998). Temperaments such as modes of thought, response, action, positive self-esteem, a sense of being capable and being in control of one's surroundings, emotional and spiritual energy, empathy, intellectual competence, perseverance and determination are also regarded as internal factors (Ungar, 2011).

Although different factors have been identified, Maddi (2013) presented the three Cs of hardiness attitudes, namely challenge, commitment and control. Individuals who are strong in the attitude of *challenge* accept that life is stressful and perceive those stressful changes as

an opportunity to grow in wisdom. They see those stressful challenges as a capability to learn by turning them to their advantage. In this, they believe that they can learn from failures as well as successes. They do not believe they can live without challenges as human beings. Instead, they feel that they can only gain fulfilment when they have managed to cope with their challenges and changed their stresses into growth opportunities. Another C of hardy attitudes is *commitment*, which involves the belief that even when individuals encounter challenges, no matter how bad they are, it is important to stay involved and committed, rather than giving up and isolating themselves from others. Furthermore, the third C of hardiness is *control,* which leads an individual to believe that no matter how bad the challenges are, they need to be courageous and stay in control. They should stay in control to be able to turn the stresses from potential misfortune into growth opportunities. It seems like a waste of energy to feel powerless and passive when difficult circumstances arise and not take control of the situation.

Maslach et al. (2001) related hardiness to locus of control and burnout. They reported that burnout is higher among people who have an external locus of control. They further indicated that a stressful prone individual is characterised by poor self-esteem, an avoidant coping style and an external locus of control (Maslach et al., 2001). Following on from this, I agree that individuals with an internal locus of control will have more hardiness and subsequently feel that they can do something to overcome a difficult situation. They will, therefore, not be as inclined to experience burnout as those with an external locus of control.

3.4 STRATEGIES TO CHANGE FROM BURNOUT TO RESILIENCE

In situations of prolonged interpersonal and emotional strain at work, employees can experience burnout. Conversely, under immense stress, some individuals demonstrate resilience and persevere in a relatively unwavering manner (Treglown et al., 2016). Resilience is potentially a protective factor against burnout and can mediate the relationship between burnout and mental health. Although definitions and ways of measuring resilience can vary, for the purposes of this study, I accept the definition that resilience refers to positive adaptation in the face of adversity. It is challenging to promote an intrinsic trait such as resilience through some kind of intervention. This can probably be done through individual counselling or psychotherapy or through intervention programmes. However, Bonanno (2012), Carver (1998) and O'Leary (1998) highlighted positive relationships and social support as the important external variables that influenced a person's ability to remain resilient in the face of adverse relationships and a significant factor for persons facing adversity. For example, if individuals experiencing traumatic incidents find that there are people to help and support them, they are likely to cope. The person may experience a sense of security and belonging in those relationships, whether support is received from a relative or another caring individual (O'Leary, 1998).

The personal and organisational costs of burnout have led to proposals for various intervention strategies. Some of these strategies try to treat burnout after it has occurred, while others focus on how to prevent burnout. In general, interventions may occur on the individual, societal and organisational level (Maslach & Leiter, 2016a). However, the main emphasis has been on individual approaches rather than on social and organisational approaches. Many of these individual approaches are derived from the work done on stress and coping by Lazarus and Folkman (1984). Therefore, different strategies that researchers have identified are discussed below.

3.4.1 Strategies on an individual level

Murali et al. (2018) pointed out that several individual-focused interventions to reduce burnout revolve around the principles of resilience, mindfulness and promotion of meaning. Weight et al. (2013) highlighted that facilitated and non-facilitated small group programmes, such as stress management training and introducing exercise/self-care programmes, as well as the availability of psychotherapy or counselling, are also crucial in the prevention and reduction of burnout. Mindfulness practice and mindfulness-based stress reduction have been shown to have multiple benefits – there was even some evidence of a reduction in overall burnout (Goldhagen et al., 2015).

Katsounari (2015) emphasised one approach that mental health professionals who work in the areas of trauma require. She indicated that the professionals need to take care of themselves in terms of personal health and physical fitness. They were encouraged by management to take care of their psychological well-being in order to prevent becoming “wounded healers” or secondarily traumatised therapists. The trauma professionals were also encouraged to focus on spirituality, finding meaning in work, and human nature, through prayer, meditation, or religious services. Randolph (2016) reported that individuals could be encouraged to use some programme or individual therapy, which includes taking regular breaks from work – breaks keep workers focused and engaged in their work enabling them to complete their tasks effectively. They are also encouraged to advocate for better social recognition of the difficult work they accomplished and focus on the positive aspects of life both at work and home (Randolph, 2016).

It has been noted by Olson et al. (2015) that self-compassion and mindfulness are core principles of resilience and can potentially be taught by psychotherapists to assist individuals with stress, anxiety and depression. HIV/AIDS counsellors can use these strategies to reduce burnout by allowing themselves to cultivate awareness, be non-judgemental, have more acceptance, patience, and take wise decisions in their lives. The most common strategies are

changing working patterns; for example, management can encourage employees to take more breaks, work less, avoid overtime and balance work with the rest of their lives. HIV/AIDS counsellors can furthermore seek social support from colleagues and support groups in order to deal with their challenges. Seeking support from friends and family members is another factor that is crucial in reducing burnout.

3.4.2 Job crafting as an intervention

Maslach and Leiter (2016a) provided an alternative proposal that people can make various changes in how they do their job and that such job changes could reduce burnout. The process that employees use to shape their job has been referred to as job crafting. Job crafting is defined as the physical and cognitive changes employees make in their task or interpersonal boundaries. Physical changes refer to changes in the procedure, scope or number of job tasks, whereas cognitive changes refer to changing how one perceives the job with the goal of becoming more engaged, satisfied, resilient and thriving at work (Demerouti et al., 2015). Tims et al. (2013) defined job crafting as the changes employees can make regarding their job demands and job resources. The availability of well-designed jobs and working conditions can facilitate employee motivation and reduce job stress and burnout.

However, Demerouti and Bakker (2011) pointed out that it may be equally important that employees mobilise their own job resources. Managers and supervisors are not always available for feedback, and organisations that are confronted with economic turmoil may set other priorities. Under such conditions, it may be particularly important for employees to mobilise their own resources and show proactive behaviour. They argued that employees might actively change the design of their jobs by choosing tasks, negotiating different job contents, and assigning meaning to their tasks or jobs (Demerouti & Bakker, 2011).

In addition, Petrou et al. (2012) suggested that individuals craft their jobs to create healthy working conditions in which they can be empowered and well-motivated. According to Tims et al. (2013), job crafting can take the form of three different types of behaviours: increasing job resources (structural or social), increasing job challenges, and decreasing job demands. They argued that employees who improve their work environment usually report the highest levels of engagement. Work engagement, therefore, increases when the work environment contains a sufficient amount of job resources and challenging tasks. According to Bakker and Demerouti (2014), the motivation for job crafting arises from three needs of individuals. First, employees engage in job crafting because they have the need to take control over certain aspects of their work. Second, employees are motivated to change aspects of their work to

enable a more positive sense of self to be expressed and confirmed by others. Third, job crafting allows employees to fulfil their basic human need for connection to others.

If the JDR Model integrates job crafting, that would be a very interesting idea; for example, employees could craft a work environment that contains a suitable amount of job resources to enable them to cope with challenging job demands. It could increase their levels of energy, commitment and engagement. This will lead them to be more confident and not easily susceptible to burnout.

3.4.3 Strengths-based interventions

According to Proyer et al. (2015), work engagement most probably depends on the match between individual strengths and the degree to which individuals can draw from their strengths in their daily work activities. They indicated that individual strengths could be defined as positive traits reflected in thoughts, feelings, and behaviours. Examples are curiosity, bravery, kindness, and gratitude. It has been argued that using one's strengths is fulfilling and engaging and brings a feeling of acting in a reliable manner and being true to oneself (Proyer et al., 2015). Employees who can be encouraged or helped to use their strengths at work should be able to reach a specific goal or complete a task successfully. This intervention can therefore be seen as an individual-level intervention aimed at increasing personal resources.

Although strengths-based interventions within the context of work have not yet been scientifically evaluated, research on well-being, in general, has revealed some promising findings. For example, in one strength-based intervention by Gander and co-workers, participants were asked first to identify their highest individual strengths. Then, they were encouraged to use one of their strengths in a new or different way every day for at least one week. Participants were randomly allocated to an experimental or control group and tracked over time. Results showed that this intervention led to significant increases in happiness and significant reductions in depressive symptoms at one week, one month, three months, and six-month follow-up (Gander et al., 2013).

3.4.4 Strategies on an educational and organisational level

Montano et al. (2014) mentioned that studies of burnout reduction focused on educational interventions (for example, psychoeducational interventions, which combine education and other activities such as counselling and supportive interventions) to improve the individual's ability to cope with the workplace pressures. Changes in managerial practice combined with organisational interventions are other effective modes of intervention. Managerial interventions are insufficient unless educational interventions convey the required individual

skills and attitudes. The recognition of six areas of work life such as workload, control, reward, community, fairness and values increases the range of options for organisational intervention. Instead of focusing on the area of workload for an intervention, individuals may be able to endure a greater workload if they value the work. They may be able to tolerate their workload if they feel that they are well-rewarded for their efforts. Therefore, an intervention should target the value and reward areas of work life. The main advantage of a combined organisational, managerial and educational approach to intervention is that it can encourage the development of engagement with work (Montano et al., 2014).

Ledesma (2014) indicated that organisations should build their employees' resilience capacity through leadership development while reinforcing the resilience of the organisation. Hence, organisations must commit to fostering the resiliency of both the employee and the organisation. Organisational resiliency refers to an organisation's ability to create an environment that encourages employees to be career resilient. An organisation dedicated to building resilient employees should encourage openness in communication. Management should also encourage individual contributions for personal growth with the promise of employee recognition and rewards.

Resilient organisations should restructure themselves to achieve a goal, support the optimal development of shared decision making, provide feedback, set goals, and have regular strategic meetings (Ledesma, 2014). Howard and Irving (2013) found that leadership development is expanded and designed by actively facing hardship and overcoming challenges. They argue that by overcoming challenges, a person builds an ability to deal with and bounce back from adversity successfully. Hence, it is important that organisations have an invaluable influence on building their employees' resilience capacity. Employees should be able to have access to trusted peers and colleagues, time to reflect and collaborate with professional peers and colleagues, and transformational development opportunities that demand less social isolation and more opportunities for partnerships.

3.4.5 Job redesign as an intervention

Job redesign is a structural intervention at the organisational level that aims to change the source of employee well-being – their job demands and job resources. Job design describes the process in which jobs, tasks and roles are structured, adapted and presented as well as the impact of these modifications on the individual, group, and organisational outcomes (Rai, 2018). Job design usually represents a top-down process in which organisations create jobs and form the conditions under which the job holders/incumbents execute their tasks. Job redesign is usually seen as the process through which the organisation or supervisor changes

something in the job, tasks, or the conditions of the individual. An example of a traditional work redesign effort is the increase of individual and team autonomy in the production process. Bakker et al. (2016) presented a modern example where individuals within and outside an organisation should work interdependently on the development of a product, often under time pressure. Both the organisation and the employees can redesign the structure and content of the work to improve the outcomes such as employee well-being, work engagement, and job performance.

Note that it is also possible to ask employees to fill in an electronic version of the JDR questionnaire and offer them online and personalised feedback on their computer or smartphone about their most important job demands and resources (Bakker et al., 2016). The feedback may include histograms of the organisation under study as well as written information about the specific demands and resources identified as important for engagement. The human resources managers and personal coaches can use the personal JDR profile as input for interviews. This will assist the organisation to improve the working environment for individual employees.

3.4.6 Work engagement as an intervention

Maslach et al. (2001) indicated that the focus on engagement should permit a closer alliance with the organisational mission, especially those aspects that pertain to the quality of work life in the organisation. A work setting that is designed to support the positive development and effectiveness among its employees should be successful in promoting their well-being and productivity (Maslach et al., 2001). Finding meaning in work as well as intrinsic motivating factors such as having a sense of calling, hope, effective coping and self-efficacy appear to protect an individual from burnout and should be encouraged (Murali et al., 2018). Engaged employees will put a great deal of effort into their work since they identify with it; therefore, they are not likely to develop burnout. Since job demands are the most important predictors of burnout, job resources such as finding meaning in their work, self-efficacy, effective coping strategies and hope are the most important predictors of work engagement. Therefore, for individuals to move from burnout to resilience, they should have the resources that lead to work engagement (Bakker et al., 2014).

3.4.7 Training as an intervention

Elnaga and Imran (2013) indicated that one of the foundations of human resources management consists of training and development of employees, and these can be seen as an organisational level intervention. Training may directly focus on personal resources where employees may acquire new skills, technical knowledge, and problem-solving abilities.

Through training, employees may acquire improved knowledge, skills and may facilitate personal resources such as self-efficacy, resilience, and optimism. Peterson et al. (2011) highlighted that if there is a positive change in personal resources, we would observe a positive change in supervisor-rated performance and financial performance. Demerouti et al. (2011) showed that such interventions do not only increase self-reported personal resources; however, external rates can also observe increases in personal resources. Therefore, personal resources are flexible and can be increased to improve work engagement and performance.

Luthans et al. (2010) allocated participants randomly to treatment or control groups. The treatment groups received a 2-hour training intervention conducted by training facilitators that utilised a sequence of exercises and group discussions designed to improve the participants' level of efficacy, hope, optimism, and resilience. In the intervention training, the facilitators used a sequence of writing, discussion, and reflective exercises specific to each of the four personal resources mentioned above. One example of an exercise used to broaden the hope-oriented self-regulating capacity and pathways thinking toward a specific goal is the following: First, each participant was asked to reflect and then write down personal goals. The facilitator led participants through a series of techniques to set and increase their power to control their own goals (Bandura, 2008). This included parcelling large goals into manageable units, thereby also increasing efficacy over smaller sub-goals. Next, participants were asked to consider multiple pathways to accomplish each goal and to share those pathways in small discussion groups within the intervention session. Therefore, the capacity for pathway generation was expected to be increased through vicarious learning through others' experiences. In addition, by increasing their efficacy in accomplishing the goal, the participants were expected to increase their positive expectations of goal accomplishment, which is their optimism (Luthans et al., 2010).

3.4.8 Coping strategies as an intervention

Coping is the process of reducing the impact of a stressor or stressors. Thompson et al. (2014) indicated that there are different coping strategies that are strongly associated with promoting either burnout or resilience. For example, maladaptive coping was a significant predictor of burnout, indicating that respondents were exposed to high levels of risk and were unable to cope with their challenges; hence they resorted to substance use, denial, distraction, and self-blame coping strategies. In contrast to this, those who were exposed to lower levels of risk were able to cope with their challenges. Montero-Marin et al. (2014) indicated that burnout occurs when professionals (HIV/AIDS counsellors) make use of ineffective coping strategies to protect themselves from work-related stress and cope with challenges. Seeking help and

support from others is imperative because HIV/AIDS counsellors who do not obtain the required support and assistance are usually unable to assist their clients effectively. They would be psychologically susceptible to difficult circumstances if they do not have sufficient coping resources to handle the challenges adequately; however, those who use effective coping strategies can resist the challenges and grow personally from their adversities (Montero-Marin et al., 2014).

According to the contextual cognitive theory, coping is defined as either emotion-focused or problem-focused coping. Emotion-focused coping strategies deal with negative emotions in response to the stressor (Lazarus, 1991; Lazarus & Folkman, 1984). Therefore, emotion-focused coping may be employed when an individual is unable to deal with or does not have any control over the situation (Thompson et al., 1994). Problem-focused coping strategies aim to change or eradicate the individual's association with the stressor (Lazarus, 1991; Lazarus & Folkman, 1984). Problem-focused coping typically occurs when an individual perceives control over the situation, and he/she is able to change or manipulate the stressor. It is important to note that neither emotion-focused coping nor problem-focused coping are inherently good or bad (Lazarus, 1991; Lazarus & Folkman, 1984).

Rather, the coping strategy must be evaluated based on its usefulness in the context of the situation. One coping strategy may be effective in one situation and not in another. For example, when an individual works on a project for a long period, he/she may develop a feeling of mental and/or behavioural disengagement distancing oneself from the task. After a short period, the individual may then reengage in the task while having relieved the stress from working for long hours. However, mental and behavioural disengagement may not be suitable when taking a test in class. Disengaging from the task in this instance would be negative to the outcome. According to the COR Model (see section 3.2.3.3), how individuals cope is dependent on their resources and the demands they face (Hobfoll, 1989). Therefore, coping has a direct relationship with the outcomes, such as burnout and/or engagement.

3.5 CONCLUSION

This chapter has sought to cover the theoretical framework of this study. The background of the study and the important concepts (burnout and resilience) were discussed. The chapter also highlighted burnout as one of the main challenges of daily employee functioning and also, in particular, of HIV/AIDS counsellors. It also indicated that chronic burnout deteriorates the cycle of daily job resources, daily work engagement, and daily job production.

Different models of burnout were discussed, and the Job Demand Resource (JDR) Model seemed to be the most applicable to the study. The model was recognised by many

researchers as a model reaching over the spectrum of positive and negative outcomes. Its key ideas are that burnout develops when there are too high job demands and the individual does not have the resources to cope with the demands.

Resilience as an aspect of positive psychology was also discussed as a countermeasure against burnout. Positive psychology emphasises the study of individual strong points and good qualities with an intention to understand and facilitate positive outcomes. Therefore, different models of resilience were discussed to show how individuals cope with their challenges in their working environment. Work engagement was also discussed as one of the factors that can be used to highlight the process of moving from a burnout state to resilience. The concepts thriving, and hardiness were discussed to highlight their relationship to resilience. Important strategies to counteract burnout were discussed. Management in organisations can develop a work plan that is a practical strategy to support employees who may be experiencing burnout. A workplace plan always comprises specific solutions from the past, current and potential work-related issues. Individuals can be encouraged to develop self-care strategies and offered counselling and training to assist them in handling their jobs and avoid burnout. The following chapter discusses the research methodology employed in this study.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The previous chapters focused on the aims of this study and delved into the life stories of HIV/AIDS lay counsellors and the nature in which burnout affects them and their resilience. Through studying the literature and existing research, it became apparent that there is a necessity for research into the factors contributing to burnout as well as their coping strategies. This study attempts to generate knowledge on lay counsellor burnout and resilience as part of the scientific knowledge on this topic. This research study, therefore, seeks to understand how lay counsellors can be resilient despite the challenges they encounter that lead them to suffer from burnout. This chapter describes the research approach that directed this study, pointing out the methods that contributed to achieving the research objectives. The research design gives an overview of the research strategy employed, the population, sampling method, data gathering techniques and how data will be analysed. Lastly, this chapter concludes with the measures of trustworthiness and ethical principles that will be followed when doing this study to safeguard the rights of the partakers in this research.

4.2 RESEARCH DESIGN

Creswell and Creswell (2017) indicated that a research design is a strategy of enquiry that gives specific guidelines for procedures in a research study. It serves as a plan of action that connects the problems to be investigated with the execution of the research. They further point out that qualitative research is an approach used to explore and understand the meaning individuals give to a particular social phenomenon. In qualitative research, the researcher studies the lived experiences of individuals and asks them to provide stories about their lives. The researcher then describes the experiences of individuals about the phenomenon as described by the participants (Creswell & Creswell, 2017). In this study, a qualitative research method enabled me to obtain a deep perception of the life stories of HIV/AIDS lay counsellors.

Hesse-Biber (2016) stated that qualitative research has to do with comprehending and investigating the truth of the participants; hence this research would be limited if a quantitative method was used. If the research used the quantitative method, what the participants go through would not be discovered as it focuses on numbers or the choice between true or false, measuring quantities and analysing them statistically. Using a qualitative method allowed me to gather verbal data. I also intended to pinpoint and comprehend the types of topics that emerged from the gathered information (Roller & Lavrakas, 2015).

4.2.1 Strengths and limitations of qualitative research

According to Roller and Lavrakas (2015), qualitative research provides a rich source of information, and it is useful for gaining in-depth, meaningful information from a hard to reach or hidden population. It aims to understand the meaning of naturally occurring, complex phenomena and limitations in contexts. Qualitative research also provides an understanding of the participant's personal experiences. It uses a naturalistic approach that allows the generating of rich, descriptive data that assist the researcher in understanding the participant's experiences and attitudes (Silverman, 2013).

Creswell and Creswell (2017) alluded that the most important strengths of qualitative research are that the inquiry is broad and open-ended. It supports a way of looking at research that focuses on individual meaning as well as reporting on the characteristics of the specific situation. Another benefit of a qualitative approach is that it encourages participants to expand their responses and possibly open up new topic areas that the researcher may not have considered.

Leavy (2017) emphasised that qualitative research is generally characterised by inductive approaches to knowledge building that aims at generating meaning and the integrity of narrated data. It does not focus on deductive testing of preconceived theories. Researchers use the qualitative approach to explore, strongly investigate and learn about social phenomena, unpack the meanings people assign to activities, situations and events or build a depth of understanding about some dimension of social life (Leavy, 2017).

Hesse-Biber (2016) pointed out that to distinguish qualitative and quantitative research is to recognise that qualitative research focuses on revealing real-life experiences and does not focus on separating and testing hypotheses, and the emphasis is on exploring and discovering meaning as identified by participants and can therefore also be called hypothesis-generating. The focus of qualitative research is to extend ordinary language and expressions to assist us in understanding our social world. Qualitative research explores the occurrences in their social surroundings and does not attempt to remove them from their usual environment. It also attempts to explain the mindsets and encounters of the participants (Hesse-Biber, 2016). Although there are advantages to qualitative research, the approach also has disadvantages.

Qualitative research has its own limitations; the most important is the researcher's inability to generalise research findings (Silverman, 2013). The knowledge produced might not be able to be generalised to other people in other settings. Furthermore, data collection and analysis in qualitative studies is more time-consuming in comparison to quantitative studies. As a result, qualitative researchers may prefer to have a small sample size to minimise time constraints.

Silverman (2013) also adds that the researcher always interprets the findings; therefore, the study's credibility is highly dependent on the effectiveness of the researcher, and the findings can easily be influenced by the researcher's biases. Gibbson (2015) also warns against the de-contextualisation of meaning because, in most cases, data analysis without taking into account the background of the participants and their context could lead to meanings getting lost.

4.2.2 Rationale for using the qualitative research approach

According to Cunsolo Willox et al. (2013), when using the qualitative research method, the researcher can look into and explore participants' life stories and experiences by using interviews. This is in harmony with the idea that people find meaning in their lives and give an account of what they go through by telling and sharing stories. These stories form the cultural, mythological, and historical explanation of everyday life. Stories are the expression of lived experiences, are always continuous, already embedded within cultures, as well as reveal how people think and philosophy about their existence and the meaning of their lives. They indicated that storytelling should be respected as a way of sharing lived experiences, exploring personal beliefs and values, and discovering place-based wisdom. Brannen (2013) explains that storytelling represents a distinctive way of knowing. Instead of getting to conclusions that can be applied to all humans, the researcher strives to comprehend the personal realm of the interviewees, which is best understood through a qualitative research method. Hence, the qualitative research method was suitable for my research since my intention was to explore the life stories of HIV/AIDS lay counsellors.

According to Leavy (2017), the values underlying qualitative research include the importance of people's subjective experiences, meaning-making process and acquiring detailed information from a small sample. Qualitative research is generally appropriate when your primary purpose is to explore, describe or explain. With this study, I intended to explore, describe and explain the lay counsellors' counselling experiences, including possible problems, for example, burnout and possible coping mechanisms, for example, resilience. The major advantage of the qualitative approach is that you can collect rich data with descriptions and examples, and the participants' language and concerns would be at the forefront (Leavy, 2017).

Howitt (2019) highlighted that qualitative research is concerned with the richness of description. Rich data (giving more personal or intimate information) is a characteristic of qualitative methods. Qualitative research methods emphasise the perspective of the individual

and their individuality; hence, it would be important for the researcher to focus on the individual's uniqueness during the process.

Hesse-Biber (2016) pointed out that the focus of qualitative research is generally words, texts, and images as opposed to the gathering of statistical data (numbers) with the goal of generalising and confirming research hypotheses. However, these differences do not mean that qualitative researchers do not use numbers or that quantitative researchers do not use words. Rather, numbers can be used by a qualitative researcher to summarise some of the major qualitative themes generated from participants' in-depth interviews. Qualitative researchers also test out emergent hypotheses on their qualitatively-driven data as they engage in writing reflexive memos, which inductively assist them with the coding and thematic analysis of their data (Hesse-Biber, 2016).

4.2.3 Research participants

Participants for this study had to be found at organisations (or clinics) where lay counsellors were counselling people infected by HIV and AIDS. To carry out the research, permission was requested from two clinics (under the Department of Health, also called organisations interchangeably in this discussion) in a Tshwane residential area. The population in that area are mostly African Setswana and Zulu-speaking people (Stats SA, 2013). I clearly explained to them the conditions for the choice of the organisations, participants and the purpose of the study. The following criteria applied:

- The clinic should be registered with the Department of Health (DoH); otherwise, it was left out.
- The clinic should employ lay counsellors for people affected and infected by HIV and AIDS.
- The organisations should have lay counsellors who had been there for a minimum of twelve months in order to be suitable.

Two clinics met the required conditions, and I made a second visit to each one. However, due to COVID-19 restrictions, I decided to go with only one organisation, limiting the number of contacts with various people. Permission to conduct the study was obtained from the Department of Health (DoH) as well as the manager of the organisation (Appendix A & B refers), and appropriate participants were singled out. Accordingly, I further got approval from the manager~~s~~ to approach the lay counsellors to be part of the study; hereafter, permission to include the participants was obtained from each counsellor individually.

The population of this study refers to all the lay counsellors for people affected and infected by HIV and AIDS in a clinic located in a Tshwane area. A convenient sample comprising seven HIV and AIDS lay counsellors was selected to participate in the study. Only those who met the conditions were considered for the study. Mertens (2014) contended that purposive sampling enables the researcher to select suitable individuals who will be able to give rich information about their experiences. They were sampled from one clinic providing HIV and AIDS counselling in the community. One of the key requirements was that each participant should have worked at least one year in the clinic and had training in how to help people infected and affected by HIV and AIDS. I used the site visit to the clinic to recruit participants in person after obtaining permission from the DoH and the clinic manager. Moreover, I gave them an information sheet (see Appendix C) and got their agreement to include them in my study. Permission was obtained from each lay counsellor separately who also signed a consent form (see Appendix D).

4.2.4 Sampling plan

Moser and Korstjens (2018) refer to sampling as a process of selecting or searching for situations, contexts and participants who provide rich data regarding the phenomenon of interest. According to Moser and Korstjens (2018), a sampling plan is a formal plan specifying a sampling method, a sample size, and a procedure for recruiting participants. A qualitative sampling plan describes how many observations, interviews, or focus group discussions are needed to ensure that the findings will contribute to gathering rich data. Moser and Korstjens (2018) define a sample as a subset of a population that is used to represent the entire group as a whole. They highlighted the key features of a qualitative sampling plan as follows. First, participants are always sampled deliberately. Second, the sample size differs for each study and is small. Third, the sample will emerge during the study: based on further questions raised in the process of data collection and analysis, inclusion and exclusion criteria might be altered, or the sampling sites might be changed. Finally, the sample is determined by conceptual requirements, not primarily by representativeness. The researcher needs to provide a description of and rationale for the choices in the sampling plan. The sampling plan is appropriate when the selected participants and settings are sufficient to provide the information needed for a full understanding of the phenomenon under study. In this research study, the sample was derived from the population of all lay counsellors working at the community clinic who met the requirements.

4.2.5 Sampling technique

This study used a goal-directed sampling method choosing sample members from a population who satisfy certain required characteristics for the target population. Fouché and Schurink (2011) pointed out that the central aim of purposive sampling is to enable the researcher to gather the most possible data. Furthermore, purposive sampling refers to a method of sampling that can be suitable for social situations in which a small number of participants share their life events for an in-depth investigation by the researcher. Purposive sampling is also seen by some researchers as judgmental sampling as it is based completely on the subjective decision of the researcher (Creswell, 2014).

Etikan and Bala (2017) concur that the researcher's decision is guided by features that contain the most distinctive, illustrative, representative, typical characteristics of the population that assist in reaching the aims of the study. They also mention that if the researcher uses goal-directed sampling, he/she will find suitable individuals who are especially illuminating with regard to the research topic. Hence, the selected participants should meet all the requirements to be used in the study (Neuman, 2014).

Neuman (2014) emphasised that purposive sampling is used in situations in which an expert uses his/her judgment in selecting cases with a specific purpose in mind. Since the current study is exploratory in nature, I selected participants who probably could provide answers to the research questions that guide the entire research project. I also hoped to find participants who would share an experience but vary in characteristics and individual experiences (Moser & Korstjens, 2018). The participants were purposefully selected in this study so that they could provide typical and divergent data; they had been doing counselling at the clinic for at least a year. Some counsellors were from other organisations at the clinic; however, those who worked for the DoH were preferred and were selected for this study.

4.2.6 Data collection methods

Creswell (2014) indicated that the selection of suitable participants is made with the purpose to gather data that will provide answers to the research questions. Therefore, it is very crucial that researchers establish what will enable them to resolve their research question and consequently, semi-structured interviews were chosen as the chief information collecting method for the reasons discussed below. I decided to also use a biographical questionnaire to provide me with some background information about the participants before the interview. Concerning both these tools, the participants were assured that their responses would remain anonymous.

4.2.6.1 Data collection tools

A biographical questionnaire that could be answered in 15 minutes and semi-structured telephone interviews (lasting approximately 45 minutes to an hour) were used for data collection. These instruments are discussed in more detail below.

Biographical questionnaire (Appendix E)

Relevant biographical information about the participants was obtained through the use of a questionnaire. The information helped me to have some background information about the participant I was going to interview, and it allowed me to compare participants. The variables covered by the questions were age, gender, marital status, educational qualification, the type of training they received to perform their duties and the number of clients the participant had to see on a daily basis. After the interviews were conducted, I also reflected on the participants' accounts to ascertain whether lay counsellors' stories are different, if challenges affect them differently and also if they cope differently according to their age, gender, educational qualification and marital status.

I left the biographical questionnaire for each participant in an envelope at the clinic since they had no access to email. I requested that they answer the questionnaire and leave their answers again in an envelope at the clinic, where I collected it before our interview.

I used their answers to the biographical questions at the beginning of the interview in an effort to build a relationship and reach a connection with my participants. I shared some commonalities with the participants, and I told them that I, too, was a lay counsellor some years ago. The aim of sharing my personal experiences was to make them more at ease in unfolding and sharing their own personal experiences. I used the biographical questionnaire as an ice breaker and a tool to build rapport because it does not have difficult or confusing questions.

Semi-structured interviews (Appendix F)

The choice of semi-structured interviews was motivated because of the following reasons: Atkins and Wallace (2012) confirm that interviewing is one of the principal methods used to collect material in qualitative research. With interviewing, the researcher can get a look into people's interpretation of the here and now, their views of what is significant and definitions of their circumstances. This approach gives the researcher and participants more flexibility as the researcher is able to follow-up on particular interesting avenues that arise in the interview. The participant can also provide a deeper insight into the situation when required (De Vos et

al., 2011). I decided to use interviews to focus on one person and build rapport with the participants as well as I could. I believe that participants may be willing to discuss personal experiences during an interview, and it would allow me time to pursue interesting areas (Curtis & Curtis, 2011).

Moser and Korstjens (2018) mentioned that interviews are a data collection method in which an interviewer asks the respondents questions, face-to-face, by telephone or online. The qualitative research interview seeks to explore the meanings of central themes in the life world of the participants. The main task in interviewing is to understand the experiences of the participants/interviewees as well as how significant the occurrence is to them. Therefore, through verbal expressions, the individual must be able to share information and describe incidents so that the interviewer can uncover the story behind those experiences. I conducted semi-structured telephone interviews to augment the information gained through the biographical questionnaire. Through the interviews, I hoped to obtain a comprehensive view and an in-depth understanding of the HIV/AIDS lay counsellors' stories and the challenges they face when counselling people infected and affected by HIV and AIDS. I also explored the factors that contributed to burnout and resilience among these HIV/AIDS lay counsellors. An interview plan was prepared to make some pre-set questions available for me to use (De Vos et al., 2011). However, I used these questions as guidelines, and they did not dictate the interview.

Before the data collection commenced for this study, I first did a small-scale study (pilot study) to find out how usable the interview schedule is. De Vos et al. (2011) mention that it is imperative to conduct this kind of study in qualitative research to assist in planning and modification of the main study. A pilot study is usually undertaken with a few participants possessing the same qualities as those of the major research to determine certain tendencies. The chief aim of the small-scale study is to ascertain whether the appropriate information could be gathered from the participants of the main study (Strydom & Delport, 2011). After the interview schedule had been put together, three participants in the recommended organisation were arranged to pilot test the interview schedules. The participants' responses were evaluated to refine the questions and assess the time required. Consequently, the schedule questions that did not contribute to gathering the appropriate information or the relevant data were altered prior to the main enquiry.

The decision was further made to conduct the interviews by telephone because of the following motivations: In the University of South Africa COVID-19 guidelines, Meyiwa (2020) reported that UNISA supports the continuation of research activities, where possible, guided by principles and activities supported by the Policy on Research Ethics. The guidelines

highlighted that where feasible, researchers may move from face-to-face to remote data collection and follow-up visits with the participants' consent. This could be in the form of online data collection, telephonic, email or other platforms considered only when safety and confidence can be ensured. Therefore, these guidelines were taken into consideration when the method of data collection was changed from face-to-face interviews to telephone interviews. We could not use Zoom, Skype or one of the video technologies because the participants did not have computers and internet connections. Due to COVID-19 restrictions and the participants working on a rotational basis, it was not conducive to interview the participants in the office provided by the organisation. There was an agreement that interviewing within the organisation might be a challenge because there can be many distractions. Therefore, I agreed with the manager and participants that telephone interviews would be the most practical in the current circumstances. Some participants suggested that they could only partake in the study if they could do it after working hours because they have a busy schedule while at work.

During my visit to the organisation, I met with the participants and informed them that the telephonic interview would be audio-recorded and asked them to give me permission to audio record the interview. The participants' written consent was obtained during the site visit (see Appendix D). The audio recordings I made of the interviews allowed me to refer back to the interview data, which would not be possible if I had to rely on my memory alone. It was also more trustworthy than just making some notes and relying on my own observations as I could listen attentively to the participants using this method (Fouché & Schurink, 2011).

I noticed that when telephone interviews were suggested, all the participants agreed to the option as an alternative for a face-to-face interview and were grateful for being given this opportunity. One main reason for this preference was that I did not want to interfere with their work during the day, and therefore, I suggested that the interviews be conducted when they knock off in the afternoon. Another reason for the choice of telephone interviews is that it provides participants with a greater level of anonymity and privacy. They supported the option because it is flexible since we agreed to communicate after hours (between 17:00 and 19:00) which was more conducive to them. In order to maintain consistency and avoid distractions, all interviews were conducted after hours on the date and time scheduled by myself and the participants. Participants were promised that if they were interested in the results of the study, an outline of the results of the study would be made available to their organisation.

Because I previously met with the participants, they knew what I looked like and consequently, when we had the telephone interview, I was not just a voice of an unknown person. Glogowska et al. (2011) advise that the interviewer should listen attentively and not rush the interviewee

to respond. The interviewer should develop a rapport with the interviewees, make them comfortable and ensure that they feel that their opinions have been noted and regarded as valuable contributions. I tried to make the participants comfortable by starting with simple questions and also made some notes during the data collection process. Since there was no face-to-face contact, I was able to take notes and write probes without any concern of distracting the interviewee. However, I did not rely only on taking notes during the progression of the interviews since that would have made me concentrate more on jotting down what they say rather than attending to and grasping what they say. An audio recorder was used in the process.

I also prepared myself for the possibility of technical problems during interviews, for example, if either my or the participant's phone would lose contact due to a cellular network coverage problem. I decided that I would then pause the audio recording and make notes about what was covered. Then I would reschedule an interview for another day. When starting the second interview session, the participant would be briefed about what was covered, and the interview schedule's questions could be continued.

The interviews were conducted in Setswana or English – the participants could select the language they felt comfortable with when answering the research questions. I am fluent in both languages and do not require a translator to be present during the interview proceedings. Interviews were arranged for a date and time that was most suitable for the participants. I encouraged the participants to be on a spot with network coverage, ensure their devices are fully charged and have no noise or any distractions. Before the interview, I ensured that the participants were at ease, in a noiseless area, and there were no distractions. I also asked the participants if they were ready to proceed with the conversation or if they would like to rearrange the session. Privacy is considered crucial at both ends, especially when sensitive or confidential matters are covered (Mealer & Jones, 2014). Environmental sounds can disturb both the dialogue and the recording, and because I asked them to avoid noise as far as possible, some of the participants indicated that they locked themselves in their bedrooms to avoid distraction from their children or family members.

The interview started with the biographical questionnaire before continuing with the interview schedule. I expressed my gratitude to the participants for taking time out of their busy schedules to participate in the interview. The use of simple personal questions encouraged the participants to talk about themselves (e.g. age group, marital status, educational qualifications etc.). This is regarded as an effective method in gaining important background information and a connection with the participants (Mealer & Jones, 2014). This approach

offered an effective way to relieve a tense situation (overcoming uneasiness) and get the conversation going.

Then I moved to the interview schedule, which consists of questions that were used to guide the interviews as mentioned above (see Appendix F for a complete list of questions). I found that some participants needed to be questioned thoroughly in order to give more information on some of the questions. The interview schedule ends with asking the participants about their experiences with the COVID-19 pandemic. When concluding the session, I informed the participants that they were welcome to raise any questions, express any apprehension and feel free to say if they needed assistance.

After the interviews, I reflected on the conversation and tried to recall key issues identified through the discussion. I also tried to recall further matters to explore in more questions since I promised the participants that if any responses were unclear, they would be contacted again for clarity.

The recording of the interviews was done using an audio recorder which was placed next to the mobile phone speaker. I made sure that the phone was fully charged, had enough air time and performed without any technical failure or power stoppages for the entire interview period. The digital audio recorder was connected directly to my personal computer or laptop. In this way, I easily transferred audio files from the phone onto a laptop. I dealt with the data immediately after all the participants had been interviewed and all the necessary data was gathered. All the gathered data was organised and converted into electronic files on my computer. The way in which the data was analysed, is explained under the section on data analysis.

The strengths and limitations of telephone interviews

Qu and Dumay (2011) indicated that qualitative interviews are traditionally conducted on a face-to-face basis. This approach is viewed as necessary for the interviewer to build and maintain rapport with interviewees enabling the gathering of rich, in-depth data. During face-to-face interviews, the participants' non-verbal communication and signs in the touchable surroundings can add to researchers' understanding (Farooq & De Villiers, 2017). Traditionalists contend that facial expressions and body language are an integral part of the communication process; however, these visible signs are potentially lost during telephone interviews (Rowley, 2012).

With telephonic interviews, the researcher is unable to use body language as a natural tool for probing and seeking clarifications or elaborations to the given answers (Farooq & De Villiers,

2017). Irvine et al. (2013) argue that interviewers using telephones cannot rely on visible signs to assess the participant's level of interest and inform them when they need to encourage and increase the participant's interest. Subsequently, Kassianos (2014) highlighted that the use of telephone interviews in qualitative research is thought to minimise the richness of qualitative data by restricting rapport. According to this view, the richness of qualitative data is minimised by the absence of visual encounters between the interviewer and the interviewee.

Irvine et al. (2013) conducted an exploratory study and used conversation analysis to investigate interactional differences between face-to-face and telephone semi-structured qualitative interviews. They established that the most fundamental difference between telephone and face-to-face interviews is the absence of a visual encounter. This is thought to affect the interaction in several ways. Furthermore, telephone interviews tended to be shorter and constantly needed more clarification. Miles et al. (2014) indicated that telephone interviews do not allow the researcher to visually access the participant's natural environment, preventing the researcher from collecting important contextual information.

Moreover, the researcher cannot ensure a good interview atmosphere since he/she is unable to evaluate whether the interviewee is at ease in their environment or not (Farooq & De Villiers, 2017). Another limitation is that the interviewer is not aware of elements that may create distractions in the interviewee's environment, and it is difficult to take remedial action (Glogowska et al., 2011). Therefore, traditionalists criticise this lack of contextual information and argue that the telephone is a substandard data gathering instrument, not appropriate for qualitative research (Farooq & De Villiers, 2017).

Although there are some limitations in the usage of telephone interviews in qualitative research, researchers who have used them support the approach and indicate its strengths. Indeed, qualitative researchers who are familiar with the use of the telephone or who have compared telephonic and face-to-face interviews disagree with the traditionalists' negative views of the approach (Irvine et al., 2013; Vogl, 2013). Vogl (2013) reports that telephone interviews provide a more balanced distribution of power between interview participants. The participants are encouraged to express themselves and may be able to steer the conversation in the direction of the areas they view are important.

Furthermore, the use of telephone interviews can remove biases and stereotyping by both the interviewer and interviewee with regard to appearance, visual traits and behaviour of each other. Therefore, the use of telephone interviews can remove those visual distractions and reduce some of these biases (Vogl, 2013). When using telephone interviews, too much rapport is avoided since that could lead to the discussion drifting and losing its focus. Interviewers

maintain a certain degree of remoteness and reservation from interviewees (Tucker & Parker, 2014). Tucker and Parker (2014) highlighted that telephone interviews give the participants a greater level of anonymity and privacy while accommodating those who are shy. The approach can also assist the participant by reducing social tension whilst the interviewer is connecting to him or her (Vogl, 2013). Telephone interviews allow the participants to cancel and reschedule the meetings because the interviewer has not taken on any expenses for travel or accommodation (Cachia & Millward, 2011).

Vogl (2013) compared 56 face-to-face with 56 telephone interviews. The study found no significant difference in the quantity, type or seriousness of responses using the two methods of communication. The study then concluded that there is no difference in the purpose and intensity of rapport achieved. Consequently, Deakin and Wakefield (2014) shared their experience of conducting face-to-face interviews and virtual conferencing (e.g. using Skype). They argued that there was no difficulty in finding connection with their study participants and that the level of rapport achieved was similar to their face-to-face interviews. Therefore, the telephonic interview was seen as a valuable qualitative data collection tool for this research during this period of the COVID-19 pandemic. Based on the strengths indicated above, I felt comfortable using telephone interviews for data collection.

I planned that in cases where the interview would evoke distress, it might be necessary to refer the participant to a counsellor or therapist for assistance. After every session, I made sure that each participant was debriefed to ensure no harm occurred due to the research process. None of the participants in this study reported that they experienced psychological challenges due to the interviews, and nobody was referred for therapy.

Table 4.1 presents a summary of the approaches described above to ensure useful telephonic qualitative research interviews in this study.

Table 4. 1

Summary of strategies for useful telephonic qualitative research interviews

	Strategy	Discussion
Before the interview		
1	The interview guide	• An interview schedule was used, and it helped me to keep to the topic
2	Pilot-testing the interview guide	• The guide was tested on three participants before the actual interviews

	Strategy	Discussion
		• After conducting the pilot test, the guide was revised accordingly
3	Negotiating interview time	• Negotiated more time with the participants • The researcher was adaptable and offered to schedule the interview for when the participant was available
4	Setting up the equipment	• Made sure that my mobile phone was fully charged • Made sure that my mobile had enough air time • Made sure that the participant was where there was network coverage
5	The interview location and environment	• Allowed the participants to choose their preferred environment • Made sure that the participants were comfortable • Made sure that the room was noiseless and without interruptions • Made sure that the interviewee was ready to proceed or offer to reschedule to another date
6	Scheduling of interviews	• Allowed the counsellors to choose a date and time they preferred • Organised my diary to suit that of the participants • If there were disruptions due to network and load shedding problems during the interview, the session was rescheduled/postponed for another day
7	Data organisation	• Allocated a numeral code to the interviews • Prepared an Excel file to summarise the information obtained in each interview
During the interview		
1	The use of interview guide	• Used the interview guide in a flexible manner
2	Communicate without visual cues	• Listened carefully and articulated questions clearly • Jotted notes but remembered to focus on listening • Communicated presence and sounded interested
3	Start, middle and end	• Started with simple questions • Probed and rephrased • Ended on a positive note
4	If interviews were cut short because of some technological problem	• Phoned back and rescheduled for another day

	Strategy	Discussion
5	Provide comfort to participants	• Research ethics taken into consideration
After the interview		
1	Immediately after the interview	• Saved the audio acoustic footage on a laptop, deleted the recording from the recorder. • Transcribed interview in a Word document • Data was saved and protected with a password • Reviewed and completed interview notes • Reflected on the interview and made notes of any outstanding events or phenomena. Also assessed how the interview guide and my way of conversation could be improved for the next interview.

4.2.7 Data analysis

Data analysis is the process used by researchers of reducing data into meaningful units to create structure in the bulk of collected data (De Vos et al., 2011). Creswell (2014) provides an understandable exposition of qualitative data: it is presented as written material (words, phrases or symbols) portraying the occurrences in people's lives. Ngulube (2015) alluded that qualitative data analysis is involved in converting raw data by assessing, enciphering, explaining, depicting, coding, mapping and exploring tendencies, themes, groups and classes in the raw data. Kekeya (2016) also states that the purpose of investigating the data is to portray, assess and expose the features and attributes of the data gathered during the research process.

Kekeya (2016) further highlighted that qualitative data could be analysed using many techniques to unveil reality. I decided to use thematic analysis as described by Braun and Clarke (2013). They indicated that researchers often use this method to analyse data from their interviews. In thematic analysis, the researcher explores patterns across qualitative data from participants by identifying themes in the data. Themes are the overarching categories of common data across multiple participants. The researcher systematically codes all data and then begins to organise the codes, based on some similarity, into larger categories that may lead to themes and subthemes (Braun & Clarke, 2013). I chose thematic analysis to analyse the collected data in order to organise the data into categories and identify themes because it would enable me to understand the common topics of lay counsellors' experiences and ways of dealing with what they encountered.

The data of this study were obtained from the soundtracks of the interviews. The interviews were written out in full, and these written versions and remarks that I wrote down during interviews were analysed according to themes. Thematic analysis was chosen because it assisted me to understand the aspects of a phenomenon that participants talked about frequently or in-depth and the ways in which those aspects of a phenomenon may be connected. In this regard, I followed Braun and Clarke's six steps of qualitative data analysis for this process. The following steps were taken: familiarising yourself with your data, generating initial codes, searching for themes, reviewing themes, definition and naming of themes and production of the report. These steps are discussed below.

Familiarising yourself with your data

This stage followed after all the interviews had been conducted and all the essential information was gathered. I, therefore, read the transcripts several times and listened to the audio-recorded interviews thoroughly and repeatedly to gain an overall idea about the contents of the interviews before splitting the data into separate chunks. The data I collected from the participants was mostly presented in the form of short stories. Furthermore, minor editing was undertaken where I needed to make the notes accessible, and I generally tidied it up where it seemed vast and uncontrollable. I then singled out all the key topics and issues in the gathered data.

Generating initial codes

Once the researcher is familiar with the data, he/she must start classifying primary codes, which are the features of the data that seem exciting, standing out and meaningful. I, consequently, jotted down some comments about the coding process, which consist of notes in the form of brief formulations, impressions or important notions. Data were recorded in a Microsoft Excel file with each participant in a separate folder. I then identified the cruxes of the matter and allotted them into classes or groups, and assigned symbols to each category. I used different colours to point out separate groups. Hereafter I read through the data of the different groups to check for any data that was categorised erroneously.

Searching for themes

As mentioned above, the interviews were written out in full, and the transcripts and my notes were analysed according to themes. To be able to identify mutual topics in the participants' accounts of actual incidents, I read the data thoroughly and repeatedly and highlighted key phrases that corresponded to the research questions, keeping in mind that the research questions relevant to the study serve as a guide to identify themes. Then the gathered

information was organised into meaningful units by allocating factors with commonalities together. New classes were pinpointed, and data that could be categorised in certain categories were documented.

Reviewing themes

Themes were identified by labelling recurring or common phrases that appeared to have theoretical meaning. Furthermore, I continually compared their answers to research questions against the transcripts and notes gathered that pertained to the aims of the study. The common themes among the answers to the interview questions were then classified under appropriate topics as well as the subtopics.

Definition and naming of themes

All the data related to each question was carefully arranged and systematised. I, therefore, carefully organised all the data according to each question and noted them in sequence. This enabled me to explore and identify any differences, similarities and connections between themes. I condensed the data into small sets of topics in order to make it manageable when writing the final report. In addition, I filtered the data to resolve the significance of the categories – this interpretation involves understanding the information or the lessons learned. Hence, I distanced myself to get an overview and idea of the gathered data and, therefore, clarified them accordingly.

Production of the report

This is the last stage of doing data analysis. I attended to all relevant information until all the themes were saturated. The data was quite overwhelming, and I needed to understand that it was not possible to present all the data. It was necessary for me to be selective in terms of what I wanted to portray. I also had to edit the data and select significant portions, concentrating on certain parts instead of others (De Vos et al., 2011); hereafter, data were put forward in terms of the identified themes and subthemes.

The study was peer-reviewed by the supervisor and an assigned qualified researcher familiar with qualitative research methods to make it credible. The research associate was requested to assist with editing themes and validating that they were suitably classified. The research associate and I worked independently and compared the data for similarities or differences, and then we discussed the themes that we did not agree on and came to a consensus. The researcher's associate was reminded of confidentiality and the code of ethics in research. The trustworthiness of the data analysis is discussed below.

4.3 MEASURES OF TRUSTWORTHINESS

According to Creswell and Poth (2016), both quantitative and qualitative researchers need to test and demonstrate that their studies are credible. In quantitative research, researchers refer to research reliability and validity of a study that is credible. In contrast, in qualitative research, the researcher is the instrument and therefore, credibility in qualitative research depends on the researcher's abilities and effectiveness. Connelly (2016) states that reliability and validity are two factors that any quantitative researcher should be concerned about while designing a study. In qualitative research, these terms are not viewed or defined as separate concepts. Instead, trustworthiness is used to describe these concepts. The trustworthiness of a study is synonymous with and can encompass both the reliability and validity of a study. In qualitative research, reliability refers to the trustworthiness of observations of data, whereas validity refers to the trustworthiness of interpretations and conclusions (Connelly, 2016). Although qualitative studies do not draw a clear boundary between observations and interpretation, it is useful to distinguish between the two: Reliability in qualitative studies has to do with whether the observations are repeatable and whether the researcher's report conveys what other researchers would have seen had they been observing. Validity relates to how trustworthy the researcher's interpretations are considered to be. Concerns can arise about interpretations because words do not mean the same to everybody and because events may look different from different perspectives (Ezzy, 2013).

Moser and Korstjens (2018) state that trustworthiness is the degree to which the data and data analysis are believable and trustworthy. Therefore, to ensure a high standard of trustworthiness, I made use of the core principles of the person-centred theory when interviewing the participants, which are congruence (genuineness, or realness), unconditional positive regard (acceptance and caring), as well as empathic understanding (the ability to comprehend the personal experiences of another individual deeply). Person-centred research is a matter of seeing oneself, others, contexts and their interrelationship as human beings (Jacobs et al., 2017). I maintained congruence by showing genuineness and being authentic to myself. Unconditional positive regard was maintained by acknowledging the participants' worldviews and appreciating that they were unique. I displayed empathic understanding by seeing the participants' point of view to the best of my ability. Trustworthiness includes the credibility, transferability, dependability, conformability and authenticity of data (Lincoln & Guba, 2013), and these aspects are discussed below.

4.3.1 Credibility

Denscombe (2014) highlighted that a study is considered to have credible findings if it accurately reproduces the experience and perceptions of research participants. I was able to build rapport with the participants by having respective curiosity while engaging with them. I also had a non-judgemental attitude, having unconditional positive regard for the participants. Rapport was built with the lay counsellors by creating a warm and trusting relationship that assisted in creating the necessary space for them to be congruent and honest. Simple biographical information was initially asked to make the participants comfortable and relaxed.

Furthermore, credibility was ensured by recording and transcribing interviews (Creswell & Poth, 2016). Semi-structured interviews were recorded, and transcriptions of these were made, and I also took some notes while conducting the interviews. The fully written down texts were given to each interviewee so that they could verify and validate the transcribed data. Participants were asked if they were in accordance with my representation of them. Arrangements were made with the manager of the clinic to give the participants sealed envelopes with transcripts to collect on the scheduled date. The participants were requested to verify the contents, and then an appointment was scheduled to communicate with them telephonically so that they could confirm with me that the data was correct. They were also required to send back the transcripts in the envelopes I had provided for them.

4.3.2 Transferability

De Vos et al. (2011) state that the researcher asks whether the research findings can be transferred from a specific situation to another. They indicated that transferability could be achieved by describing the phenomenon in sufficient detail so that the conclusions drawn can be evaluated to the extent that they can be transferrable. Polit and Beck (2014) support this idea by indicating that transferability refers to the extent to which the findings from data can be transferred to other comparable situations, groups of people or communities. Transferability refers to the degree to which the results can be applied in other settings and contexts; however, it cannot be generalised to the entire population (Burke, 2016).

4.3.3 Dependability

This construct refers to the stability of data analysis – the researcher needs to check whether the analysis process is in line with the accepted standards for a particular design. Polit and Beck (2014) state that dependability refers to a criterion for evaluating integrity over time and conditions related to reliability in research. It is determined by the degree to which the findings

of the study would be the same if the study is done again with the same participants in a comparable setting (Polit & Beck, 2014).

In this research process, dependability was accomplished by stating the exact methods of gathering data, analysis, and elucidation. The interviewees were asked comparable questions in line with the research question that the study strived to answer. I continuously consulted with the supervisor to make sure that I was in line with the theoretical and methodological approach of my study.

4.3.4 Conformability

Conformability addresses the status of whether the findings of the study can be validated by another person. Cope (2014) states that conformability is concerned with whether the data can be verified, meaning that the researcher must ensure that there is no prejudice in the research process or presentation of the results. It is a measure that establishes that the data represents what the participants have provided. The participants were probed to ensure that I understood what they meant to convey to me.

Conformability in this study was also maintained through bracketing, which means the ability to hold back subjective views. Tufford and Newman (2010) posit bracketing as a scientific process whereby the researcher recognises and sets aside his/her presuppositions, biases, assumptions and prior knowledge with the goal of attending to the participants with an open mind. The technique necessitates that the researcher intentionally put away her perception about the incident under investigation. It requires the researcher to set aside her previous comprehension of the subject before and during the investigation (Sloan & Bowe, 2014). My endeavour to adhere to the principles of bracketing allowed me to remain as neutral as possible. It also helped me to avoid a potential trap of filtering the participants' lived experiences through my own experience.

4.3.5 Authenticity

I used the member check strategy by providing feedback to participants in order to validate the authenticity and interpretation of data collected. I further provided a summary of the information collected and presented it to the participants for comments (Polit & Beck, 2014).

4.4 ETHICAL CONSIDERATIONS

Adherence to basic ethical principles is an essential part of the research design, particularly with regard to complex and delicate matters that can be sensitive for the research participants and concerning contentious concerns in general (Atkins & Wallace, 2012). These authors also

indicate that ethical principles offer a code of conduct and moral guidelines to the researchers so that they can execute their projects in a morally acceptable way. Bless et al. (2013) allude that one of the reasons that ethics are important in research is that there has been an abuse of people's rights in the name of social research. Ethics will furthermore ensure that the research produces original facts by making sure that it is not producing recurring projects. They indicated that every research must produce some novel information, promote authentic facts and minimise error. Research ethics prevent behaviours such as falsifying data, incorrect reporting and misrepresentation of data. Research is an activity that relies on the support of society and the public; hence it is very important for researchers to obey ethical principles in order to win the public over to have faith in research (Boyd, 2015).

When I was doing this research, I adhered to the following ethical considerations: informed consent, confidentiality and anonymity, avoidance of harm to respondents, deception, actions and competence of the researcher, as well as the truthful release of findings.

4.4.1 Informed consent

Informed consent is fundamentally a matter of human rights and involves implementing a range of procedures when using humans as subjects (Hesse-Biber, 2016). The partakers in the research must have information about the type, aims and possible outcomes of the project. The chief aim of arranging informed consent is to ensure that the research participants know what to expect. Consent involves a mindful decision and giving the researcher the right to certain research procedures (e.g. interviewing). Furthermore, people must not be forced to take part in a research study. They must know that they participate voluntarily, and they have the right to pull out at any time (Arifin, 2018). It is an ethical principle for the researcher to make sure that the participants in his/her research do not only approve and consent to partake in the research without being pressured but that they are completely aware of what the details are of what they agree to do (Davies, 2013). In the case of this study, informed consent meant agreeing to be interviewed about their work as HIV counsellors and giving permission (without being under any duress) that the interviews would be recorded and that quotes from the interviews might be used in research reports.

Creswell (2014) stated that the value of informed consent expects the researcher to reveal the facts pertaining to the research so that potential partakers can make a well-judged knowledgeable choice about possible participation in the study. Therefore, I communicated with the managers of the organisation in writing, where I explained the aims and processes of the study I intended to carry out and requested their approval to do so (see Appendix B). I also wrote an information sheet which I sent to the prospective participants (see Appendix C). In

both these letters, I provided facts about the study, such as the aims and the processes that would be pursued. I also outlined possible gains and shortcomings. I provided true and comprehensive facts so that the manager and participants could fully understand the particulars of the study so that they could make a voluntary and fully rational decision about their possible involvement. I informed them that they were free to quit if they wanted to, and no one should coerce them to participate (Arifin, 2018). I also notified them that the interviews would be tape-recorded. The counsellors who were willing to participate in this study gave their consent by signing a letter of informed consent giving their permission to willingly take part in the study, including an agreement to be interviewed and permission to audio record the interviews and that quotes from the interviews may be used (see Appendix D).

4.4.2 Confidentiality

According to Neuman (2014), confidentiality is the ethical protection of those who are studied by keeping the research data secret from the public, not releasing information in a way that permits linking specific individuals to specific responses. In this study, the findings of this research are not completely confidential because it is written up in a thesis, but the anonymity of the clinic and participants are upheld by using pseudonyms. All researchers should try to safeguard that all research data are treated with suitable discretion and secrecy (Arifin, 2018). Confidentiality should be respected in all circumstances. However, there are circumstances where it may be limited and conditional. Participants should be informed in cases compelling reasons could lead to a breach of confidentiality. It is the duty of the researcher to ensure that the participants are made aware of the situations where and if the research project may not be able to respect confidentiality or the circumstances where information has to be revealed (Arifin, 2018).

Participants need to be confident that identifying details about them will not be revealed and that information that they presented will be confidential. In this study, participants gave permission that they could be quoted. It is also necessary that participants know in what form the results will be presented so that they can decide about participation in the study based on their knowledge about the study. In this study, a consent form presenting information about confidentiality and about the study itself was given to the participants to sign. I ensured the prospective participants that pseudonyms would be used (therefore, their real names will not be mentioned) and also that the clinic's name will not be mentioned when reporting about the research. Creswell (2014) mentioned that there is a non-confidentiality risk of including the collected data in the final report. This was mentioned to the participants of this study by indicating that even though the information will be kept safe and confidential, the same information will be compiled and recorded in the final report (a thesis), which will be submitted

to examiners for academic purposes and it might be presented at conferences and published in academic journals. However, the names of the clinic and participants will not be mentioned in the reports.

4.4.3 Avoidance of harm to participants

Neuman (2014) indicated that social research could harm a research participant in several ways, including physical, psychological, and legal harm, as well as harm to a person's career reputation or income. He mentioned that different types of harm are more likely in other types of research, such as experiments versus field research. It is always a researcher's responsibility to be aware of all these types of potential harm and to take them into consideration to minimise the risk to participants.

According to Strydom and Delport (2011), the researcher is ethically obliged to protect participants from any form of physical harm and discomfort that may arise from the research process. They warn that participants may experience actual damage pertaining to how they are esteemed at work, including loss of privacy, emotional distress, monetary costs and loss of time (Strydom & Delport, 2011). I am aware that specific problems could develop that may perhaps cause participants' emotional damage during the interviews. Hence, I followed the essential ethical principles of social research of preventing any possible hurt. After every interview, I made sure that each participant was debriefed to ensure no damage or even any possible chance of emotional hurt (such as confusion, depression, loss of self-esteem, feelings of tension and remorse) would be caused due to the research process.

4.4.4 Deception

Neuman (2014) emphasised that researchers should never force anyone to participate in research. They should not lie to anyone unless necessary and the only way to accomplish a legitimate research purpose. The people who participate in social research should explicitly agree to participate because their right not to participate can be a critical issue whenever the researcher uses deception. Although social researchers sometimes deceive or lie to participants in field and experimental research, deception is never preferable if the researcher can accomplish the same thing without using deception.

Curtis and Curtis (2011) mention that dishonesty often involves pretension by the researcher where the participants are not fully informed about the research by providing false information and concealing information from them in such a way that if they had been aware of the real facts about the study, they might have refused to participate. According to Denscombe (2014), researchers ought to operate in an open and honest manner in respect to the research

investigation. Therefore, I communicated the purpose of the study and participants were given true facts about the full research process. Nothing about my research procedures and aims were kept secret from them. The facts about the research were made known to the participants. Furthermore, nobody was paid to participate in the study, and they were not forced or pressurised to agree to participate

4.4.5 Actions and competence of the researcher

Researchers should be skilled and truthful when undertaking their planned research (Strydom & Delport, 2011). I have completed a master's degree as part of my professional studies. Therefore, I have been exposed previously to doing qualitative research as well as to doing it according to ethical principles (e.g. following the Code of Ethics by Creswell, 2014). I also gained experience through working as an HIV/AIDS counsellor, establishing and helping to maintain support groups and conducting interviews.

4.4.6 Release of findings

Neuman (2014) states that a research report is a way to portray and explain a completed study. The report is aimed at other people, as indicated earlier, whether they are co-workers or a worldwide audience. The findings of this study will be made known in the form of a written doctoral thesis and submitted to the Department of Psychology of the University of South Africa for degree purposes. In addition, articles on the research or parts of the research findings might be published in academic journals.

4.5 CONCLUSION

In this chapter, I explained the research methodology implemented in this study and also the motivation for choosing a qualitative research approach. The research participants, sampling method, sampling techniques, data collection methods, and data analysis were discussed.

I explained the use of a biographical questionnaire to gather demographic information and the use of semi-structured interviews in order to obtain rich and detailed data from the participants. I explained why the method of data collection was changed from semi-structured face-to-face interviews to telephone interviews: Due to the COVID-19 pandemic, it was important to use telephone interviews as a method of collecting data to avoid breaking the rules and regulations stipulated. A pilot study was used to validate whether the methods of data collection would be feasible or not. The research design utilised in this study clearly indicated that each step is important in achieving the research results. Measures of trustworthiness and ethical

considerations are important when planning and doing any research, and these were taken into account in this study.

The next chapter discusses the participants' short stories about their work as lay counsellors.

CHAPTER 5

RESEARCH RESULTS

5.1 INTRODUCTION

In Chapter 4, I discussed how data was collected and the kind of approach employed. In this chapter, I report on the results of my study, derived from the stories of the participants. The stories of the participants are discussed in terms of the objective to explore and describe the life stories of HIV/AIDS lay counsellors in a clinic in the Gauteng province, South Africa. The stories depict the experiences of the participants, with reference to their background, what they experience as counsellors, what motivate them to be counsellors, what effects the counselling has on them, what could contribute to their burnout or resilience, and what kind of support they have. I also refer to the influence of the COVID-19 pandemic on them. The stories are based on the transcribed interviews that I conducted with each participant, and the transcripts are available on request. Statements will be illustrated by quotations from the interviews where appropriate. Please note that grammatical errors or apparent errors in quoted material do not result from errors in the transcription but are deliberately duplicated, exactly as the participants said it, because it will not confuse readers and it may make the quotes more alive or "real" (authentic). Pseudonyms are used for each participant so that their real names will be kept confidential.

5.2 MAVIS'S STORY: "I MAKE A DIFFERENCE"

5.2.1 The background

Mavis is a 37-year-old woman who is an HIV/AIDS lay counsellor for a local clinic in Tshwane, Gauteng, South Africa. She is married and has completed her tertiary education but not in counselling. She was trained for HIV/AIDS counselling at a hospice for three weeks, and she received a certificate of attendance. She is not a member of any support group. Her clients are HIV/AIDS clients coming for treatment at the clinic.

Her daily responsibilities are HIV testing and counselling, client screening on the queue, health talk (TB, STIs), counselling those who want TOP (termination of pregnancy) and referrals for HIV testing.

She used to see 30 to 40 clients per day, and it was very strenuous and stressful. After some time and discussions with the manager with regard to their problems of having many clients, there was a positive outcome. Things started to change, and they are currently seeing a maximum of 15 clients a day. The lay counsellors are required to have a session lasting for

45 minutes to an hour, and they monitor the time. She said: *"There is a timer that you set, and it stops when the time is up and then you have to close the session."*

Mavis started working in 2009 at an NGO (non-governmental organisation) doing a door-to-door campaign for HIV/AIDS. She also worked at the local hospital for some time before she came to the clinic. She then started working at the clinic in 2014 doing HIV/AIDS counselling. Factors that motivated her to become a counsellor are discussed below.

5.2.2 Factors that motivated her to become a lay counsellor

The aspects below reflect what motivated her and contributed to Mavis's willingness to be a lay counsellor. She conveyed the information about her motivation during the interviews.

5.2.2.1 Family support and encouragement

Mavis started volunteering because she had many family members who were infected and were dying of HIV/AIDS during that time. She started attending the HIV and AIDS courses before starting with volunteer work. She wanted to support her family members and others who were still alive. She faced a lot of challenges in convincing her family members to understand HIV/AIDS. They believed that when somebody is sick, the person is bewitched (it is called Vuloyi-witchcraft in the Sotho culture). She had to encourage them to take their treatment and encouraged them to go for HIV testing. She also encourages them to start using condoms. She said:

> *"Eish! I realised that my family members are dying, and some are affected then I started volunteering. I did not start by working . . . I had to attend some courses. . . . I help because I see that there are many people who need my help, especially my family members because I am close to them."*

It seems that Mavis was motivated to work as a counsellor to assist her family members who did not understand the disease. She had to encourage the family members to take their treatment and encouraged them to test for HIV.

5.2.2.2 The willingness to help others

The fact that she loves people and is willing to assist them is another motivation. She gives support to people, where she realises that if they were on their own, they would not survive. She worked as a volunteer for many years without being paid, taking care of her community members. This is what she said:

"I am willing to assist the community members. If I do not assist them, they will give up and die. Because of me they gather the courage to move on. . . . I worked as a volunteer without any pay, because I did not go there for money, I just wanted to help others who do not know anything about HIV."

It is clear that helping other people is a real source of energy for her and she feels greatly rewarded afterwards. She is compassionate and has a positive state of mind which makes her efficient in this work, regardless of the challenges. Her willingness to help others motivated her to assist sick people in the community.

5.2.3 Mavis's experiences of her counselling role

Although Mavis has several positive experiences, she also has negative experiences when counselling.

5.2.3.1 Positive experiences

The aspects below reflect Mavis's positive experiences while working as a lay counsellor. Some of these experiences were personal fulfilment, appreciation by clients and acknowledgement by clients. These experiences are discussed below.

Personal fulfilment

This aspect discusses how Mavis makes sense of the work that she does. It seems that Mavis's desire to help others is satisfied by what she does as a lay counsellor, and she is pleased with what she accomplishes. Mavis feels positive when she counsels the client, and after some time, the client looks healthy and strong. That makes her feel good and fulfilled. This is how she described it:

"Clients are different then I need to assist them regardless of their characters and status, then I am happy. Clients come to say that I have helped them so much, now they have accepted their status. . . . There are some clients who would refuse to be assisted by others and prefer to consult in my office. That indicates that I am doing a good job."

She believes that the work of lay counsellors is valued by the clients, and her compensations have been their expressed thankfulness. She experiences a feeling of accomplishment when she believes that some client's life was saved through her efforts. This gives her fulfilment and courage to move forward.

Appreciation by clients

Mavis takes pleasure in being of assistance to other people, and she feels appreciated by her clients. Her clients come and show appreciation for her assistance. If this was not the case (that clients show their thankfulness) she would perhaps have felt discouraged and given up in the process. Mavis feels good when the clients appreciate what she does for them. She expressed these feelings as follows:

> *"If I am to leave my job, I think they will remember me. You know I am not supposed to praise myself but because we are talking then that's how I see my clients, they are always happy when they come back to thank me for support I have given to them in time of need, and that makes me proud and satisfied. I understand that even if I am just a lay counsellor, it does make a difference."*

The fact that Mavis likes to help other people and feels that she is regarded highly by the patients making her feel content. Her clients made it clear to her that she has made it easier for them to get through difficult times.

Acknowledged/acknowledgement

Sometimes she counsels clients who want to terminate a pregnancy, and after counselling, they change their minds and decide to stay pregnant. That is fulfilment to her. She also reflected:

> *"When the client come back to the clinic and say, 'You have helped me so much you spoke to me until I understand my status, now I accept'. I feel that I worked in a good way and I managed to help and save another human being."*

If she did not experience this kind of appreciation, her dedication would perhaps have declined. She feels content that whatever she is doing to assist the client is not in vain because she now sees the results.

5.2.3.2 Negative experiences

The aspects below reflect Mavis's negative experiences while doing her work as a lay counsellor. She talked about quite a few difficulties related to the counselling role, such as difficult clients, being undermined by clients and uncertainty about her rapport with clients.

Difficult clients

When clients receive a positive result (that they are HIV-positive), it becomes strenuous because she ends up spending more time with them trying to calm them down. She then has to monitor the client and escort her for treatment in the other sections of the clinic. Sometimes she comes across difficult clients who do not want to cooperate. She said:

> *"Eish! It is difficult sometimes because some clients decide to be rude and say: 'I will not take any treatment; I am not sick.' Others refuse to accept an HIV-positive status and say I am lying to them, so they will try somewhere else. I feel so bad because the test is right in front of the client and there is no way I can change the result."*

She further commented on teenagers specifically:

> *"Teenagers are the target group that must test for HIV because they are sexually active; however, they choose to refuse and ignore the matter."*

She realises that even if clients are not cooperating, she needs to encourage and support them because as a counsellor, she should not be judgemental. She also realises that she should make sure that the clients have received the necessary service required when they leave the clinic. That is where the problem starts because she becomes stressed in the process.

Undermined by clients

There is a point where Mavis feels that she is being undermined by her clients. The negative experience is when the teenagers undermine her. Because they have their rights, she does not force them to take the test without their consent. Other clients who visit the antenatal clinic and do not want to test make her feel bad. It becomes a concern because there is nothing she can do about it as a counsellor except to accept them and support and encourage them to cooperate. She explained:

> *"Ohh! When the teenagers come to do TOP (Termination of Pregnancy), when I ask them to test for HIV they give me that undermining look and I feel bad."*

She continued to say:

> *"The fact that the client is pregnant it means she had sex without a condom and to know her status she needs to test. But they have their rights and I cannot force them to test . . . they must volunteer and give consent to test."*

It is evident that some clients make the counsellor’s work difficult by coming to the clinic with their negative attitudes. Mavis knows that it is her duty to calm down and assist the clients regardless of their attitudes.

Uncertainty about her rapport with clients

As depicted above, Mavis sometimes feels uncertain about her skills and value as a counsellor. She usually feels certain about her role as a counsellor, but from time to time, she has doubts about her accomplishments. Mavis occasionally has negative experiences where partners come for testing, and one tests positive and the other negative. She explained:

> *"When one partner test negative and one positive, then I need to explain how come the other one is negative, and it is always a challenge because clients usually do not understand and that leads to frustration and anger. Yaah! Difficult clients. . . maybe we might not be understanding each other. Maybe they do not understand me, but they can understand somebody else. I really do not want the client to go without assistance. I refer the clients to other counsellors when they agree in order to avoid being with them for a longer period."*

It is clear from the above comment that Mavis realises that she cannot help every client and that sometimes they can be better helped by another counsellor. She may be uncertain about her relationship with certain clients who do not want to accept her suggestions, but she shows insight in doing the best for them by referring them to another counsellor.

5.2.4 Mavis's experiences of the COVID-19 pandemic

The aspects discussed below reflect Mavis's experiences of the COVID-19 pandemic.

5.2.4.1 Feeling of fear

Mavis's main fear is that she will be infected with the COVID-19 virus. The importance of maintaining social distance to control the COVID-19 pandemic becomes a serious challenge. That leads to Mavis's increased psychological stress because she is of the opinion that rules and regulations need to be adhered to. She described her feelings as follows:

> *"I am not at peace at all! There are four counsellors who tested positive for COVID-19 and I am very scared. I am not trained for COVID-19 counselling, but I do counsel clients every day, so I am working in fear even though I know the rules and regulation on how to protect myself. So, because clients are coming for counselling, there is no way I can avoid physical presence, and it is frightening. If I can receive other options instead of meeting the clients face-to-face, I would be relieved."*

The complicated, diverse and changing nature of COVID-19 and the need to maintain safe distances is a concern for Mavis because there are no other alternatives in the organisation

on how to assist the clients without seeing them face-to-face. She further emphasised that the lack of space and adequate ventilation could contribute to the spread of COVID-19.

5.2.4.2 Not easy to adapt to changes

Mavis has other roles in addition to her counselling role, such as housekeeping, child care and other additional responsibilities. She must, therefore, strive to protect herself and her family members from the virus transmission. All of these come with some changes to cope with the situation around her. She expressed her frustration as follows:

> *"Ohh! Since COVID-19 started things change, and it is difficult to adapt in such short notice. Although I am not assigned to test COVID-19 clients, there are clients coming for HIV/AIDS testing in large numbers. I noticed that my family routine has been disrupted due to changes that occur to cope with the disease. When I get home, I must wait outside and remove the clothes that I was wearing before I enter the house. I also need to take a bath before I meet with the family. Since I am always tired when I get home, I do not have time to relax before I take a bath and it is so frustrating."*

Mavis thinks that if the organisation can introduce other options in place of physical consultation with clients, it can be helpful. However, it would be a challenge to adapt in a short period because the situation will be unique for everyone involved.

5.2.4.3 Not enough resources

Mavis is concerned with the scarcity of equipment necessary for her work. Many times, there are not sufficient resources to do her work properly. The counselling rooms are small, and it is problematic because she needs to practice social distancing. She said:

> *"When I have two clients/couples coming for counselling it becomes really a test since the room is not well ventilated. I become scared when a client coughs, I am just afraid that I might be infected by the infection from the client. The clinic does not provide caps and aprons, overalls. I am expected to buy, I am only given one glove per day and a sanitiser. Eish! That is not enough for the whole day."*

It is evident from Mavis's responses that the lack of resources is a contributory factor towards ineffective service delivery and causes her to get scared and frustrated. Shortage of resources (e.g. not enough space, testing kits, gloves and other personal protection equipment, etc.) affect the management, treatment and assistance of clients with HIV and AIDS. Mavis indicated that lack of private space and equipment is a barrier to her counselling job because it means that the privacy and confidentiality of the clients are compromised.

5.2.5 How Mavis is affected by her counselling role

It seems that feeling exhausted and having headaches are the most prominent effects on Mavis as a result of doing this kind of counselling.

5.2.5.1 Headaches

Mavis reported some physical health symptoms, of which headaches are the most prominent. Mavis indicated that she is experiencing constant headaches. She said:

> *"Aaah! I have a serious headache every day, but I drink a lot of water and it becomes better. I do not want to use any medication or tablets because I am afraid of being addicted to them."*

It appears that Mavis often experiences headaches because of the strenuous nature of this job which is physically and mentally tiring. She is always on her feet and has to use her mind to solve problems all the time, every day.

5.2.5.2 Exhaustion

Mavis reported that she feels worn-out and drained most of the time after work due to working with many clients. She explained:

> *"I am always exhausted when I get home, and I sleep first before I can do anything. My family understands me; they do not disturb me when I take a nap. When I give a client a HIV-positive result, it becomes a problem and time-consuming. I become strained because when you get a positive result, I have to win the client. I spend more than 45 minutes with a client, trying to convince or calm her down. Then I must escort him/her for other services, such as (Antiretrovirals) ARVs counselling etc."*

Apparently, Mavis does not have sufficient rest because she works every day with the purpose to help others.

5.2.6 How Mavis copes with her role

In this section, I point out how Mavis handles the problems she experiences in her work. It is evident that Mavis will continuously need support because of the difficult nature of her work. She needs other people (peers and family) to give her support and assistance when situations are difficult and also some time alone.

5.2.6.1 Peer support

Mavis reported that a psychologist from Wits used to come once a month to support them, but he stopped visiting them. He used to come and debrief all of them, but she says it was not enough because it was a short session. She does not have a support group, and therefore she relies on other lay counsellors for debriefing. She said:

> *"We support each other because we do not have a good support system. As counsellors, we share our problems and try to assist each other."*

She also tries to work with other counsellors as a team and to have discussions with them about the work in order to lessen the pressure they experience.

5.2.6.2 Support from her family

Mavis further describes the support she receives from her family:

> *"Every day when I get back from work, I sleep for 30 minutes before I can start with house chores, and that helps me a lot. I have a good relationship with my family because they understand my job. They give me some time to rest and a space when I need it."*

It is clear that family support is indispensable for Mavis and that she is fortunate to have an understanding family.

5.2.6.3 Time alone

Mavis prefers some time alone when she is stressed or overwhelmed with work. While sitting alone in a quiet space, she feels calmness and physical relaxation. This improves her psychological balance and enhances her overall health and well-being. She explained:

> *"I feel comfortable sitting by myself in a corner, without any noise or disturbances around me. I then join the others when I feel better. It happens when I am at home."*

She apparently uses some kind of meditation to relieve her stress. For her, meditation is a beneficial coping strategy because it seems to increase her quality of life and also improves her quality of sleep and social functioning.

5.2.7 The lack of support from the organisation

The aspects indicated below reflect the dearth of support from the organisation.

5.2.7.1 Lack of support and recognition

Mavis wants to feel a sense of belonging and recognition for her role. She feels that her emotional well-being is not taken into account as a lay counsellor. She is not given the option of taking off from work when she undergoes distress herself. Mavis explained:

> *"The support is not enough. I only attend meetings with management when they want to address something or want to inform us about the changes in the clinic. There is nothing about us, no referral to other service providers for debriefing. Since I started working as counsellor I only receive a stipend. Basically, I feel like I am not recognised as a lay counsellor. What I see, the management do not take us seriously, because I am regarded as a volunteer and yet I am expected to come to work because I am called a health worker . . . recognition is a problem."*

The lack of recognition stems directly from the lay counsellors' ambiguous employment status. It appears that Mavis believes that she is not a volunteer but a health worker with the sole purpose of HIV and AIDS management. She hoped to be recognised as part of the health system since she had been volunteering for a long period in the organisation.

5.2.7.2 Not taken care of (debriefing stopped)

They used to have debriefing sessions a long time ago, but that was stopped. Debriefing was a good idea because they had the opportunity to meet other counsellors who shared their own experiences, and they learned from each other. She said:

> *"They used to take us out and spend some days somewhere . . . we socialise, and we used to share our experiences. It was interesting because you can read the Bible but not explain it the same, like us, we have different clients, but we do not assist them the same and we do not experience the same problems."*

It seems that Mavis thinks that debriefing can safeguard counsellors from the negative consequences of their own difficulties so that they can put clients first. However, if there is no opportunity for debriefing (it was terminated in this case), it undermines the counsellor's recovery and causes her to feel unsupported, which can jeopardise services to the client.

5.2.8 What Mavis needs to function effectively in her role

It appeared that Mavis does not have confidence in the performance of the organisation, and she indicated that if the organisation can arrange that they, as counsellors, get debriefing sessions again, it would improve their abilities to provide good services to clients. If there can

also be some other changes in the working environment, the following can help her greatly: she needs a bigger office with air conditioning and new furniture. She also needs training and workshops to enhance her abilities. She remarked as follows:

> *"Ohh! There are many things that I need. There should be changes in the environment that we work in. The office is very small, and it has small windows. There is no air conditioner in the office, and I am expected to share it with other lay counsellors. When I have two clients, it is not easy to work in that office because it becomes crowded. Then I must rush the session so that I can finish and release the clients. I also need training and HIV/AIDS workshops to keep updated with new information in the counselling field."*

Clearly, Mavis wishes to get more training to become a better counsellor. It is further obvious that she wishes that the organisation should prioritise steps to give attention to employees' needs, for instance, improving the physical conditions and providing training if they want to keep their employees happy and fully functioning.

5.3 NORMA'S STORY: "THIS JOB NEEDS YOUR HEART"

5.3.1 The background

Norma is a 55-year-old widow and her highest qualification is secondary school. She attended informal training for HIV/AIDS counselling which lasted for about two and a half weeks. She does not belong to any support group. Norma started working in a non-government organisation in 2007 as a home-based-caregiver. She used to see many clients because she worked from 8:00 until 16:00 in the afternoon. Most of her work was with clients in their homes in the community, and she would see 20 to 30 clients per day.

Then she came to the clinic in 2012. Although the clinic absorbed her clients, it was indicated that there was no accommodation for her group at the clinic. While the clinic was arranging a space for them, they were sent to the local church. There she was offered a room where she could relax and write her reports when she returned from the field. In 2016 she was informed that the space had been arranged, and she started to work at the clinic. That is where she started to work as an HIV/AIDS lay counsellor, not being a home-based caregiver anymore. The other group members remained on the church premises, although they were still under the Department of Health (DoH). Since she started working at the clinic, she has been required to see at least 10 to 15 clients per day.

Her daily responsibilities at the clinic are counselling clients. She is responsible for receiving the clients who are referred from other clinics. Norma is also responsible for clients who need

to be transferred to other clinics. She also is an assistant within the clinic to receive clients from other sections in the clinic. She makes sure that daily and weekly stats are prepared, and testing tools are available and in good order. Norma assists the clients on where to go (navigating inside the clinic, e.g. maternity wards, emergency rooms).

Norma feels that counselling becomes tiring, especially when she sometimes has to counsel relatives, as then it becomes strenuous because she must be patient and supportive.

5.3.2 Factors that motivated her to become a lay counsellor

The factors discussed below motivated Norma to be a lay counsellor and to be resilient even in times of adversity.

5.3.2.1 My job is a calling from God

Her motivation to do the job is God. She mentioned a deep-rooted calling from God and a passion for counselling as another motivating factor to serve people in the community. The belief that she could make a difference and fulfil God's work was highly motivating. She declared:

> "*Ooh! God gives me power to serve; then I serve even when it is tough. This is what I have known from long time ago, if I quit now what will I be doing? So, I know that God sent me out to serve his people, then I will continue working because he gives me strength. . . . Then you will end up fighting with clients if you are not willing to work or if you are not called . . . others think that we are doing a simple job, but no, it is difficult."*

Norma's belief that God chose her to assist people in her community encouraged her to be resilient in her job even when things were tough. It is important to know what motivated her to join voluntary services in the first place because it explains why she will not give up easily on her job.

5.3.2.2 Family member died of HIV/AIDS

Some of her family members died of AIDS, and then she started volunteering at a hospice to assist people. When she noticed that many people are HIV-positive and accept their status because of her counselling, she felt encouraged to persevere. She also realised that many people are working hard to become well again because of her support and motivation. She expressed it as follows:

> *"When I think of stopping, I start thinking of those people whom I could assist, then I pick up strength and continue to work. The will to help others is what motivate me to work harder*

every day. Many people became better, and they would come and appreciate my effort…. My family members also died of HIV, so I decided to assist so that others can be saved."

Norma had her own distress that led her to volunteer as a counsellor. She started helping and looking after relatives, family members, and friends who had been severely ill or who later had passed away because of the disease.

5.3.2.3 Being an employee and not a volunteer anymore

She reported that she is regarded as a volunteer at the organisation, exposing her to various challenges. She had been a volunteer for more than 10 years and worked for 8 hours a day like other staff members. She starts work at 8:00 and ends at 16:00, receiving only a stipend. There was also a delay in getting paid, and she received money after two to three months. That caused a lot of stress. However, that has changed, and she is now recognised as a permanent worker, and that contributes to her resilience. She said:

"I am really happy that I did not quit like others who decided to quit along the way . . . look now I receive a salary and I am permanent. At hospice, it was bad because we would wait for 6 months without any money."

She is very happy because something very important happened to her. She was working as a volunteer for a very long time, and recently she was appointed as a permanent worker at the clinic. She now receives a salary like other staff members instead of stipends. She reported that the stipend was not enough to pay for her transport to and from work and buy food for her family. She is now committed to working even harder because she is a permanent employee.

5.3.3 Norma's experiences of her counselling role

Norma experiencers her counselling role positively as well as negatively.

5.3.3.1 Positive experiences

Norma experiences the following positive experiences while doing her work as a lay counsellor.

Happy when clients are recovering

A positive experience for Norma is the recovery of her clients. Norma realises that she has little control over a client's desire to change, and often the client's motivation to change has been a source of frustration. However, she tries to find an approach that meets the client's

needs. Although change is ultimately in the hands of the client, her role is to help, motivate and encourages the client throughout each stage of their recovery. She explained:

> *"When I see my clients recovering and fighting the disease, it is a joy to me. I know that my words were not falling down the drain, the clients actually grabbed them and practised them to recovery . . . my efforts were not in vain."*

Norma's role as a counsellor goes far beyond simply listening. Instead, she believes her responsibility is to help the clients recognise problematic behaviours and guide them to recovery. She also empowers them to take action and change these behaviours and maintain healthy ones.

Appreciation by clients

The thankfulness of her clients gives meaning to her life and motivates her to carry on with her counselling work. She thinks that her clients like her because they do not complain in her presence; unless they complain to others without her knowledge. She told me:

> **"***I think they like me because many of them request to see me on their return. Some come back and appreciate my assistance; they come to say thank you for what you did to me. I am calm by nature, so it is not easy to attack me."*

Availability of resources

She makes sure that she gets material resources from other clinics when they are finished. When all the counsellors have everything, they need in terms of resources, she feels good. Since she is responsible for the storeroom for resources, when the resources are finished, management gets her a driver to fetch the supplies from other clinics. She said:

> *"Yaaah [Laughs] I feel good and happy when all the required resources are available for us to use. Supplies from DoH sometimes takes longer to be delivered. I then check with other clinics if they still have the resources, then I go and fetch them."*

Norma is proud of doing her job effectively. She acknowledged that she manages to work hard and excel in any position that she is placed in. She seems to be a hard worker who works with courage and determination.

5.3.3.2 Negative experiences

Norma's negative experiences while doing her work as a lay counsellor are the following:

Difficult clients and problems with clients

Norma receives clients that are problematic sometimes, clients who do not want to cooperate. She sometimes comes across clients who speak harshly and try to belittle her when she tries to give health talks and encourage them to come for testing. It becomes a difficult situation when people do not respond to the call for testing. Some of them become negative and refuse to start with their treatment. She explained:

> *"When you work with people, you need to be kind, because clients do not want to cooperate sometimes . . . this job needs your heart. Remember, you cannot force people to test. They should volunteer to come. Others will just look at you as if you are mad, and it is so embarrassing. My problem is that I want to fix, and I want to heal if there is hurting of some kind, then I get hurt in the process."*

When some of the clients do not want to be tested, Norma knows that she is not supposed to force them. The clients should be willing or volunteer to come for testing by themselves without being coerced. Some of the clients give her a negative attitude and create an unnecessary argument during the process. She described it as follows:

> *"Sometimes clients fight with you, they vent their frustrations on you . . . and then later come back to apologise for their behaviour. You should accept the apology and move forward. I get too involved with things, and I am someone who wants to fix things and if it's not fixed. Eish! It's a problem for me, I need to work very hard to win a client, re nyaka bophelo [we need their life]."*

The unexpected nature of the situations that Norma, as a lay counsellor, has to confront and the inability to manage certain outcomes or how clients react make her work difficult. Norma holds herself responsible if she cannot control the circumstances.

Lack of space for counselling

The counselling room does not have enough space for her to assist the clients effectively. Norma is concerned about the infections that could occur in a limited space. The organisation only has one bigger room for counselling whilst the others are small. Due to lack of space, she ends up counselling people in groups in the bigger room. She said:

> *"I end up counselling them in groups and there is no confidentiality at all. They do not feel free, and some clients return home without expressing their views. They avoid asking personal questions. They do not want others to hear what they are saying. I do not think group counselling is as effective as individual counselling."*

She reported that she does not have a dedicated room in which to work. She must share the available offices with other counsellors. She must use any available room, and, on some days, it becomes a problem because others also have clients to counsel at the same time. Then she must rush the session, and that is not satisfactory. Therefore, she sometimes opts for group counselling.

Working under pressure

She sometimes works under pressure due to the set requirement to counsel and test at least 10 clients per day. This is stressful as she said:

> *"When it is hot, then you work under pressure. You try to work faster so that you can come out of the room. It is a problem because the client also feels the pressure to answer your questions quickly so that he/she can get out of the office because of heat. The rooms are small and social distancing during this period of COVID-19 is a problem."*

Norma also reported that sometimes clients are not coming to the clinic as expected, and only a few come for testing. She is expected to see 10 to 15 clients per day, and if she does not reach the target, she becomes frustrated. She always works under pressure to reach the weekly goal, which is 50 to 75 clients.

Problems with colleagues

Norma sometimes has problems with colleagues. Due to these problems she was moved from the counselling position for a certain period to sort out the matter. Her responsibility was to take care of all the counsellors' needs (resources). She revealed:

> *"Aaah! The relationship with my colleagues is good but not with all of them. You know when you work with people you will not get along with all of them, but we work together. Others will try to sabotage you so that you can lose your job and make sure that they make your life difficult. I was given another position temporarily by the supervisor because I had a problem with one of my colleagues."*

Furthermore, she felt that there was poor communication between the counsellors.

5.3.4 Norma's experiences of the COVID-19 pandemic

The aspects identified below reflect Norma's experiences of the COVID-19 pandemic.

5.3.4.1 Difficulty working

Norma finds it difficult to cope in this era of COVID-19 because it is a new disease, and she still needs to learn about the complex characteristics of the disease. She also feels that the workload has increased, making it difficult to manage her daily responsibilities. She declared:

> *"Yoo! It is difficult . . . we rely on our prayers every day, what can we do? There are many people coming for testing, and it is the opportunity to encourage clients to test also for HIV, but it is time-consuming and strenuous. There are other duties that I need to perform besides testing and counselling, so it is really difficult to cope."*

She believes that since HIV counselling and testing on its own is a strenuous job, adding duties related to COVID-19 makes it even more difficult and can lead to counsellor burnout.

5.3.4.2 Working in fear

Norma described the situation at the clinic as follows:

> *"Counselling demand is too much. We now deal with a number of clients coming for testing. We are not assigned to test COVID-19 clients, but many are also coming for HIV testing."*

Norma is afraid that she might test positive for COVID-19 since some of the counsellors tested positive while on duty. She was attending a meeting on behalf of all the counsellors for three days. She explained:

> *"Four counsellors tested positive for COVID-19, I was informed about the case, and I decided to stay at home after the meeting. I was surprised, and that is why I am telling you that the rooms are small. I am scared. I am working in fear every day. Our rooms are small, and it jeopardise our health because social distancing is difficult when I have two clients or couples coming for counselling."*

Norma was wondering how this pandemic happened. She received training and information on how to protect herself from COVID-19. She realises that there are rules and regulations to adhere to, but people still become infected by the virus. It is frightening for her to work in that environment.

5.3.4.3 Not enough resources

The clinic does not provide the counsellors with enough resources, and they are required to buy them. The clinic provides Norma with sanitisers, masks and gloves, but she must buy some equipment herself. For example, she buys her own caps and extra masks. Although

Norma's clinic is the biggest in the community, the clinic does not have enough space. They also provide COVID-19 testing services, and the clinic is always full because other clinics do not provide this testing. Many clients are coming to the clinic for testing for HIV and COVID. She stated:

> *"I must always wear a mask, gloves and cap, and the clinic only provide one mask and do not provide a cap. I understand that we are required to wear a mask not more than 4 hours; however, in two hours when it is hot my mask is wet because I sweat a lot and I need to change it. . . . The money that I earn is not enough to buy things for myself."*

It is not easy for her to work when some of the resources are not available. She experiences it as a problem when a high number of clients are coming to the clinic. She said:

> *"The demand for our time is too much hence, I am always exhausted . . . hey! The number of clients goes up because many of them are coming to collect their medication for a longer period to avoid coming to the clinic frequently. . . . The test kits are not enough, so we have to share, and when the clients are many, then it is a problem . . . I use my lunchtime to push the required target."*

Norma works under pressure due to the shortage of material resources. She works under a lot of pressure due to the high volume of clients – she sometimes works without taking a break which can be very strenuous. Sometimes, she pushes harder in order to reach the target of the day before she gives the test kits to other counsellors.

5.3.5 How Norma is affected by her counselling role

Norma experiences physical and emotional effects as a result of doing her counselling job, as indicated below.

5.3.5.1 Tiredness and headaches

Norma is affected physically by her job because she is always tired when she goes off duty. She also has constant headaches, but she tries to alleviate the pain with rest and medication. Norma told me:

> *"When I get home, I sometimes sleep on the sofa while they are busy preparing some tea for me . . . I am always tired. I love my job, but it is tiring. I drink paracetamol to stop the headache, but it does not work sometimes. Maybe it is used to my system [laughs]."*

5.3.5.2 Frustration

She sometimes feels frustrated when things do not go as expected. Sometimes clients do not do what they agreed upon during the sessions saying they sometimes forgot to take the medication, and when they do not comply, she starts to blame herself for the problem. Another source of frustration is that she has to share some of the working tools with her colleagues because they are not equipped with enough means to do their work. She described the situation as follows:

> *"Yaah! I become frustrated sometimes when the clients default. It becomes difficult to share the working resources. The test kits are not enough, then I have to wait for others to finish so that they can lend me, and that make your progress to be slow."*

It is clear that Norma's frustration originates from her inability to fulfil her duties due to clients who are not cooperative as well as the resources that are not enough. She feels annoyed and less confident because she is unable to achieve what she wants to achieve. Her goals to assist the clients are often distracted by the challenges and frustrations in the situation.

5.3.6 How Norma copes with her role

The strategies that Norma uses to cope with challenges she faces on a daily basis are the following:

5.3.6.1 Talking to others

Norma talks about the problem when she experiences a challenge. She has many good friends who are available when she needs reassurance and kindness. It was clear to me that Norma talks about her work difficulties with her friends, and that assists her a lot. She said:

> *"The more you talk to others, it helps a lot. I have close friends of mine. I talk to them just to remove the burden on my shoulders. I know that they might not understand the issues but when they listen to me, I feel relieved."*

Norma realises that her support system is of great help because she can share her problems with her confidants, which she is inclined to do.

5.3.6.2 Watching TV

Norma finds watching TV enjoyable, and it helps her to deal with her stress. TV watching even helps her when she starts to feel too overwhelmed with everyday life and her work problems.

"Eish! [Laughs]. I do not want to lie to you . . . the first thing I grab one glass of wine to relieve stress. . . . I drink a glass of wine by myself while watching TV. I try to forget everything that happened at work."

For Norma, watching a TV show relaxes her and helps her destress. She becomes distracted from the worries and stresses that typically fill her mind. She always needs a time-out to unplug from life and re-energise. Watching a good movie or TV show recharges her mind because it gives her a chance to escape the everyday stresses that often consume her thoughts. Therefore, watching TV is a coping skill for her.

5.3.6.3 Prayer and the Bible

She reported that in order to cope with challenges, she finds relief from stress in the form of religious practices. She prays and read the Bible since it makes her feel that the burden becomes lighter. The Bible has encouraging words, and it helps her remove her mind from the issues. She revealed:

"I used to pray only when I have a problem, then my husband passes away, and it was difficult for me to do my job. It was not easy to come to work after my leave, but I managed to cope because of prayer. I have a friend who used to pray with me, and the church members supported me a lot. I recovered from the loss, and now I use the same strategy when I have a problem, and it works."

She believes that God listens and that has positive consequences for her emotionally and for her behaviour. Prayer and support from fellow church members raised her sense of self-worth, allowing her to cope with some of the problems she encountered.

5.3.7 The lack of support from the organisation

Norma feels that the organisation does not give them enough support. She gets the impression that the organisation does not care about the counsellors. She sometimes feels that she needs counselling, and there is no time for that. She feels that she is not listened to because she does not have all the necessary protective equipment, and it makes her job difficult. She explained:

"Eish I do not want to lie to you, sometimes you need debriefing, and they do not give us, it worries me a lot. There is no support inside the clinic, nothing! There is no support from outside also. I do not even have a support group. I do not have PEP [Post Exposure Prophylaxis kit]. When I request from the management, they ignore me. They do not want us to mention anything even when we have meetings with them. They do not give us

reasons why they refuse to give us other resources during our meetings. I am not satisfied with the way management is operating."

Norma is not a member of any support group. The only support she receives is from her family members and friends. She could have perhaps coped more effectively with her counselling job if she felt supported by management.

5.3.8 What Norma needs to function effectively in her role

The following aspects reflect Norma's requirements to enable her to function effectively as a counsellor:

5.3.8.1 The need for debriefing

Norma acknowledges that HIV counselling comes with stress due to various reasons. She feels that disclosing the results to a client that he/she is HIV-positive is like giving someone a death sentence. Sometimes the client does not accept the result and reacts negatively (e.g. crying out loud, denying the results [that's not true], acting with shock, asking questions like what? Why me? Are you sure?), which is strenuous for Norma. She felt that she needed debriefing after each session and stated it as follows:

"Sometimes after the session I feel drained. I need somebody to talk to . . . if maybe I can have meetings with a mentor – somebody from management in the beginning of every week to check if I am okay. I only have our supervisor, and I do not have much to say to her because she is also a counsellor. I tried to complain but feel like I am being ignored."

The client's reaction determines the level of stress that Norma will endure – it becomes more strenuous when the client is unable to accept the results. It is difficult to convince clients of the results and then to contain them and help them to accept the results and understand the treatment that is available. Therefore, she needs debriefing sessions time and again.

5.3.8.2 The need for a safe and secure environment

Norma expressed dissatisfaction with the unfavourable work environment in which she works. She complains about the lack of dedicated rooms for HIV counselling and testing in the organisation. Inadequate infrastructure is a problem because she reported that the furniture in the office is falling apart, and there are no secure cabinets for her to store the client's confidential documents. She described the physical environment:

"*I would also change the cupboards that we can lock our documents in. The cupboards that we currently have are falling apart, and they do not lock. We are expected to have locking*

cabinets as counsellors, but they are not available. The books and forms are not safe because the cabinets are broken. Cupboards are broken . . . we do not have confidentiality with our files."

She is concerned because the situation does not guarantee privacy and confidentiality practices during the counselling session. She is also worried about her own safety – her sense of security is threatened. She explained:

"Yes! My safety is compromised! In the main office the door is broken . . . it is not safe because I only lock the door from outside and if I am inside, it is easy to lock yourself in the room. I will need somebody to open for me from outside. I am concerned it is not safe if you have a male client and the door locks itself. What would happen? [Laughs]. You do not know how dangerous the client is, so you become scared, so you will be doing your job in fear."

Norma would appreciate having proper furniture and bigger offices with more space for counselling sessions. The clients' confidentiality will not be compromised if the cupboards can be locked. If the organisation provided the resources mentioned above to counsellors, it would maintain the privacy and security of both parties.

5.3.8.3 The need for more training

Norma also needs more staff development initiatives in the form of more specific training for counselling HIV patients. She is of the opinion that lay counsellors are not trained well enough, although she realises that lay counsellors are not expected to become experts in the field. However, she feels that she should be updated with new developments in her area of work. She found herself particularly unqualified to handle some of the situations. She is dedicated to her job and has a deep sense of commitment to her role, but she knows she is not trained as a professional counsellor. She said:

"If we can also have courses to update our knowledge and to get new information, I can be happy. I was trained long time ago, and I used to attend workshops, and all of that now stopped. I think I need more (training) than just what we have. I think we need a different kind of training. I don't know, I'm not an expert on counselling, so I can't really say what, but more updates are required."

Although Norma pointed out that she needs more training, especially with regard to what to expect from clients' behaviour and how to handle their different and difficult responses, she suggests that trainees also get practical training to prepare them to handle certain situations.

This could help her to feel more confident and be prepared to face the potential hazards that she might be confronted with. This could ward off possible burnout. Without such kind of training, Norma will continue to struggle with difficult situations.

5.4 GRACE'S STORY: "I AM PROUD OF MY WORK"

5.4.1 The background

Grace is a 55-year-old woman and a divorcée. She completed her studies at the tertiary level. Her training for HIV counselling was informal training which lasted for five days. Grace does not belong to any support group. When she started working as a counsellor, she would test 20 to 22 clients per day. However, things changed, and now it is much better because she tests around 10 to 15 clients per day, and she has to work from 8:00 to 15:00 with breaks. Her daily responsibilities are HIV counselling and testing every day. She also does adherence counselling, where she assists clients to take their medication correctly. She said:

> *"It is important to encourage the clients to adhere to their treatment in order to avoid relapse. I also assist with Prevention of Mother to Child Transmission. I counsel pregnant women and assist them to understand the importance of taking their medication correctly. I also encourage them to take care of themselves to protect their unborn children."*

She started volunteering in an NGO (non-government organisation) in 2004 as a home-based-caregiver. She has worked as a caregiver doing door-to-door campaigns (visiting and helping people who are sick in their homes). She was employed as a volunteer lay counsellor in 2011 at the local clinic.

5.4.2 Factors that motivated her to become a lay counsellor

The aspects that motivated Grace to be a counsellor and contributed to her willingness to be a lay counsellor are discussed below.

5.4.2.1 Self-development

Grace initially wanted to be a social worker but could not afford the university fees. She then became a counsellor. Grace worked as a counsellor for a year and decided to join the police station to do some volunteer work to gain experience. She reflected:

> "*Actually, I did not want to be a counsellor, but I wanted to be a social worker. Due to some financial problems at home, I did not manage to go to the university to further my studies, I worked at the police station in the domestic violence programme. Then I would do some campaigns against domestic violence and skills project. Then I moved to home nursing*

where I worked as a home-based care caregiver. I realised that I can do better if I can go for counselling, so I joined the group of volunteers."

She also assisted with counselling the families when she did home visits in the community before she came to the clinic. She could not become a social worker, but she realised that doing volunteer work in counselling would gratify her wish to be of assistance to other people. Although volunteers do not get paid in South Africa, Grace was committed to the belief that counselling will help her to reach a sense of self-actualisation.

5.4.2.2 Becoming willing for HIV counselling

She was not interested in HIV projects, but then she volunteered at an organisation at a church that catered for HIV/AIDS clients. She did not feel comfortable there because of the contact with people with HIV. She revealed:

I had issues with people who are living with HIV due to lack of understanding of the disease. I also happened to be partnered with a person who was HIV-positive, and that was a tough one for me. Eish! Then I had a client with a child who had meningitis and was HIV-positive, then the fear escalated. I indicated my concern to the supervisor then she sent me for training."

She attended many courses about HIV/AIDS and workshops that changed her attitude toward HIV-positive people. She had gained knowledge about HIV/AIDS and understood the disease better. Then the local clinic advertised a post for which she applied, and after the interviews, she was appointed. She is now proud of herself for her achievement. She said: *"I now call myself a 'Pro of HIV/AIDS', meaning a professor of HV/AIDS [laughs]."*

5.4.2.3 Finances improved

Grace used to wait for her stipends for almost three months. Due to her perseverance, she is now employed as a permanent worker. She now receives her salary every month like other staff members, she explained:

"I am so excited. Hard work always pays. Now that I receive a salary every month, I am so happy, and I enjoy my job more."

She volunteered for a long time without pay and experienced challenges in this kind of counselling, but she persevered because she enjoyed it and loves the job.

5.4.3 Grace's experiences of her counselling role

The following are her positive and negative experiences of her counselling role:

5.4.3.1 Positive experiences

Grace has quite a few positive experiences while doing her work as a lay counsellor:

Client recovery from illness

Grace feels content when her clients recover from their sicknesses. For example, clients who recover after being in a wheelchair makes her want to do more for others on a daily basis because she loves them. She feels satisfied when they come back and show appreciation to her. She said:

> *"There are some clients who will come on wheelchairs. When they come back without their wheelchairs, walking on their own, I feel good. I feel like I am over the moon because they are now strong, and they can do things for themselves. They usually come to thank me for the assistance that I have provided to them."*

She continued:

> "*Others will come very sick, and after counselling, they become motivated, adhere to their medication and recover. Some who I counsel for TOP would come and tell me that they are married and now have their own kids."*

Grace feels good when clients appreciate her job, and that keeps her going every day. She believes that her clients are recovering because they are able to go for follow-up appointments and take their medication. She reports that clients contribute to their recovery by being very involved in their treatment and every aspect of their follow-up. She also establishes a trust relationship with her clients; hence they return to say thank you.

Being proud of her work

She also has clients who come for termination of pregnancy but change their minds after counselling. Many of her clients show their gratitude by bringing their children to her and reporting the children tested negative for HIV. She remarked as follows:

> "*That is an honour to me, and I feel so happy that I am indeed making an impact in our community; I feel so proud because I know that my teachings are producing fruit."*

It is evident that Grace is proud because she also teaches her clients about exclusive breastfeeding (the infant receives only breast milk) when living with HIV. Then she appreciates that her teachings are making a difference because clients are coming back with positive attitudes.

5.4.3.2 Negative experiences

Grace also has some negative experiences while doing her work as a lay counsellor:

Language barrier

Grace experiences a language barrier with some clients. The languages that are spoken in the local community are Sotho, Tsonga, Isizulu and Venda. Currently, people are coming from neighbouring countries who speak different languages from the ones spoken in the community. They also come to the clinic in numbers for assistance. It becomes a challenge for her because communication becomes difficult for her as she does not understand their language. She explained:

> *"There are clients who speak the local languages then I understand two or three languages, we can change to another language in order to make a conversation and understand each other. There are many clients coming from our neighbouring countries, and I am supposed to assist them in respect of their nationality. However, communication becomes a problem because I do not understand their language. It becomes difficult because even if I try to refer to a colleague, the problem continues. It is better if the client can speak English because we can communicate and understand each other. So that's something that came out – that maybe they must come with another person to translate, but still, the client's confidentiality will be compromised."*

She is worried that she will not get through to clients who speak foreign languages. However, she is of the opinion that counsellors can show empathy in spite of language barriers.

Clients default from treatment

The work is difficult because sometimes the client will claim to understand the instructions, and when the client comes for the next visit, she realises that there was a misunderstanding. She said:

> *"I then try to explain again until I see some progress in the clients, but it is time-consuming and delays the progress. The clients usually take the treatment wrongly due to*

misunderstandings, and sometimes they miss the follow-up dates then default in the process."

She realises that the client did not follow the instructions as agreed, especially those on ARVs. For these clients, adherence to medication is a challenge.

Cultural beliefs

Grace also experiences cultural beliefs as a negative experience. She sometimes counsels clients whose beliefs are different from hers, and it is not easy to work with them. There are clients who believe in traditional healing and those who believe in Christianity, and it is difficult to work with them. Cultural barriers apply to both the local and foreign clients. She remarked as follows:

"Not only those who are foreigners have a problem, also those who are local they sometimes say they are okay, they understand everything, and when they come back they have defaulted, when you investigate further they will say at church they said they should stop the medication and pray and they will be fine. Others say they went to the traditional healer and receives some medicines. They were requested to stop taking their tablets."

Grace has a strong cultural identity but still appreciates her clients' convictions without bias. However, she feels like she is fighting a losing battle because some clients are ignorant about taking medicine because of their spiritual and cultural beliefs.

Poor working environment

Her working environment is not good because the rooms that she uses for counselling are too small. When she counsels a pregnant woman and finds that she tested positive for HIV, the client is advised to bring the partner for counselling. However, it becomes a challenge to counsel a couple in those small rooms. She said:

"It is not comfortable to counsel partners in those rooms. When there are three people, the room become crowded because it is small … then I try to work faster so that I can come out of the room, especially in summer when it is hot."

Grace feels that an inappropriate counselling office such as a small one with small windows for ventilation compromises the counselling effectiveness. The sessions are conducted in a hurry and have the potential for discouraging clients from seeking counselling and testing services in future.

Working under pressure

She works under pressure due to the target of 10 clients that she must reach per day. She is required to submit a list of statistics on how many clients she has assisted per day. It becomes a problem because the counsellors try to counsel as many clients as possible to reach the target. Furthermore, she does not have her own test kit – all of them share the available test kits. She explained:

> *"When there are no clients then I start to be stressful because of the set target that I must reach, eeh! The statistics are required, period. Maybe, I will have my own test kit bag. I am looking forward to having my own working resources and not sharing with colleagues – that will assist because I will not wait for my colleagues to finish."*

Grace experiences pressure because of the target number of clients she is expected to counsel and not having enough test kits.

Non-cooperative clients

Although many clients come and appreciate her work, there are some who come with a negative attitude. She sometimes has difficult clients who insult her while doing her job. She expressed this as follows:

> *"It is painful to be insulted because there is nothing you can do about it. You just need to try and show the client that what he/she is doing is unacceptable, and it is so discouraging. Aaah! I ask a client did you test before, and she says no. When you test her and get a positive result she would say, 'I knew I just thought maybe it will be negative this time'. Then it shows that the client is still in denial. And she did not disclose to me in the first place before testing."*

She further said:

> *"It is so strenuous to try and locate their correct addresses and cell phone numbers. You even lose them in the process if you cannot get it right. There are also clients who do not want to talk about their status, especially those who are coming for TOP. They want to do TOP, and they will come back for treatment. And they end up not coming back."*

Clients who are not cooperative make her life difficult in this role. Sometimes she wants to do a follow-up on the clients only to find that they gave her the wrong address and cell phone number. Many of them, when they return, have defaulted, and others just disappear.

5.4.4 Grace's experiences of the COVID-19 pandemic

The discussions below reflect Grace's experiences of the COVID-19 pandemic.

5.4.4.1 Tough working conditions

It is difficult for her to work during the pandemic because the clinic has become full of people. Apart from the HIV clients, the clinic is also full of people who want to test for COVID-19, which makes her uncomfortable. The clinic becomes overcrowded, and then some of her clients decide to leave and return on another day. She told me*:*

> *"When others decide to come back another day, it becomes a problem because some clients end up not returning. They then miss their medication collection dates and default. If I receive a client who have defaulted, I try to check because I know if she was counselled by myself, there should be no defaults except the misunderstandings caused by language barrier. I then give them medication for the next three months if we have enough in the store."*

Grace reports that the conditions (overcrowded clinic and hurried sessions) cause clients to lose interest in the process, and some decide to stop coming for treatment.

5.4.4.2 Statistics required (target)

Grace's job requires her to counsel at least 10 or 15 clients per day. That adds up to 50 or 75 clients per week, which is not an easy target for her to maintain because some days, only a few clients visit the clinic. What makes it difficult for Grace is that there are counsellors from a university working (part-time) in the same clinic, and she is compared with them because their statistics indicate that they have many clients. She finds this painful and frustrating because they are in the same space. She remarked as follows:

> *"I wonder how they get many clients while I struggle. But then I do not know how they were trained . . . maybe they had better training than me."*

The presence of counsellors from a university upsets her work and she cannot reach her required target. She aired her frustration:

> *"Although we do not test COVID-19 people, their presence disrupts the normal functioning of our section, and it is so frustrating because we are working towards reaching a target."*

5.4.5 How Grace is affected by her counselling role

The aspects identified below reflect the effects that Grace experiences while doing her job as a counsellor.

5.4.5.1 Effect on her marriage

Grace acknowledges that her experiences with some of her cases contributed to her problem with her husband. Observing people testing positive made her think about her own life and made her afraid of sex. Her fear of sex led her to abstain from it, which contributed to her divorce. Her marriage problem affected her so much that she could not concentrate at work. She felt helpless and hopeless. She said:

> *"The role of counselling does not affect me at all. However, the divorce situation has affected me psychologically, and I felt like I was losing it. I do not trust anybody at all. Since I counsel male and female every day and some test positive, I am afraid of sex. I am now in the process of divorce, but I was already abstaining."*

The counselling role had negatively influenced her marriage which in turn had a negative effect, which was her inability to concentrate on her counselling work.

5.4.5.2 Fatigue and muscle aches

Grace complains about muscle aches because she spends most of the time standing on her feet while doing her job. She understands that muscle aches can sometimes be a symptom of an underlying illness but she knows the cause. She stated it as follows:

> *"It will be much better if we can have younger counsellors to assist . . . I am getting old [laughs]. I always have muscular aches because of the time that we spend standing and going from one ward to the other. I also do not have a good sleep nowadays, I wake up in the middle of the night and sleep after some time, and when I wake up, I am tired."*

She understands that sleep allows the body to rest and recuperate and that her muscle aches may be because of her strenuous work during the day and not enough sleep. She also does not have quality sleep, which makes her feel fatigued.

5.4.6 How Grace copes with her role

Grace finds that talking to others helps her cope with her counselling role. It was clear that Grace could talk about her counselling difficulties with fellow counsellors and nurses who know what she is talking about. When talking to fellow counsellors, they would address certain

problems and discuss how they could be good counsellors. These discussions and the support of her friends encouraged her and gave her the courage to carry on in her role. She said:

> *"Uumm! After work I communicate with the nurses for debriefing. I am friends with the nursing sisters, so I manage to ask questions and ask for assistance. I have a very good friend of mine, and we actually talk about each one's case."*

Talking to fellow counsellors and some of the nurses is the necessary reassurance that she needs to cope with her role. She does not have any support group outside the organisation, but she can share her concerns with fellow counsellors and nurses. They support and respect one another as colleagues. She realises that she needs this support to enable her to provide an effective service to her clients.

5.4.7 The lack of support from the organisation

Grace feels that she does not receive any support from the management in the workplace. She does not receive good treatment from the management. Her experiences are that management does not respect her as a lay counsellor. She feels that she is not appreciated as a lay counsellor because she is given only one surgical mask for the whole day. According to the work regulations, she is supposed to change the mask every 4 hours to avoid the risk of infection. She reflected:

> *"I feel undermined. The management should respect us as lay counsellors. We need to respect one another according to our seniority. When you raise your concern, you will be told that the nurses are a priority because they are in a high-risk environment*."

The lack of enough equipment creates in Grace the feeling that she is not recognised and supported by the organisation.

5.4.8 What Grace needs to function effectively in her role

The aspects discussed below indicate what Grace needs in order to function effectively as a lay counsellor.

5.4.8.1 Universal Test and Treat programme (UTT) to be changed

Grace is not happy about the UTT procedure that was introduced earlier. The UTT is a strategy in which all HIV infected individuals receive treatment whether they feel sick or not. It implies that they must test and treat the client immediately. The strategy is aimed at eliminating HIV as it reduces the rate of spreading the virus to other people. She perceives the UTT programme as inappropriate with regard to addressing the needs of the clients. She did not

have a say in the matter as a lay counsellor who works with clients on a daily basis. When the decision was made, she was not part of the discussions, and she feels that the UTT affects her relationship with the clients negatively. The way the programme functions makes clients feel that they are forced to make rushed decisions. She declared:

> *"The UTT programme is a problem because, after counselling, you test, and others feel that they cannot cope. I do not know what to do . . . Universal Treat and Test is a problem because clients are required to take treatment immediately, and they are not ready for it. Others refuse and say they are undecided on whether to start or not. Then it looks like you are not doing your job. They do not care. They want only the numbers."*

Grace is not happy about the procedure because she now has to deal with clients who have a negative attitude towards being treated immediately. The situation jeopardises her relationship with the clients because the clients feel that they are not given the opportunity to make decisions for themselves. She feels that the clients lose trust in the HIV programme, and some do not come back for follow-up sessions.

5.4.8.2 Debriefing and support by management

Grace needs debriefing sessions inside the organisation. She thinks if management can be supportive by arranging debriefing and training for lay counsellors, her job would be easier. Furthermore, if she can receive respect from her seniors, she would be happy – some respect and recognition from management, which will contribute to her more effective functioning as a counsellor. She explained:

> *"Management do not even ask us about our challenges. I also receive a serious problem when I have a difficult client . . . then I need debriefing afterwards, and I only rely on my colleagues if they are not busy."*

Grace seems to be aware of the significance to get backing from her managers. Therefore, she needs support from management and a favourable work environment to perform her work effectively.

5.5 BONTLE'S STORY: "THE JOB THAT I AM DOING IS A CALLING FROM GOD"

5.5.1 The background

Bontle is a 44-year-old woman working as a lay counsellor at a local clinic in the community. She is single, and her home language is Setswana. She has a tertiary diploma qualification, and she received informal training for HIV/AIDS counselling, for which she received a

certificate. The training for counselling lasted for one year and six months. She used to counsel many people like 20 to 30 per day. Currently, on a normal day, she counsels 15 clients per day because it is the new requirement from the Health Department.

Since COVID-19 started, the number dropped down, and she could see 10 clients per day. Her daily responsibilities are counselling, testing and facilitating a small support group for HIV clients.

Bontle started working as a volunteer in 2002 at an NGO in her community. During that time, she was doing a door-to-door campaign to identify people who were sick in their homes. She was providing home-based care and counselling to families with members who were infected and affected by HIV and other diseases. In 2016 she started working at the local clinic as a lay counsellor.

5.5.2 Factors that motivated her to become a lay counsellor

The aspects discussed below indicate the causes that motivated Bontle and contributed to her willingness to be a lay counsellor.

5.5.2.1 A calling from God

Working as a lay counsellor is a calling to her. She sometimes had to work without gloves using plastic to wrap up her hands to bathe the sick clients. At times the counsellors at the clinic did not have masks to cover their noses, they used a piece of cloth as a mask, but she persevered because of her calling. She reflected as follows:

> *"I think working with HI/AIDS is a calling for me. As I mentioned since 2002 until now, I am still working in the field. Many people dropped along the way long time ago, but I stayed. The job that I am doing is a calling [laughs]. I am proud of myself because due to my patience, I am a permanent worker now, and I will continue to serve as usual."*

When she started working at the clinic, she had to wait for a stipend for three to six months. Now the situation has changed for the better, although not everything is in order because some of the resources are not available as expected.

5.5.2.2 Family members died

Bontle had watched how her loved ones died of AIDS with little help from anybody. She was drawn to this type of job because of the deaths of people close to her. She realised that she could have helped her loved ones if she had the skills by that time. These situations led her to end up training and volunteering for home-based care. Many of the family members were

infected and affected and came to her for advice which encouraged her to continue working. She said:

> *"My sister was sick, and I did not do anything to try and help until she passed away, and I feel guilty about my ignorance. My uncle and cousin also died of AIDS, and there was no support; I felt responsible. I was there watching them suffer every day until they die. I promised my cousin I will learn about the disease and try to help others. I decided to volunteer to ease the guilty conscience."*

It is evident that she has guilt feelings about the late loved ones that she was not able to help. Because she could not forgive herself, she started with training to enable her to work with sick people to ease her conscience.

5.5.3 Bontle's experiences of her counselling role

Bontle has positive as well as negative experiences in her role as lay counsellor.

5.5.3.1 Positive experiences

The fact that many clients recover is a positive experience for Bontle. She is delighted when her clients recover from their conditions. She understands that healing is a personal journey and is something that a client might be able to attain with support from others. Through her support, clients work towards something that is important to them – recovery. When she encourages the clients to take their treatment, and they listen to her, she feels happy. She explained:

> *"I am pleased when I give support to the client; then they recover from their illness. Some come back to say thank you for your assistance, then I become happy that I am winning them to do the right things. Many of the clients adhere to their medication and become stronger every day. Aaah! Many of the clients are happy with me. They come to say they are happy because they are now strong."*

She acknowledges that different things may help the client recover. However, support from others and medical treatment plays a crucial role. Despite the reasons for recovery, the fact that many clients recover is an affirming, positive experience for her.

5.5.3.2 Negative experiences

Bontle also has the following negative experiences while doing her work as a lay counsellor.

Difficult and shocked clients

There are clients who sometimes have a negative attitude towards her. They do not accept their HIV status, and then they will create a scene in the counselling room. Others are suicidal, then she needs to counsel and support them until they are okay which is difficult. Some of the clients are coming from other clinics just to confirm that what they heard is true. She remarked as follows:

> *"The client starts crying uncontrollably, telling me a lot of stories that I did not even ask, asking questions such as 'Why me? Eish! So there is no change? I am still positive. Ooh! My parents passed away, which means I am going to die'. I feel frustrated sometimes because I need to calm the client down before I can refer him or her for further assistance because I am only trained for HIV counselling and testing."*

She verbalised that dealing with difficult and shocked clients is one of the challenges which leads to her frustration. She struggles with clients who start to discuss their personal problems during the counselling session. It is frustrating because she is not trained to deal with other issues outside of HIV counselling. Although she knows that she must refer these cases; she must first calm down the client before she can refer for further assistance.

Cultural and traditional beliefs

It is difficult for Bontle to work with clients from different cultures because usually, they do not understand each other. She has clients who, according to their own belief system, are expected to first confirm with their traditional healers before they can accept their results. Then it is difficult to make them understand their condition, and the counselling process becomes distracted. She, therefore, needs to understand her clients' culture, including their beliefs and values, so that they can work together effectively. Some believe in traditional medicines, and they stop using the medicine she provided. Others believe in Christianity, and they also stop using the treatment because they believe that prayers will heal them. She explained:

> *"Eish! The problem is that we have different beliefs, and it becomes a problem when you try to assist somebody from a different belief to yours. Others would say, 'my pastor prayed for me, and I stopped the medication'. Therefore, we still have a number of people who default in the process because they do not adhere to their treatment."*

Because there are many cultural groups in the community, it is difficult for her to know everything about every culture. It is therefore important for her to work with different clients from different cultural backgrounds without her being biased. She realises that she will only

work effectively if she is aware of her own cultural beliefs, attitudes and values and those of others.

Lack of resources and unfair treatment

She feels as a counsellor, she is not taken seriously because many negative things happen, and nobody listens to her when she raises them. She experiences that she is not treated equally with the other employees, making her feel excluded. There is only one big office, but she must share a small office with other colleagues. She is concerned about the lack of enough gloves and masks for counsellors, while they are required to assist clients every day. She said:

> *"I really do not feel comfortable at all because I am not taken seriously. My voice is not heard. When I complain, I do not receive a response, so I feel left out. I feel discriminated and excluded by the management because I do not receive equal treatment with the other workers for example, nurses and admin workers. Is it because I am a lay counsellor? Eish! I don't know."*

Bontle feels frustrated with her managers, who expect too much from her without proper working equipment (e.g. masks and gloves). The environment (small offices) is also not conducive for her to deliver a proper job. She feels that for the sake of their clients' welfare, these problems with the physical conditions should be dealt with.

5.5.4 Bontle's experiences of the COVID-19 pandemic

The aspects considered below reflect Bontle's experiences of the COVID-19 pandemic.

5.5.4.1 Working in fear

Bontle verbalised that working during this period of COVID-19 is tough for her because she tested positive for the virus. She was sick and stayed in quarantine until she recovered. She felt that they as counsellors are not protected enough against possible COVID infections, which caused four of her colleagues also to become infected. She expressed her fear as follows:

> *"You cannot say no, any referral from the doctor or nursing staff … you must take it. You have no choice but to do your job. I am always concerned and afraid because I do not feel that I have enough protection."*

It becomes a problem because she has to work more than before due to the rise in absenteeism of counsellors. Many of her colleagues are sometimes not available due to

illnesses or the death of a family member. Her experiences are that increasing illness and death amongst health workers impose high workloads on the remaining employees.

5.5.4.2 Working with anger

Bontle has masks and sanitisers, but she does not have aprons and caps for protection. She was trained about COVID-19 and given information on the protective measures, and therefore she realises that the resources for protection are not enough. When she tested positive for COVID-19 she felt angry because she knew that sharing a room with different people is risky. She said:

> *"I felt undermined and angry because when I test positive, I was asked what happened, and the management know that we do not have enough space for counselling and we do not have the required resources for protection."*

To Bontle, it is a challenge to counsel clients in an environment that she experiences as unsafe because she does not have enough protective material. She alluded that her anger can be reduced if management supports her with managerial practices that enable her to contribute effectively, efficiently and treat her as part of the organisation.

5.5.5 How Bontle is affected by her counselling role

Bontle experiences tiredness and frustration while doing her counselling job.

5.5.5.1 Tiredness

Bontle feels tired all the time and has constant headaches because she always handles things by herself. She spends most of her time trying to help her clients. She has become a victim of exhaustion which hampers the success of her counselling. This makes it clear that her welfare is hindered by her work as a counsellor and by the circumstances at the clinic. She described it as follows:

> *"When I sleep every day, I feel so drained. It is even difficult to wake up in the morning, but when I think of my clients, I have to wake up. . . . Eish! It's like being tired appears to be a 'normal' reaction to this job of counselling."*

Bontle always thinks of her client and forgets to self-care. Hence, she is unable to rest and is always tired. She channels all her energy and time towards her clients and deprives herself of her own peace and serenity. She understands that she needs to learn to take care of herself first, allowing her to be there for others without losing herself.

5.5.5.2 Frustration

Bontle becomes frustrated when there are things that she feels are beyond her control. Her frustrations stem from negative clients who do not cooperate and her unsatisfactory relationships with colleagues.

Concerning clients, she always feels a sense of helplessness because of her inability to rectify the situation or assist the client. She aired her frustration as follows:

> *"Sometimes I feel so frustrated due to clients who come to you with negative attitudes – those who do not adhere to the medication. It becomes difficult for me because I cannot go with them to their homes to monitor them."*

Another source of frustration is that she does not always have a good relationship with her colleagues:

> *"It is a problem for me because the relationship with colleagues sometimes is not so good, then you have no one to turn to…. The relationship with my colleagues is on and off, and it is strenuous – it depends on how the mood is today. If somebody is in a bad mood, then you will feel the heat."*

Frustration generally occurs because of negative clients and uneasy relationships with colleagues. She said she realises that acceptance of the situation will reduce her frustrations to a more manageable level.

5.5.6 What Bontle uses to cope with her counselling role

Prayer and the support of her family help Bontle to cope with her role.

5.5.6.1 Prayer

Bontle believes that prayer relieves distress and enhances her sense of well-being. She belongs to a church in her community, and she actively participates in church services. According to her, prayer is a powerful and desirable form of behaviour assisting her in coping with challenges. She commented:

> *"Eish! Prayer helps a lot, and I always go to church and meet with others in prayer. I love God, and I believe that when I pray, He answers my prayers."*

Bontle believes that God is fully capable of rendering any kind of help to her as a believer. She underscores the common saying among religiously oriented people that "With God, everything is possible." By making a regular commitment of her faith to talk to God in the good

and bad times, she feels calmer inside. She acknowledges that she does seek prayer more consistently in pain and trouble.

5.5.6.2 Family and friends

She also has the support of her family. She has support from her extended family and friends; they regularly call to check if she is doing well. Her immediate family are there to support her because they spend more time with her after work. This is what she said:

> *"I feel the support of my family members because we make sure to have supper together. They also assist me with house chores. My sisters and friends also call me every day then we will have a long chat because we use the Vodacom free minutes … that helps me a lot because I talk about everything, even my stress [laughs]."*

Support from her family and friends plays an important role for her since she has time to chat and laugh about things. Her immediate family spends more time with her after work which is the kind of support that she needs. They also try to have supper together to communicate about their day.

5.5.7 The lack of support from the organisation

Bontle experiences that the support inside the organisation is not enough. She only receives support from fellow counsellors. A mentor used to support her, but she disappeared without informing her. She feels that management only gives preference to others and lets her work every day without rotation. She shares a counselling room with another colleague, and rotation could assist because it would be one person working in a room per day. Her argument about this situation is as follows:

> *"I feel like I am abandoned. I do not receive the support that I expect from the management. I previously had support from a mentor who visited me regularly, but the mentor disappeared, and no one is giving me information about her whereabout. I tried to raise my concern, but I have not received a response. If one counsellor comes on Monday, the other come on Tuesday. We could avoid the situation of working under pressure and sharing a room on the same day."*

She feels that the managers do not have the time or ability to execute their supervisory duties to her as a lay counsellor. She believes that supervision should provide a platform for a counsellor to reflect on what is happening on a daily basis. She feels that it would be good to receive assistance with solving common problems she encounters daily. However, this is not

happening in the organisation. Inside the organisation, she only has support from other counsellors; they assist each other where they can do so in terms of their duties.

5.5.8 What Bontle needs to function effectively in her role

Bontle feels that the following will help her to function effectively as a counsellor:

5.5.8.1 UTT to be reconsidered

The system of UTT needs to be changed, according to her, because many clients default due to this process. Sometimes people are not ready to take treatment, but they are forced to do so because of the implemented new system. She declared:

> *"Clients come for testing, and when they test positive, they are required to take treatment. I feel that it is not right because they did not anticipate a positive result. While still trying to comprehend what happened, they are advised to take treatment. Since they are not ready, they default in the process."*

She feels that clients should be given an opportunity to decide whether they want to start with treatment immediately after the diagnosis or later. She acknowledges that early ART initiation is acceptable. However, the general same-day ART initiation following HIV diagnosis seems to be challenging. This is because clients are different, and their understanding and preparedness to start with a lifelong treatment can be scary to some of them. Hence she feels that it is important to allow the clients to decide for themselves and not be forced by the system. She stated that she is only there to support and help a client prepare and decide to start therapy. Therefore, it is crucial to establish the client's willingness and readiness before commencing treatment.

5.5.8.2 Follow-ups to be restored

She is of the opinion that she needs to do follow-up visits or calls because some clients do not come for further assistance. She needs to go back to the old ways where she used to provide the clients with adherence counselling and do follow-ups because she does not know where they end up. They just disappear. Others decide to test in different places hoping to get different results because they are not ready. She stated it as follows:

> *"Yaaa! There are clients who come once and shop around wishing to hear a different change in their results. If we can have some changes on the working days, if they can say I should not work every day, I would be over the moon … we can rotate to work in one*

office but not on the same day. It would be good to hear where my clients are, maybe a follow-up with a phone call because visiting them at their homes is a problem."

Bontle loves her clients and is always committed to assisting them. She also gets motivation from the knowledge that there are people who need her help, but when they disappear, it becomes a serious concern to her. She wishes that she could again do follow-up visits as in the past or have more time to contact clients with phone calls to find out how they are.

5.6 TSAKANI'S STORY: "TO ASSIST OTHERS INSTEAD OF RUNNING AWAY"

5.6.1 The background

Tsakani is a 55-year-old woman currently working as a lay counsellor at a local clinic in the community. She is a widow, and her highest qualification is high school. She attended informal training for HIV/AIDS counselling which lasted for two weeks. She received a certificate after completing the training. She does not belong to any support group inside and outside the organisation.

She started volunteering in 2002, and she was working as a volunteer under an NGO doing both home-based care and counselling under the Department of Health. She cannot count the number of people she previously used to counsel because she combined home-based care and counselling. As she was working in the field, it was difficult to keep records of the numbers.

She started working at the clinic in 2016 as a lay counsellor. Fortunately, she usually sees 15 per day on busy days and on a normal basis, she can see 10 to 12 clients a day. Her daily responsibilities at the clinic are counselling and testing, emotional support for women coming for antenatal visits, counselling and family planning. She provides group counselling to pregnant women who visit the clinic daily. Other than pregnant women, people are coming for family planning whom she assists. She also counsels people who come for TOP at the clinic.

5.6.2 Factors that motivated her to become a lay counsellor

The factors that motivated Tsakani and contributed to her willingness to be a lay counsellor are discussed below.

5.6.2.1 Concern for others

Tsakani had a friend who tested positive for HIV while still in high school. She learned some of the information from her, for example, that she must always check the viral load, condomise and have a positive attitude. Her friend later passed away, and one of her family members

also died. She was upset with herself because she did not do anything to assist them. She expressed it as follows:

> *"I feel guilty for not assisting my friend and my loved ones. My friend and cousin died of HIV, and there was nobody to assist as we all did not know anything about the disease. One of my friends was very sick, and I could not handle the situation, then I stopped visiting her. I was so traumatised as it was for the first time to see a person who was sick, but that opened my eyes to assist others instead of running away."*

Being exposed to trauma herself motivated Tsakani to work as a counsellor in the HIV/AIDS field. She thought that she may have assisted the members of her family if she had the skills by the time they had needed help. However, these experiences prepared her for the work she is doing now.

5.6.2.2 To gain experience

She could not find a job after she had completed her studies. Then she started volunteering at the clinic to gain experience. She also wanted to get more knowledge about HIV/AIDS to open an organisation in future. She remarked:

> *"Many decided to quit along the way, but I did not quit because I needed experience. I was interested in opening my own organisation to assist people. That is what motivated me to be involved in an HIV/AIDS field. I realised that opening an organisation is not an easy task then I decided to continue working at the clinic until today. But I am still dreaming of opening one when I retire [laughs]."*

Acquiring the expertise and experience about HIV/AIDS, as well as the possibilities to find work in the time to come, had drawn her to volunteer as a caregiver and later as a lay counsellor. However, she experienced much dissatisfactions because there were not many chances to develop herself at the clinic, although she worked there for many years without moving to another institution.

5.6.2.3 The love for people and desire to help

She viewed her work as meaningful and important because she takes care of people who need her assistance. She is interested in helping others and expressed a desire to see people healthy and well. She reflected as follows:

> "*I love people. I love to see people being assisted. When I go to the clinic, people are there on the benches with nobody to assist them. I wish to see people recover when they are*

sick. I decided to volunteer when the opportunity arise to help people, to help with campaigns and to educate people about the disease."

This indicates that Tsakani has realised that many people need assistance and do not know what to do to get help. Therefore, because she loves people, she decided to volunteer to assist them.

5.6.3 Tsakani's experiences of her counselling role

The aspects discussed below reflect Tsakani's positive and negative experiences while working as a lay counsellor.

5.6.3.1 Positive experiences

Excitement when clients recover

When Tsakani receives a happy client at the end of the day, she feels fulfilled. She feels excited when people adhere to their treatment and recover. This is very important to her. When her clients come back with smiles on their faces, she feels content. She said:

"*My happy clients encourage me to continue working even when it is hard. Some of the clients feel good about me and return for further sessions, only few who come once and disappears. I am not sure whether they disappear because they do not like me, or maybe it is about their issues. However, I have not received a client who complained to the supervisor or management about me, they only report positive behaviour and support, and that makes me happy."*

Tsakani believes that recovery is possible when the clients receive support from others. Otherwise, it can be difficult for them to get well. She feels that it may be helpful for clients to utilise support from friends, family or their counsellor to avoid the issue of them disappearing after one session. She adds that clients should remember that it is not always easy to do everything on their own. Therefore, it is important to accept help from others.

Accepted by clients

There are clients who come to the clinic thinking that they will test negative, but when they receive a positive result, it becomes a problem. They become frustrated and suicidal. However, at the end of the day, she wins them over and assists them to accept their results. She tries to assist the clients as much as she can. She commented as follows:

"I keep motivated by the assurance that what I am doing is good. We do not get paid properly, but the main reason to continue is appreciation by the clients and their families. I feel content when they say 'thank you' after they have recovered from their illness."

She is proud of herself because she feels accepted by her clients. She is able to assist her clients until they recover from their conditions.

5.6.3.2 Negative experiences

Language barriers

Tsakani has difficulty with clients from different cultural backgrounds, as there are usually misunderstandings, and it is very frustrating to her. She feels that the language barrier could hamper her effectiveness as a counsellor. Lately, she has had difficulty counselling people who have cultures that are different from her own. She is concerned about language barriers, and sometimes she does not understand what the client says. She said:

"You need to spend more time trying to explain to the client. It is better when the client understands English because you can communicate and understand each other. I become worried after the session as to whether the client understood me or not."

Because people in the community use many different languages, she will come across clients with languages unknown to her, and she realises that she must handle it somehow. She says it sometimes makes her question her effectiveness, and then she finds it difficult to distance herself from stressful situations with such clients, causing her to feel stressed.

Problematic clients

There are difficult clients who come to her with negative attitudes and refuse to cooperate. Some indicate that they are not ready for treatment, and it is her duty to convince them. The matter becomes worse when clients refuse to accept their status especially discordant couples (where one partner tests positive and the other tests negative for HIV); she must counsel them until they reach an agreement. She reflected as follows:

"Some client refuses to accept her HIV-positive status, and she reflects: 'This is not me, it's not possible, those are not my results' while others are confused and ask 'why me?' One of the clients told me why do I encourage them to test, 'who said I am here for testing?' Only to find out later that she is HIV-positive and she is breastfeeding a nine-months old baby. She did not attend any antenatal sessions properly, or she ignored the classes, and

that was painful because as a youngster, I expected her to have more knowledge about the disease than others."

Difficult clients become a challenge because it means more work for her. It means she should spend more time trying to explain or convince the client to do the right things. There are difficult clients who agree that they are ready to be tested and then suddenly change their minds and refuse to be tested. This makes her wonder whether she did not do well in her pre-counselling session or if the client changed her mind due to fear.

Poor working conditions: feeling disrespected

The working conditions are not conducive to effective counselling because the rooms are very small, there is no fan for cooling, and the windows are also small. The bookshelves are not in good condition; they are falling apart. When she requests working equipment, she is given a negative attitude and an inappropriate response. One day, she was advised to use a shelter outside for group counselling because many clients came for counselling. She explained:

"I am most of the times stressed because the rooms or offices are small and not enough to cater us as lay counsellors, and nobody is communicating anything to us. Ooh, it's worse, we need to share the space with my colleagues, and it is difficult to wait for them to finish so that you can use the room. I was requested to work under a gazebo one time, and I felt so disrespected. I requested an apron, and I was told I am a counsellor. I do not need an apron – it is so frustrating. I cannot decide or make a suggestion. I do not get recognition, I am a counsellor – it ends there. I am treated differently from other workers … felt discriminated and not taken seriously. Like now, with the situation I am facing, I am not taken serious at all. The UTT programme is not working for me, I am to spend more time with the clients that I should because I have to make them understand and be ready for treatment."

Tsakani felt insulted because she understood that the confidentiality of her clients would be compromised. She realised that working in a tent would not work out because it is a public space. She is also concerned about UTT, which is not working for her because most people are not ready to take treatment immediately. She is not happy about how management treats her and the group of lay counsellors.

5.6.4 Tsakani's experiences of the COVID-19 pandemic

The aspects mentioned below reflect Tsakani's experiences of the COVID-19 pandemic.

5.6.4.1 Working in fear

Tsakani is not happy about the situation with COVID-19 and how management is handling the matter. Four lay counsellors tested positive for COVID-19, and she wonders how that happened because they try to follow the rules and regulations all the time. She said:

> *"It's not nice at all. I am scared. I work in fear because I do not know how the others got infected. The experience is not good. We had four of our staff members who tested positive for COVID-19."*

The number of people coming for HIV testing is dropping, but many come to collect their medication. What scares her is that the queues for COVID testing become long, increasing the possibility for them as counsellors to become infected.

5.6.4.2 No safety: not enough resources

Tsakani verbalised that lack or shortage of resources hinders her from doing her job effectively. She works with difficulty and feels unsafe because the necessary means they need for their work is not enough. She is also expected to achieve ridiculous targets without the necessary resources. She remarked:

> *"We do not have aprons – PPE (Personal Protective Equipment) to use while doing our job, we were told to have our own doek – no caps will be given to us. We only have masks and only one per day – we were given one mask for the whole day, and we complained until they give us two per day. We have to come with our own masks to protect ourselves…. I am required to reach a particular target per day, and that is so frustrating if you do not have the resources required to do the job."*

The shortage of resources results in her being frustrated, and her performance may be reduced due to this challenge. She understands that it is the organisation's responsibility to provide the tools and resources that she needs in order to complete the necessary tasks that lead to the achievement of organisational goals. However, that is not happening, and it gives her the impression that management does not care about her well-being.

5.6.5 How Tsakani is affected by her counselling role

The aspects discussed below reflect the effects that Tsakani experiences while doing her counselling job.

5.6.5.1 Exhaustion and headaches

Tsakani usually experiences headaches, and she is always tired – physically and mentally. She feels helpless since she does not have debriefing sessions and experiences constant headaches and exhaustion. This is what she reported:

> *"You become frustrated and exhaustion due to work. You become used to it; it ends up like it is your life that is how things should be. You sometimes have your own problems and sleepless nights…. When you get to work and find a difficult patient, then you become drained. Although I am a PP – people's person, the role is strenuous because you are always tired. I always have a headache, especially in the morning and evening*."

She suffers from constant headaches, and she suspects it might be because of her apparent occupational stress. Apart from her frustrations and fears, she often has to deal with unexpected responsibilities beyond her abilities, and that causes stress. The stress and fatigue are reinforced because she feels that she does not have support from management. She is aware that she needs to attend to her situation because prolonged tension can damage her health and work performance.

5.6.5.2 No time for family and friends

She only has weekends to visit friends and relatives because she works five days a week (from Monday to Friday), and she feels that she does not have enough time to keep up with these relationships. She told me:

> "*I am always tired when I get home. I am unable to do the house chores when I knock off because of tiredness and weekends I force myself to do so then I do not have enough time to see my friends."*

It is evident that she suffers from physical exhaustion because of her strenuous job and can only spend time with friends and family on weekends. She feels that she does not have enough time for these relationships while trying to do her counselling job.

5.6.6 What Tsakani does to cope with her role

Tsakani talks to her partner and family about her work problems. Fortunately, she has a supportive family and has the type of relationship with her partner where they can talk. Therefore, she can talk about her problems without restraint, especially with her partner. She explains:

"I do not have anything to cope with my challenges except talking to others when I have time. My partner is supportive, so I am able to talk to him to clear my mind. I know that I am not supposed to discuss the cases due to confidentiality issues but talking to somebody; it eases things for me."

Expressing herself about the problems that she experiences seems to help Tsakani. She knows that expressing herself in words, helps her to find meaning in and through her experiences.

5.6.7 The lack of support from the organisation

Apart from shortages of the material (masks, caps, etc.) they need to do their work. Tsakani also experiences that management does not provide support (emotional support and recognition) to them as counsellors and does not offer any more training. She feels left out and not taken care of at all. She said:

"I feel undermined, all the decisions are made for us, I am not given a chance to say anything concerning my work, I am just dictated on what do to do. When I am at the meeting, I do not talk; I only listen. I feel ignored because whatever I try to say it is not taken into consideration."

Tsakani understands that support from management is not just a matter of words. It means allowing them as counsellors to develop and use their skills and abilities. Managers show a lack of support when they fail to give the counsellors a chance to communicate with them. She further feels that management demonstrates a lack of support when they do not recognise the knowledge that counsellors may have.

5.6.8 What Tsakani needs to function effectively in her role

The aspects discussed below indicate what will enable Tsakani to function effectively as a counsellor.

5.6.8.1 Debriefing

Tsakani needs communication with counsellors from outside the clinic. She suggested that it would be good to meet with counsellors from other clinics for debriefing in order to share their experiences. She reflected as follows:

"After a difficult day with clients, I just need to offload the burden and talking to somebody can make a difference in my life. Even if it is once a week, I think that can help me to be rejuvenated and be strong again."

She needs continuous support and debriefing sessions. She feels that this can allow her to talk about the challenges that she experiences.

5.6.8.2 The need for larger offices

Another very urgent need is that the counselling rooms need to be larger and equipped with air conditioners. She reported as follows:

> *"When I get a difficult client, it become more strenuous when it is hot because the room is small and there are no air conditioners. When you are done, you need to offload, and there is nobody to assist because colleagues are also busy, then you go home with your stress and then you are exhausted than ever."*

She states that if the physical working environment is not conducive to the workers, they are more likely to burn out; hence, there is an urgent need for the offices to be improved.

5.6.8.3 Continuing development

She needs continuing guidance and training which can be inside or outside the organisation. She has the insight that it is necessary to keep up to date with the newest information with regard to counselling and HIV/AIDS. She needs to undergo training (in the form of workshops, attending courses, etc.) to be empowered with new skills. She declared:

> *"I need to study further and improve my skills. I trained for three weeks, and I think it is better if get more and new information."*

It is evident that she would like to develop her skills. She is of the opinion that the organisation should prioritise training if they want to improve the functioning of their counsellors.

5.7 DIKELEDI'S STORY: "HELPING A PERSON … IS AN HONOUR TO ME"

5.7.1 The background

Dikeledi is a 38-year-old woman who is married and works as a lay counsellor at a local clinic in the community. She has a tertiary qualification and attended informal HIV/AIDS counselling training. The training lasted for three days, and she obtained a certificate of attendance after completing the training. She is not a member of any support group.

Dikeledi started working at a local NGO as a caregiver in 2010, doing home visits to sick people. She describes it as tiring because she used to do home visits (door-to-door campaigns to identify sick patients in the families). When she visited a family, she also counselled the family members, which she found very difficult. Then she had to see as many families/patients

as possible because she was expected to record the statistics. In 2016, she started working at the clinic as a lay counsellor.

In her present work at the clinic, her daily responsibilities are counselling and testing. She counsels 10 to 15 clients per day. She also conducts health talks to people visiting the clinic in the mornings. She encourages people to come for testing after the presentation. She is responsible for many things, including PMTCT – Prevention of Mother to Child Transmission teachings and giving support for clients who are six weeks under treatment.

5.7.2 Motivation to become a lay counsellor

Dikeledi's willingness to serve motivated her to become a lay counsellor. When she was growing up she wanted to be a nurse but could not achieve her goal due to the financial situation at home. Her parents could not afford to pay for her college fees. Therefore, she felt it would be good to join the NGO to gain experience. Then her younger brother became sick with HIV/AIDS, and he later passed away. She reflected as follows:

> *"I felt the need to move on because I believe that God gave me those people, so I can assist them, and I am doing the work effectively. I worked as a dental assistant, and I realised that I am not gaining anything; then, I decided to change and come for counselling. Helping a person and the person recover, it is an honour to me."*

Dikeledi wanted to learn more about this disease to understand and help her family. She is helping many people, and she is happy to see countless surviving and becoming strong.

5.7.3 Dikeledi's experiences of her counselling role

There are positive and negative aspects to her experiences of her counselling role.

5.7.3.1 Positive experiences

Dikeledi feels positive about her work as a lay counsellor when clients adhere to the instructions for taking their medication. She realises that clients who are prescribed medications usually do not necessarily take them according to the instructions and default in the process. However, those who follow the instructions and adhere to their medication are likely to improve their health and recover from their illness. She described it as follows:

> *"When I hear my client say that I am now coping very well, I am happy. The clients are happy. They love me. Others also phone me just to greet me; others just call to say thank you and update me about their condition. It is an honour to work for the community. I love*

my job … they take their treatment and recover from their illness, and that makes me feel content."

Dikeledi understands that it can be difficult for some clients to accept their conditions, and some have found that their recovery journey may be easier after they learn to accept their illness. Therefore, it is important for her to support them until they are ready to take their treatment and move on with their lives. She agrees that acceptance may help her clients to make positive changes and help them to reach new goals.

5.7.3.2 Negative experiences

The following aspects describe Dikeledi's negative experiences while doing her work as a lay counsellor:

Negative attitude and behaviour of clients

Dikeledi sees clients who have negative attitudes, making her work difficult. It becomes a problem because she feels that she is not accomplishing her goal of assisting people. Some are at the clinic for the first time, and others are returning clients. Dikeledi thinks that the first-timers may be afraid of the unknown, which can lead them to behave emotionally and strangely. In situations when a client does not know why something is being done, they are much more likely to be defensive and act out negatively. She alluded:

"Okay, the client agrees that she will continue with the counselling process, then I open a file. After the first session, the client vanishes and does not come for follow-up sessions. I try to contact … she provided a wrong number, then I feel deceived. I sometimes find clients who do not want to cooperate. They do not want to queue and push each other, causing a commotion."

The clinic can be busy sometimes, especially during rainy days, because clients want to be inside, and they overcrowd the only waiting room. It becomes difficult because there is not enough space to accommodate all. Therefore, there was no social distancing by that time! But they had no choice but to squeeze in one room. Dikeledi realises that she needs to have a bit of understanding as to why these clients are acting the way they are in order to assist them effectively.

Shortage of Personal Protective Equipment (PPE)

Dikeledi has experienced a shortage of personal protective equipment (PPE) needed for counsellors to do their jobs effectively. She feels that she is not supported by her managers

since they are not providing enough PPE for the workers. She tells me that the clinic has small offices, but she is expected to do her work in that space without proper protective gear. Some of the counsellors must share space, and without proper PPE, they are more likely to become infected. She said:

> *"I am not well equipped, but I try to work hard. I try to manage with the little that I have, and I notice that it is risky."*

It is clear that without proper PPE, she is more likely to become sick and be absent from work. She argues that when she is sick, the demand for care will increase, and the remaining counsellors will struggle with the workload. She is of the opinion that these challenges may cause the organisation to become unstable, and the quality of care will be compromised.

5.7.4 Dikeledi's experiences of the COVID-19 pandemic

Dikeledi's experiences of the COVID-19 pandemic are that she fears COVID and is worried about clients who do not adhere to their medication programme.

5.7.4.1 Fear

Since COVID-19 started, she has been afraid to come to the workplace. She has experienced a shortage of PPE, which is needed to protect one from COVID-19 infection. Management fails to supply her with protective equipment, especially goggles or face shields, gowns or aprons. She receives one sanitiser and one mask per day, and she feels that it is not enough. She expressed her concern as follows:

> *"I only receive one mask per day when it is hot. I sweat, and the mask needs to be changed, so I do not have another one. I am afraid that I may become sick while trying to assist others."*

Although she has information on how to protect herself, she still has this fear when she comes to work.

5.7.4.2 Clients' defaults

There was a drop in the number of people coming for HIV counselling and testing since the COVID-19 pandemic. She tries to communicate with clients to come and collect medication for two to three months. However, she only communicates with those whose details are in their records. Some clients do not update their contact details, and then she finds it difficult to contact them. When their medication is finished, many of them default. However, when they

come again. she tries to give them enough medication to cover them for longer. This is what she said:

"When the client visits the clinic for collection of medication, I tell them to come again sooner because I don't feel comfortable when they stay longer. They do not adhere to their medication when they are left alone and only come when the medication is finished. However, I do not have airtime to call all of them to check how they are doing because, indeed, they are not to come to the clinic due to COVID-19 restrictions. Even if I try, I do not find some of them because their numbers are not working."

She feels that it is important to have face-to-face contact with the clients because you can observe whether they are taking treatment or not. However, due to limitations on people's movements due to the pandemic, more HIV clients stay away, and their treatment is neglected or discontinued. This is a great concern to her because she cannot encourage them and make sure they adhere to their treatment.

5.7.5 How Dikeledi is affected by her counselling role

Dikeledi experiences headaches all the time. She is always tired because she works for long hours, doing stressful work. She told me:

"I have headaches, and sometimes I am unable to wake up in the morning, but when I think of my clients, I force myself to get up and prepare to go to work."

She acknowledges that headaches are a major cause of her absenteeism from work. Her headaches also affect her social and family life.

5.7.6 What Dikeledi does to cope with her role

Dikeledi listens to music, talks to people and prays when she feels stressed and has problems.

5.7.6.1 Listens to music

Dikeledi verbalised when she gets home, she is always tired, but she listens to gospel music. She listens to music to deal with the challenges that she experiences at work. She listens to music in order to reduce stress. She explained it by giving the following account:

"I am always tired when I get home, so I sit down and listen to gospel music softly, so I feel relaxed, then when I start with the house chores, I increase the volume, then I become energetic and my mood changes."

Dikeledi found that rather than focusing on the stressor itself, music leads her thoughts away, and it reduces or eliminates the emotions that arise in response to stress. She says that gospel music works for her.

5.7.6.2 Communication with others

She loves talking, so when she has a problem, she communicates with others. Sometimes she gets the idea that her loved ones do not understand the problems she has to deal with. Nevertheless, just their presence and support make her feel safe and protected. She stated it as follows:

> *"When I talk to others, I feel much better, so I make sure that when I am on the boiling point, I talk to my friends. I also have support from my family … but I sometimes feel like if I talk to them every day, they might feel like I am suffering and I should stop working with people, and I love serving them. Therefore, I choose what to talk to them about and when to communicate."*

Dikeledi has found that talking to other people helps her to thrive and build resilience. She identified people with whom she feels comfortable talking about her feelings.

5.7.6.3 Prayer

She prays when she has a problem, it is an action that she uses to manage and cope with stress better. She said:

> *"Focusing my mind on Jesus decreases my stress. I pray and forget about everything that happened at work. I become more aware of God's presence in their lives. After prayer, I feel relieved. I also go to church regularly for prayers with others, and it is helpful."*

She has learned to focus on God's presence and re-evaluate a demanding situation until it seems less overwhelming. This helps her cope by gaining control of her reactions to stress. She realises that she has a large support network and more social contacts when she participates in religious activities, so she does not feel alone due to the support system.

5.7.7 Not enough support from the organisation

Dikeledi receives support from the organisation, but it is not enough. When she has a problem as a lay counsellor, it takes a long time for management to assist her.

This year, the organisation invited two outside organisations to assist with debriefing, but both organisations terminated their services. She was not informed about how long they were

assigned to be with them and why they had stopped their assistance of the counsellors. That was the only hope she had because management failed to provide that kind of support. She remarked:

> *"I do not have any information concerning what is happening with my job, I am just introduced to other people, and some of them do not stay long (counsellors/mentors). When I am used to the process, the people disappear and leave me hanging on the air. I am treated like a child, decisions are just made for you, and you just need to obey."*

It is evident that Dikeledi feels that she has little support from the managers and she has little control over work processes. These work circumstances and lack of participation in decisions that concern her job cause her a lot of stress.

5.7.8 What Dikeledi needs to function effectively in her role

Dikeledi needs the counselling environment to be improved, and that management would support her more.

5.7.8.1 Counselling space and furniture

She needs a change in the counselling rooms, and if possible, buildings should be expanded for the counsellors to have enough space. She commented:

> *"I would be happy if I can have my own space because now the environment is not good at all. I am also not comfortable with how the files are kept, I can be neat, but if you are not working alone then is a problem to maintain the neatness."*

The files are not well kept, and it is difficult to find the clients' files when they come for their sessions. Therefore, she needs cabinets that lock in which to store the documents.

5.7.8.2 More support from management

Dikeledi needs more support from the management for her to perform her tasks effectively. She needs them to arrange for debriefing to assist her to continue with her job effectively. She feels that management should also involve her in decisions that will affect her and her duties. She also feels that counsellors should be treated equally and with respect. She said:

> *"Eish, I am not happy with how I am treated as a counsellor, because I am called a lay counsellor … it affects the way other health care workers view me, they think I do not know much because I am a lay counsellor and I feel offended and disrespected."*

She is not happy about the word ‘lay’ in her title because it affects how clients and other health workers view her. She feels that management could give the lay counsellors more recognition, although they did not receive the same training as health care workers. That would also create more respect for them from clients and other workers. She believes that other health care workers undermine her due to the training that she received.

5.8 CONCLUSION

Stories from the participants were presented, and I formulated some of the important meanings from the raw data. When telling their stories, I hoped to give a true picture of this group of lay counsellors.

In the stories, I presented the participants’ experiences and the challenges they encountered while doing their job. I also indicated their motivations, strengths, needs and problems. I endeavoured to reproduce their experiences as truthfully as possible in these stories. As mentioned in Chapter 4, I made use of the core principles of the person-centred theory in the interviews. I tried my utmost to show empathy so that I could deeply grasp their subjective world (see section 4.3) and reproduce it in these accounts. The analysis of the results obtained from the stories will be discussed in the following chapter.

CHAPTER 6

DISCUSSION OF RESULTS

6.1 INTRODUCTION

In this chapter, the results of this research are discussed according to themes that have been identified that were common to all the participants. An analysis of these themes and comparisons with scientific works published on lay counselling and its results are discussed. What my participants experience is similar with but also different from what is reported in existing research publications. The participants were recruited at a clinic in the Tshwane area located in the Gauteng province. The participants met the required criteria and were all willing to share their experiences. Some participants live near the clinic, while others use local transport to access the clinic. The participants are described regarding biographical information as well as the themes that were identified from their stories. From participants' stories in the previous chapter, common themes clearly emerged. There are striking similarities in the experiences of the participants, which will be described as themes in the following section. The themes that have been identified will be presented with regard to what factors contributed to their stress and burnout and their resilience, how they cope with their roles as lay counsellors, as well as what their common needs are.

6.2 THE PARTICIPANTS OF THIS STUDY

Relevant biographical information about the participants was obtained through the use of a biographical questionnaire (Appendix F). The participants were in the age group of 37 to 55 years, and all were females. Two of the participants are single, while two are married. One is a widow, whereas the other one is a divorcée. The educational qualifications ranged from one with primary education, two reaching secondary education, and three had attained tertiary qualifications, although not in the HIV/AIDS field. I met all the participants and communicated with them during the recruiting process at the organisation. Therefore, in this section, I present a short discussion of the observations and impressions of each participant during the recruiting and the interview processes. The first participant was Mavis, who appeared to be a confident young woman. She seemed to be very calm, thoughtful and composed despite her young age. These are the attributes that could be to her benefit when doing counselling. Through my observations, I noticed that she loves people and is constantly enthusiastic in assisting them. Therefore, the aforementioned corresponds with her attributes.

The second participant was Norma. My first impression of Norma was that she was reserved. She did not seem comfortable talking much. However, she presented as someone who has a

lot of experience in her role as a lay counsellor. Through the observations, I noticed that she is an active listener because she could engage with me more effectively by paying special attention to the conversation. That was confirmed when she asked questions about the recruitment process and the benefit of participation. I enlightened her and other participants on the benefits of participating and also referred her to the participant's information letter. I was so impressed because all along, she was quiet while others were participating.

The third participant was Grace. She appeared to be a friendly and outgoing person. Although Grace is outgoing and friendly, I could tell she was masking her sad experience and the outgoing, friendly exterior was a coping mechanism. This was discovered when she was probed, and she mentioned that she recently went through a divorce. I came to the conclusion that she had not worked through the effects that the divorce had had on her yet, although she mentioned that she is coping through prayer. I tried to convey some empathy to her, which she acknowledged later by being comfortable and asking questions about the study.

The fourth participant was Bontle, whom I found to be a reserved person, and I sensed that she was reluctant to participate as she had a fair amount of suspicion. That was confirmed when she asked numerous questions such as why did you choose the lay counsellors? Do we sign off for leave days to participate? Do we get any incentives for participating? However, since I had built rapport with the participants, and I reassured anonymity and emphasised confidentiality, it was easy to address those questions. I then felt that she trusted me because she managed to share her rather touching experience as a lay counsellor. She lost her loved ones, and this experience always brings unpleasant memories and heartaches as losing loved ones is traumatic.

The fifth participant was Tsakani. I found her to be reserved and that she has a small number of friends. Her circle is closed, meaning that she does not allow a lot of people in her personal space. She literally chooses whom she allows into her space. This was confirmed when she mentioned that she likes spending time with her family and her partner is her best friend. She was interested and excited to participate. She continuously asked when the interviews would be conducted. I explained that an interview would be done at an arranged date and time and that I would also hand her the consent form to complete and sign.

The last participant was Dikeledi, who appeared to be a calm person who always spoke with a gentle voice. She is more interested in helping people, and I think that her strong personality characteristics will help her to handle her clients. The questions she asked me showed that she was aware of the research aims.

More information about the participants' age, marital status, educational qualifications and responsibilities are discussed in the previous chapter. The next section discusses factors that contributed to lay counsellors' stress and burnout.

6.3 FACTORS THAT CONTRIBUTED TO LAY COUNSELLORS' STRESS AND BURNOUT

HIV/AIDS counselling is a difficult process by its nature. Therefore, conflict is often experienced. Clients often display resistance which leads to the counselling process being slow. These challenges lead to stress as lay counsellors become concerned about whether they would be able to assist the client effectively. In Visser and Mabota (2015)'s study about the emotional well-being of HIV lay counselling and testing counsellors, they indicated that some of these stressors are probably unique. They further found that health care workers addressing a variety of health needs also have experienced stress related to caring for people living with HIV/AIDS. The findings are in line with those of Peltzer et al. (2012), who also found that the challenges experienced by counsellors were associated clearly with experiences of stress and burnout.

Jackson et al. (2013) highlighted that lay counsellors had been incorporated in HIV programmes in the clinics and hospitals in South Africa. They managed to reduce the workload of the health care workers by providing HIV counselling and testing that improved the HIV testing and counselling (HTC) programme under the National Department of Health (NDoH) outcomes (Jackson et al., 2013). This research focused on the experiences of these lay counsellors, referring to the positive and negative experiences as well as how they cope with their situation.

Visser and Mabota (2015) reported that although lay counsellors are hardworking and full of determination, they encounter various challenges in their work which makes it difficult for them to provide good quality services. Furthermore, they highlighted the main causes of stress and burnout among lay counsellors, such as emotional involvement, consistent exposure to illness and death, and internalisation of some of the hardships of their clients, their own personal fears and vulnerability of being infected and being stigmatised, uncertainty and being unprepared for situations that may arise in counselling (Visser & Mabota, 2015). The report above resonates with the Job Demand Resource (JDR) Model, which states that burnout arises when individuals experience continuous job demands and have inadequate resources available to address them. This was discussed in Chapter 3 under the job demands heading (Bakker & Demerouti, 2014). The participants in this study experienced high work pressure and emotionally demanding interactions with clients. Due to the exceeding demands of

HIV/AIDS care and counselling, the participants in this study were not able to successfully cope with their roles and job descriptions; hence, they suffered from stress and burnout.

They reported certain experiences associated with their role that contributed to their stress and burnout. Those experiences are different from the ones identified by other researchers below. For example, Visser and Mabota (2015) identified emotional involvement, consistent exposure to illness and death, and internalisation of some of the hardships of their clients, their own personal fears and vulnerability of being infected and being stigmatised, uncertainty and being unprepared for situations that may arise in counselling as the symptoms of stress and burnout. However, Van Dyk et al. (2017) highlighted their own factors such as negative job attitude, overwhelming physical and emotional exhaustion, developing negative self-concept, feeling of inadequate helplessness, feeling irritated, and loss of concentration; Whereas Mwai et al. (2013) highlighted lack of nationally recognised training, poor recognition, low remuneration and supervision, lack of social support and poor involvement in decision making as factors that contributed to burnout in lay counsellors (Mwai et al., 2013).

Therefore, participants of this study revealed several factors that contributed to their stress and burnout and were grouped into themes such as non-cooperative clients, uncertainty with the role, language barrier, cultural and traditional beliefs, clients who default from treatment, lack of resources, lack of support from management, poor working conditions, exhaustion and headaches, frustration and difficulty to adapt to change. These themes are discussed in detail below.

6.3.1 Non-cooperative clients

Although many clients appreciate their work, some are not cooperative and make it difficult to perform the roles and duties as required. They also experience clients who belittle them and refuse to start with their treatment. This is similar to conclusions by Van Dyk et al. (2017), who found that if clients do not take their antiretroviral medicines as prescribed, counsellors feel powerless because they then cannot manage the clients' health. It becomes a concern to the counsellors because they cannot make decisions for the clients. The non-compliance of clients contributes to stress and burnout in the lay counsellors of this study because they have the mindset that they are there to support and assist the clients regardless of their attitudes.

6.3.2 Uncertainty about their role

According to the National Dept of Health (2010), lay counsellors should conduct general clinic support, HIV testing and counselling (HTC), TB education and adherence counselling, support sessions, treatment literacy, empowerment of People living with HIV/AIDS (PLWHAs),

Antiretroviral treatment (ART) preparation and adherence counselling which is not different from some of the tasks mentioned by the participants. The counsellors who are available must be familiar with what is required of them, their responsibilities and daily tasks. In a study done by Mwai et al (2013) about the role and outcomes of community health workers in HIV care in sub-Saharan Africa, it was found that in order for lay counsellors to find meaning and benefit in their work situation, there should be clearly defined roles and delegations of responsibilities.

However, during the interviews, participants revealed that they were expected to perform duties such as client screening in the queue, health talk (TB, STIs), counselling those who want to do TOP (termination of pregnancy) and referrals for HIV testing. They also provide emotional support for women coming for antenatal visits, counselling and family planning. They provide group counselling to pregnant women who visit the clinic daily and conduct health talks to people visiting the clinic in the mornings. They shared that they also provide Prevention of Mother to Child Transmission (PMTCT) teachings and receive clients referred from other clinics and transfer some clients to other clinics. When I reviewed their responsibilities, it became clear that they provide different services, yet they are all lay counsellors in the same clinic. The participants do not have a specific responsibility that they focus on, and they were not individually assigned to certain tasks, which led to their feelings of uncertainty about their roles as HIV counsellors.

6.3.3 Language barriers

Hussey (2012) acknowledged that good communication is the cornerstone of the health professional-client relationship and a lack of proficiency in a common language decreases the quality of verbal communication between people. The participants revealed that there are clients who speak foreign languages, and it is difficult to have smooth communication because they do not understand each other. The participants try to find a mutual medium in which to communicate, e.g. English, but the problem persists. Language barriers hindered the participants from providing effective counselling to the clients, and they ended up defaulting from medication due to misunderstandings. This is slightly different from Van den Berg's (2016) study, where participants who were confident about their counselling role experienced language barriers that hindered them from providing effective counselling to the clients, who ended up defaulting from medication due to misunderstandings. The healthcare providers felt that the inability to understand the client's language had a negative impact on their ability to be empathetic, decreased the quality of satisfaction with care, and led to cross-cultural misunderstandings. Thus, the participants in Van den Berg's (2016) study started to have self-doubts about their effectiveness as counsellors due to language barriers.

That led to frustration and stress when the client's defaulted because participants were unable to deal with the issue. They are always concerned about the health of their clients, and they are dedicated to helping others. However, if the participants cannot help their clients, they become stressed out. The language barrier hinders effective communication, and it impairs the quality of healthcare delivery. Hussey (2012) reported similar findings in a study done in South Africa that the language barrier compromised a large proportion of the population, affecting the quality of and access to healthcare services.

6.3.4 Cultural and traditional beliefs

Van Dyk et al. (2017) highlighted that culture is an important factor in health care, and it determines the meaning of illness or health that individuals in a particular culture will adopt as well as the healing process. In order to understand the origin of health and illness in traditional African beliefs, we need to understand the spiritual nature of being African (Mkhize, 2015). In various African communities, traditional healers have a significant influence on people's well-being and their use of health services. The participants in the current study were challenged by different cultural issues that they encountered while doing their job. There is usually a serious conflict of interest for the counsellors because many of the clients and their families visit traditional healers in addition to formal health care practitioners.

They encounter clients who believe in traditional medicines, and they stop using the medicine provided to them. Others believe in Christianity, and they also stop using the treatment because they believe that with prayers, they are healed. This causes the participants to feel frustrated because they feel like they are fighting a losing battle. They feel helpless because they are not equipped to deal with such issues. When such issues arise, they use their own understanding, which contributes to them developing stress and burnout in the process.

These findings differ from what Musumari et al. (2013) found in their study concerning religious and traditional beliefs. Religious and traditional beliefs were both barriers and facilitators of ART adherence. The belief that one's disease was caused by witchcraft led a few participants to interrupt their ARV's treatment process and use prayers or traditional medicines in search of a potential cure. On the other hand, many participants sustained the belief that God provided the knowledge to make ARVs, and this mindset motivated them to keep adhering to the treatment.

6.3.5 Clients default from treatment

The participants in this study were confronted with another challenge: the clients' failure to take their medicine as prescribed. They became upset when their clients neglected the

medication programme or turned it down. This is consistent with the study conducted by Musumari et al. (2013) in the Democratic Republic of Congo, who found that forgetfulness, fear of side effects and feeling hopeless were some of the factors that hindered the individuals from adhering to ARV treatment. The participants also reported that some clients purposefully postponed fetching their medicine at the clinic. Clients would miss out on taking their ARVs at the right time, claiming that they could not come due to COVID-19 restrictions. This is in contrast with the reports from a study done by Kagee et al. (2012) about the perspectives of users of antiretroviral therapy on structural barriers to adherence in South Africa; where the patients reported that they were often absent from work for a whole day, because of long waiting times and a large number of patients at clinics.

The participants felt that the situation was beyond their control because they do not stay with the clients in their homes. They felt helpless since there was nothing they could do to assist the clients except to encourage and motivate them when they came to the clinic. Van Dyk et al. (2017) also found with their research that if patients do not adhere to taking their ARVs promptly, the health care workers feel helpless because they do not have control over their patients' health. The participants also reported that these frustrations contribute to the stress they experience on a daily basis. When the clients default, they feel discouraged and helpless. They then had to do their best to motivate the clients to stick to the prescriptions of how to take the medication, which is a strenuous process.

6.3.6 High workload

Research done by Mwisongo et al. (2015) showed that a high workload for lay counsellors makes their work very difficult. They indicated that service delivery is compromised because they do not spend enough time with their clients. The challenge that the participants reported is the statistics that they should submit every day. The counsellors work under a lot of pressure to reach the target set for them. The number of clients for whom the counsellors are required to counsel per day is another problem that makes counselling strenuous for counsellors. The counsellors who participated in the study counsel 10 to 15 clients per day, and if they are overloaded with work, they cannot be effective, and it aggravates their stress leading to burnout. These findings are consistent with the study by Akintola et al. (2013) in South Africa, who found that forcing counsellors to do too much work and their consequent suffering from fatigue are factors contributing to their high-stress levels. Their report also resonates with Mwisongo et al. (2015), where counsellors were expected to counsel an average of 12 clients per day and test from 9 to 25 clients on a busy day leading to their burnout. Participants in this study also performed other duties apart from HIV counselling such as HIV testing, ART adherence counselling, PMTCT services and coordinating support groups. Apart from the high

workload, these were the concerns that led the study participants to feel overwhelmed and burned out in the process.

6.3.7 Shortage of resources

The participants in this study reported a shortage of resources as their main concern. This was also reported by Peu et al. (2014), who mentioned that lack of resources becomes a serious concern because it contributes towards inadequate and ineffective service delivery. Concerning the shortage of resources, the lay counsellors in my study said that they are in need of more equipment and other facilities to enable them to do their daily work effectively. They are of the opinion that if the clinic gives more recognition to their role as counsellors, they will also address their needs for better resources. According to the Job Demand Resource (JDR) Model, job resources are very important in achieving work goals. They also play a fundamental motivational role because they satisfy basic human needs for independence, affiliation and competence (Schaufeli & Taris, 2014). Lack of resources makes it difficult for the participants to achieve their work goals. Their basic human needs and affiliation, and competence are not fulfilled because they do not have enough resources to motivate them to accomplish the given tasks. Job demands may not necessarily be viewed as negative; however, when meeting those demands requires more effort from the employees, they may feel overwhelmed and unable to accomplish the tasks (Bakker, 2011). Some of the participants reported that they opted for group pre-and post-test counselling due to the shortage of space and the pressure to reach the target number. Working with a group is not suitable for the counselling process because it interferes with the continuity of the relationship of trust built with the individual clients. Ledikwe et al. (2013) reported similar findings indicating that because of the high workload, counsellors sometimes had to work without taking breaks which can be taxing on their well-being.

6.3.8 Lack of support from management

According to Van Dyk (2016), health care workers must have personal and organisational support for managing stress. Unless they get this kind of support, they will not be able to handle their work successfully. The participants of this study reported a lack of supportive systems as another concern that needs attention. It seemed that there are no established arrangements to provide assistance to them to handle the negative effects of the counselling on them. They objected to the fact that they were not kept informed and that they do not get enough assistance. They feel unsupported by their managers because nobody tries to address their issues when they raise their concerns. This is in contrast with the findings from a study done by Williams et al. (2015) about the factors of organisational culture in health care settings

that act as barriers to the implementation of evidence-based practice. They identified that employees need to feel that their inputs and ideas are valued and have the power to make changes to their practice that will positively influence patient outcomes. When the participants needed to talk about their emotional issues, they were disappointed because they felt that they were not heard. Alternatively, the perception that the managers would listen to their problems but not do anything about them led to high tension and discouragement.

6.3.9 Poor working conditions

The participants reported dissatisfaction due to the unfavourable work environment in which they work. This was also reported by Peltzer and Davids (2011), where lay counsellors reported various structural challenges such as lack of a designated counselling space, privacy, recognition and career structure. Breuer et al. (2012) also mentioned that 49% of lay counsellors in their study were unsatisfied with their work environment. These studies about the lay counsellors were conducted in Cape Town, South Africa.

The participants in this study complained about the lack of dedicated rooms for HIV counselling and testing in the organisation. Inadequate infrastructure is a problem because it interferes with the privacy and confidentiality practices during the counselling session. These findings were consistent with that of Mwisongo et al. (2015). Some participants reported that they share rooms with other lay counsellors in the organisation. This is a major concern as it compromises the effectiveness of counselling of their clients. They are compelled to rush their sessions in order to give each other a chance to do their job. Thus, the counselling session becomes less effective. Mwisongo et al. (2015) also highlighted that experiences like these might discourage clients from visiting the clinic in the future. The participants become frustrated because if the clients do not come to the clinic, they cannot reach the required target of statistics, and it contributes to their stress and burnout.

6.3.10 Exhaustion and headaches

As a result of the kind of work they do, counsellors working in the HIV and AIDS field are often confronted with numerous particular difficulties. Counsellors may suffer emotional and physical problems as a consequence of doing counselling. The participants of this study were constantly exhausted, which hampered the effectiveness of their service. Thompson et al. (2014), in their study about personal and contextual predictors of mental health counsellors' compassion fatigue and burnout, reported that emotionally demanding situations often lead to burnout that manifest as physical, mental and emotional exhaustion. Their results show that counsellors' welfare is dependent on the work they do and the circumstances under which they work.

The participants in this research often complained of overtiredness because clients affected them, and they did not allow enough time to take breaks. They also suffered from headaches, muscular aches and backaches from standing on their feet for long hours. The participants reported suffering from constant headaches because they work long hours doing stressful work. The participants spend most of their time dealing with unexpected responsibilities beyond their control. They are always exhausted because of their job's strenuous nature, which is physically and mentally tiring. They experience headaches because they handle things by themselves and use their minds to solve difficult problems. That causes much stress that hampers the effectiveness of their service.

6.3.11 Frustration

Ledikwe et al. (2013), in their study about the evaluation of a well-established task-shifting initiative of lay counsellors, documented that the lack of a widely distributed job description caused confusion in the roles and responsibilities of the counsellors. This caused a lot of frustration because the counsellors they studied in Botswana were not doing the duties that they were hired to perform (Ledikwe et al., 2013). This resonated with the participants in this study because they seemed to lack a clear job description, and that led to their frustration. Frustration falls under stage three in the process of burnout, as proposed by Edelwich and Brodsky (1980). The participants also experienced uncertainty around the effectiveness and influence of their efforts daily because when interviewed, they indicated that they were assigned different responsibilities; however, they have the same designation as lay counsellors. This made them feel helpless and frustrated because some of these duties were beyond their capacity as lay counsellors. The participants' failure to recognise and resolve difficulties led to frustration which is another symptom of burnout.

Visser and Mabota (2015) had similar research findings since many of the counsellors in their study were required to monitor complex issues outside their scope of practice. HIV counselling and testing on its own is a job; to add other responsibilities leads to frustration and burnout. The challenges caused the participants to suffer emotionally, and their job became stressful, leading them to suffer from burnout. An over-demanding challenge such as the required statistics target of 10 to 15 clients per day also leads to stress and burnout.

6.3.12 Difficulty adapting to change

The lay counsellors of this study reported experiencing difficulty adapting to change enforced by COVID-19 regulations. They are unable to cope with the rules and procedures that need to be followed in order to protect themselves from the pandemic. They are constantly working in fear because they do not have enough protective equipment to protect themselves from

COVID-19 infection. Cohen and van der Meulen Rodgers (2020), in their study about the contributing factors to personal protective equipment shortages during the COVID-19 pandemic, alluded that without proper PPE, healthcare workers are more likely to become ill; and sick healthcare workers also contribute to a viral transmission. The participants' fear in the current study is compounded because although they know the rules and regulations to adhere to, they still become infected by the virus. They reported that some of them tested positive for COVID-19, and fortunately, they managed to quarantine and recover from the infection. They further reported that the clinic sometimes becomes full because they offer COVID-19 services, not offered by other nearby organisations. Therefore, it is difficult for them to adapt to all these changes in a short period of time. Cohen and van der Meulen Rodgers (2020) also conveyed that when the health care workers are not available to provide care to the clients due to illness, it may cause healthcare infrastructure to become unstable and reduce the quality and quantity of care available.

The participants reported that while trying to learn about the complex characteristics of COVID-19 disease, they still had other roles such as housekeeping, child care and other additional responsibilities. They also strived to protect themselves and their family members from transmitting the virus; therefore, they find it difficult to cope. They also felt that their workload had increased, making it difficult to manage their daily responsibilities. All these experiences contributed to the participant's feeling of stress and burnout.

The World Health Organization (2015) recently updated its HIV treatment and prevention guidelines, recommending Universal Test and Treat (UTT) with ART to be initiated in anyone living with HIV, regardless of clinical or immunological stage. Some of the participants reported that it is difficult to adapt to the new system introduced, which is the UTT programme. The programme recommends that all people at risk should be screened for HIV infection, and those diagnosed with HIV-positive status receive early treatment regardless of their CD4 count and WHO clinical stage (Girum et al., 2020). They reported that it is difficult for them to adapt since they have to deal with clients who refuse to be treated immediately. The situation jeopardises their relationship with the clients because the clients feel that they are coerced into making rushed decisions. Therefore, they are left with a dilemma of not knowing whether to continue with the process or stop because they are not given the opportunity to voice their concerns to the clinic's management.

It was also identified in the conversation with the participants that they struggled to adapt to change after their own life trauma experiences such as the death of loved ones, divorce and other personal challenges. This was exacerbated by the clinic not having psychological resources to assist the lay counsellors in dealing with these changes in their lives.

6.4 FACTORS THAT CONTRIBUTED TO LAY COUNSELLORS' RESILIENCE

Similar to other healthcare workers, the lay counsellors of this study expressed clear reasons for them being interested in becoming counsellors, and they maintained those foundational motivations throughout their experience. This is in agreement with research findings by Jackson et al. (2013), who also reported that lay counsellors in their study were dedicated to their job. They loved their job and were adequately trained, which motivated them and enhanced their performance. Due to their extensive training and willingness to assist the community, they could adhere to their testing protocols, even in a difficult field-based setting (Jackson et al., 2013). This is not surprising, given that such strong motivational forces have been found in several studies, for example, those by Maes (2015) about community health worker capacities and values in an AIDS treatment centre in urban Ethiopia. He found that their motivations were an explicit desire to assist poor and suffering people, being praised for doing their job, their willingness to help other people and reciprocity. Others believed that since they were assisted by others, they should give back to the community and help others.

Visser and Mabota (2015), who studied the emotional well-being of lay HIV counselling and testing counsellors in Tshwane reported that the most positive aspect from their research was the finding that counsellors find rewards and purpose in their work. They had a sense of personal achievement, inner strength and a desire to help others. They find psychological development as a reward of providing support leading them to remain committed to their work. In this study, the participants saw their counselling role as an opening to fulfil their desires to help the community and achieve fulfilment. Most of the participants connected this intrinsic motivation to their religious beliefs and values related to helping others. In addition, the participants who perceived their work to be a calling from a higher power were more involved and devoted in their work. Gordon (2018) supported the idea by indicating that counsellors are often required to work with clients who have entirely different belief systems, as well as with clients with whom they share similar worldviews. She believes that where we locate ourselves spiritually influences how we view ourselves, others, and the world; hence, lay counsellors in this study worked very hard in the process of client recovery since they believe in a higher power. Maes (2015) alluded to the fact that client recovery and willingness to assist others has also been associated with more volunteering behaviours.

In this present study, it seemed that when the participants noticed that the work that they do has a positive effect on their clients and on the community as a whole, it gave them the courage to work even harder. This was confirmed by Sikorska (2017), who indicated that resilience research has many similarities to positive psychology, which offers a positive outlook on human capability by providing terms such as strength of character, quality and

courage. The participants were able to maintain their self-control and adapt to stressful conditions in their working environment. They were resilient and determined to assist their clients even when they experienced difficulty. Hence, they perceived their challenges as a learning curve. This is also supported by Stephens (2013), who identified emotional resilience as an important quality that can help an individual adapt positively to stressful working conditions, manage emotional demands, foster effective coping strategies, improve well-being and enhance professional growth. Grant and Kinman (2014) also indicated that resilient people are considered to possess characteristics that include hardiness, a sense of control, hope, perseverance and an ability to consider problems as challenges.

The lay counsellors of this study reported that they give their services to their community willingly with the aim to provide good, basic health care to their people. This was also confirmed by Masten (2014), who believes that resilience is not just resistance to adversity but the ability to grow and develop under difficult conditions. Factors that contributed to positive outcomes under extreme hardship, which implies resilience, were explored, and themes were also identified among the participants. Beddoe et al. (2013) highlighted that resilience is not an innate, fixed characteristic but can be developed through carefully targeted interventions and individuals' experiences. This is confirmed by the identified themes representing the experiences and factors that contributed to the participants' development of resilience. These themes include concern for family, willingness to help others, God's calling, client's recovery, self-development, and appreciation by clients.

6.4.1 Concern for family and others

Apart from the desire to help others, some lay counsellors in this study experienced trauma in their lives which encouraged them to offer their services willingly. Some of them told me that their personal encounters with the illness and death of their loved ones (as a result of AIDS) was their motivation to become lay counsellors. In agreement with this, Ledikwe et al. (2013) alluded that counsellors get personal satisfaction out of helping others, and they regard themselves as agents of change who can disseminate information to fellow community members. The counsellors in his study have a deep sense of commitment to their role in the organisation because of their ability to serve their communities to cope with their positive HIV status (Ledikwe et al., 2013). Some of the participants realised that many clients and family members were working hard to become well again because of their support and motivation. The participants also think that they could have been of greater help to the sick family members if they had the skills at that time. Willingness to assist others kept the participants moving, and they realised that some clients would not have survived if they were on their own.

Others indicated that they wanted to learn more about the disease in order to serve the clients and family members effectively.

6.4.2 A calling from God

The participants indicated a deep-rooted calling from God as a motivating factor to serve people in the community. The belief that God has chosen them to assist people in their community encouraged the participants to be resilient in their job even when things were tough. This is supported by the protective factor model, which explains that there is an interaction between protection and risk factors (Ledesma, 2014). It also fosters positive outcomes and healthy personality characteristics regardless of the unfavourable circumstances the individuals find themselves in (Ungar et al., 2013). According to Chance (2012), lay counsellors possessing a strong spiritual base are provided with a source of support and hope. Their faith in God is useful in counteracting negative experiences and providing protection against stress. Some of the participants indicated that they worked for an extended period of time without the necessary resources, but they persevered because of their calling. When they started working at the organisation, they were volunteers and only received a stipend, but they did not give up. Their situation has changed for the better because they now earn a salary.

6.4.3 The recovery of clients

The majority of the lay counsellors of this study felt that they had achieved something when their clients got well again. This was also reported by Visser and Mabota (2015) that counsellors find rewards and purpose in their work and experience high levels of personal achievement and that leads them to be more engaged with their work. The challenge model of resilience (see section 3.3.3) suggests that low levels of risk exposure may have a beneficial effect; for example, the lay counsellors were faced with the challenge of assisting their clients to recover and witnessing the clients recovering and fighting their challenges made them feel fulfilled. Another scenario is when the clients present with situations that are not easy to handle (e.g. serodiscordant couple). Once the participant finds a solution to the challenge and the clients understand their condition, it is beneficial. Exposure to challenging situations provided the participants with a chance to practice problem-solving skills and mobilise resources without fear of failure, as Zimmerman et al. (2013) explained. The participants were encouraged to stay on doing this work in the HIV/AIDS field because it gave them a sense of accomplishment. They feel satisfied when clients appreciate their job, and that keeps them going every day. The participants are fulfilled when they take the responsibility to help the clients recognise problematic behaviours and recovery.

6.4.4 Self-development

Some of the participants reported that they joined voluntary work in order to acquire experience with the hope that this could lead to finding permanent work. They could not afford to enrol at universities and colleges; hence, they opted for volunteering their skills to gain experience, which could assist them in acquiring permanent employment as experience is mostly required when applying for employment in South Africa. That was confirmed by Graham and Mlatsheni (2015) in their study about youth unemployment in South Africa, in which they indicated that employers are demanding higher benchmarks (such as a matric certificate) even for unskilled positions. Employers also apply additional selection criteria such as references from current employees and previous work experience. The participants wanted to learn particular skills with the wish that it could bring them into contact with better opportunities for a career. Berg et al. (2013) indicated that individuals could redefine and reimagine their jobs which can be a powerful process for cultivating meaningful work experiences. These changes can influence the meaningfulness of the work that employees believe is significant in that it serves an important purpose. Although participants of this research hoped to get better training and find permanent work, they could not reach these goals because there were not these kind of opportunities at the clinic. Since the participants worked in the HIV/AIDS field for many years without moving to another institution, they still stand a chance to open their own HIV/AIDS NGOs in future. This is related to their resilience because they were able to deal with the challenges they experienced daily, leading to positive outcomes. The view is communicated by Ledesma (2014) as thriving; he indicated that individuals are capable of changing traumatic experiences of hardship to gain more meaningful and productive lives.

6.4.5 Appreciation by clients

Schaufeli and Taris (2014) indicated that feedback from the employer to the employee might promote learning, thereby increasing job competence, whereas the freedom to make decisions and social support satisfy needs for independence and affiliation. Although they did not receive any recognition and did not feel appreciated by their organisation, their clients did appreciate them. Their clients' appreciation inspires the lay counsellors of this study, and this confirms to them that people living with HIV and AIDS need their care and help. They also believe that if they did not feel acknowledged or appreciated, perhaps they would have felt discouraged and given up. They acknowledge that they make a difference in their clients' lives when they appreciate their service. The lay counsellors of this study were willing to do the work in order to improve their communities, and they acknowledge that if they did not feel acknowledged or rewarded by their clients' appreciation, perhaps their commitment would

have waned. Therefore, their clients give them meaning in their lives, a purpose and the motivation to continue in their role, which contributes to their resilience and motivation to keep on with their work.

6.5 COPING STRATEGIES USED BY LAY COUNSELLORS

I wanted to discover the many strategies counsellors use to deal with their challenging work. The participants employed several approaches. However, talking to others and prayer were emphasised.

6.5.1 Talking to others

The lay counsellors of this study found that talking to other people helps them thrive and build resilience. Some of them realised the importance of the people who back them, such as family and friends who care for them. Although they know that these people do not have an idea of what they encounter daily, their presence and being there for them give them a feeling of being protected and cared for. Peltzer and Davids (2011) found that lay counsellors receive emotional support from the nursing sister in charge when they receive cases that are beyond their scope of practice. Others reported that they approach various avenues such as dealing with the problem independently, going to church, sharing with a close friend and participating in peer support activities. Participants in the current study reported that it is of great help to talk to fellow workers about their problems with the work because it helps them to have accurate views of their situation. Some could also talk to a nursing sister at the clinic, who helped them deal with difficulties. To ask for help is necessary because the appropriate support helps them to again help their clients efficiently. It seems that talking to an available person help the participants to be resilient in the face of difficult situations at work.

6.5.2 Religious practices

Spirituality can offer a sense of hope and purpose to the lay counsellors of this study and help them find greater strength and resilience. In their research study, Taylor et al. (2015) found that counsellors can also get help if they connect with other individuals with similar beliefs. The lay counsellors in this study did not only try to get help from fellow counsellors, but they also asked God to help them to cope. It, therefore, seems that religion is important for their resilience to face diseases and help others. Therefore, some of them prayed to God with the hope to get their problems solved. This was also mentioned by Gordon (2018) that counsellors are often required to work with clients who have different belief systems and those with whom they share similar worldviews. In both cases, there is a distinctive kind of potential for positive outcomes because, with prayers, they feel empowered to approach any problem in a more

effective manner regardless of the client's belief system. The participants also used prayer to help them to cope with their tension, stress and frustrations. Some participants of this study feel that when they focus on God's presence, it helps them cope with the overwhelming situations. They also found that when they participate in religious activities, they have a support system because they attract a large support network and more social contacts.

6.5.3 Other strategies

Apart from the coping strategies referred to above, some lay counsellors in this study also mentioned using coping strategies when they were off duty to manage their stress. For example, some of them spent some time alone, others listened to music, watched television, played with their children and slept. It is evident from the findings that most of the lay counsellors who participated in the study used self-taught coping strategies. They reported that they did not receive enough support from their managers in this regard; hence, they resorted to their own strategies. The use of strategies that they found effective, contributed to their resilience and enabled them to keep up with their counselling work.

6.6 THE NEEDS OF LAY COUNSELLORS

The lay counsellors of this study verbalised their requirements to enable them to execute their work more efficiently. These needs are reflected in what they said during the interviews (as discussed in Chapter 5). A most important trepidation for lay counsellors is their discontent with the assistance they received from the clinic's management. They are disappointed in the lack of assistance from the management. In addition to the need for support, their needs also include debriefing, staff development and counselling space.

6.6.1 Debriefing

Lay counsellors in this research said that they want to speak to somebody about their problems, but the clinic's managers are not available to talk to. They said that they needed to talk about their daily problems while working in the clinic. They especially need counselling to assist them to cope because if they receive debriefing and counselling, they would have a high capacity to help clients handle and express their emotions effectively. Katsounari (2015) recognised that mental health professionals need to take care of their psychological well-being and not only their personal health and physical fitness. She indicated that if they do not adequately work through their own issues before engaging in their work, it may lead to secondary trauma and early burnout. She encouraged them to work through their personal traumatic experiences to prevent becoming "wounded healers" (Katsounari, 2015. p. 116).

It became clear to me that my participants did not get any psychological support at the clinic. For example, they are not involved in any support groups either inside or outside of their organisation. Therefore, they many times counsel each other when there is a need because there is no professional person to approach for help. This was also found by Katsounari (2015), who indicated that colleagues have activities in and outside the workplace in order to share their problems. They schedule a time out together where they meet and have lunch or socialise after work.

The working environment of the participants of this study is experienced by them as unsupportive. There is no official support group organised for them by the clinic, but the management also does not encourage them to find support groups outside of the organisation, nor are they encouraged to begin their own groups. Therefore, my participants did not belong to any support groups, which means that they do not have the support of fellow workers with the same problems and they consequently became exhausted. All the participants expressed the need to be supported by the management to attend debriefing sessions outside the clinic or to be allowed to start their own support group.

6.6.2 Staff development

Though the majority of the lay counsellors of this study received formal training, some just had some form of informal training in the organisation where they worked previously. Therefore, the participants have different qualifications as well as different training for their counselling job. They were also trained by different organisations, and that makes them question the effectiveness of their counselling because the duration of their training is not the same. Thurling and Harris (2012) indicated that the HIV lay counsellors' initial training in our country is a 10 day nationally accredited course in HIV counselling and testing offered by the DoH; there is a problem because different organisations offer different courses. Research conducted by Thurling and Harris (2012) indicated that there is no standardisation of the training of lay counsellors in South Africa. The lack of standardisation of training means there are no minimum training requirements.

The training is offered by different organisations, which are the Department of Health, some NGOs and faith-based organisations (FBOs). They mentioned that training varies in length depending on the organisation that provides it. They also found that the training of lay counsellors varied from a five-day course to six-week training. This variance creates problems because the job description is not clear to the lay counsellors; they end up performing tasks that they are not equipped to perform. Similarly, in this study, participants received training in

different organisations, and some received training that was less than ten days while others were more than ten days.

The participants in this study show that they attended the training ranging from five days to three weeks. Other participants were trained during their training for home-based care. However, they still feel that they need additional training. This is because the participants come across a wide variety of situations while counselling clients, and they feel that they are not equipped enough to address the issues. Thurling and Harris (2012) also found that counsellors need the skills to handle difficult issues because the clients expect to be assisted in this regard. The participants indicated that they need follow-up training because information changes with time, and it is important for them to be updated with new information for effective performance. Ledikwe et al. (2013) agree with Thurling and Harris since they also found that the refresher courses are essential, and if they are not made available, the skills learned are forgotten easily, and their needs are not fulfilled. Mlotshwa et al. (2015) supported the idea of refresher courses by indicating that an orientation process at the beginning and regular in-service training may generate a positive role identity to the lay counsellor. It may also assist in supporting and teaching them how to care for themselves and others with different challenges.

6.6.3 Counselling space and infrastructure

The participants of this study work in unfavourable physical circumstances that are not beneficial for counselling clients. They reported that there is not enough space and appropriate furniture in their offices to assist the clients effectively. The counselling rooms are not equipped with air conditioners, and when it is hot, it becomes difficult to spend more time in the office with the clients. If the physical working environment is not conducive to the workers, they are more likely to burn out. The participants believe that if the offices are improved their performance can also improve. Maslach et al. (2001) supported the idea by indicating that a work setting should be designed to support employees' positive development and effectiveness, and it should be successful in promoting their well-being and productivity. When employees engage with their job, they put a great deal of effort since they identify with it; therefore, they are not likely to burn out. However, if the job demands are the most important predictors of burnout, job resources are the most important predictors of work engagement. Bakker et al. (2014) also reported similar findings that lay counsellors find meaning and enjoy their work if they have an effective working environment.

6.6.4 Support from the organisation

Van Dyk et al. (2017) highlighted that counsellors working in the HIV/AIDs field could not cope with the burden of caring for others unless they had personal and organisational support. The participants do not have a flexible and supportive working environment that considers their needs. The organisation does not ensure that the participants do not perform the duties that are not meant for them; hence they feel unsupported. The participants also feel that they are not supported when the managers fail to give them the opportunity to communicate with them, while they feel they should have the chance to give their input when decisions are made that concern them. The participants feel that they are not given the option of taking off from work when they have some kind of distress in their own lives. Mwisongo et al. (2015) found similar results where the lay counsellors mentioned that they need support with issues such as encouragement, emotional support, and debriefing.

6.7 LAY COUNSELLORS MOVE FROM BURNOUT TO RESILIENCE

The findings in this study revealed that, indeed, participants suffered from burnout because of the work demands that were exceeding the available competencies to perform the duties. Although the participants were burnt out, they were able to continue with their duties because they were not at the final stages of the burnout process. In order to understand the stage at which the participants were, I chose Edelwich and Brodsky's process of burnout for the elaboration. Edelwich and Brodsky (1980) identified four stages that describe the process of burnout as experienced by some individuals. They indicated the first stage as enthusiasm, where the individual begins with idealistic expectations, and if the individual does not receive any support, the enthusiasm then ends in stagnation. The second stage is stagnation, where an individual may feel that certain personal, financial and career needs are not fulfilled. There may be lack of incentives in the workplace, coupled with personal pressures and life stressors that may lead to frustrations and burnout. The third stage is frustration; individuals may experience uncertainty around the effectiveness, meaning and influence of their efforts on a daily basis. Frustration may affect people around the individual, and failure to recognise and resolve difficulties may lead to the final stage, which is apathy. The last stage is apathy, where an individual experiences burnout. The individual becomes insensitive towards other people's experiences and does not make an effort to assist them. This is a critical stage, and individuals mostly refuse to acknowledge that they need professional assistance (Edelwich & Brodsky, 1980). According to the process of burnout, the participants in this study fall under stage 3, which is frustration. The participants were frustrated due to the challenges and factors that are discussed under Section 6.3 above. The JDR model assumes that burnout results from high job demands and poor job resources, which we have observed from the participants of this

study. They had high job demands that they could not handle effectively due to a lack of resources. However, the participants did not focus more on their challenges, they decided to focus on the positive side of their job, and that encouraged them to continue with their work. According to the Job Resources (JDR) Model, work engagement produces a satisfying positive work-related state of mind. Schaufeli and Taris (2014) showed that work engagement is obtained either by achieving work goals or the satisfaction of basic needs. We observed this from the participants where they were motivated and satisfied through the achievement of their work goals. For example, when their clients recovered from illness and when their clients appreciated them, that enhanced their willingness to perform exceptionally. In turn, their concern for family and others, the belief that God called them and their willingness to develop themselves encouraged the participants to be more committed to performing well in the organisation, hence their resilience.

Schaufeli and Taris (2014) referred to personal resources and work engagement as some of the motivational factors of the individual's resilience in the JDR Model. They say that engaged employees have a sense of connection with their work, unlike those who suffer from burnout. In addition, they perceive their work as challenging instead of viewing it as stressful and demanding. Participants in this study seemed to be active workers who showed determination; although they experienced challenges in their work, they persisted until they experienced satisfaction, which is a sign of resilience.

Schaufeli and Taris (2014) further confirmed that personal resources are the individual's sense of their ability to control and influence their environment successfully. It has been argued that such positive self-evaluations predict goal-setting, motivation, performance, job and life satisfaction, as well as other desirable outcomes. This resonates with the findings in this study where the participants personal resources played a crucial role in their lives and the organisation. The participants reported a lack of resources to the management, and they could not receive assistance. However, they were able to organise and perform their duties with the limited resources that were available. I, therefore, identify the participants as resilient employees because they did not allow the challenges in their organisation to discourage them. They would complain but continue to work and produce a desirable outcome. I also agree that the participants managed to move from the burnout state to resilience. This is evident because they did not end up at the last stage of full-blown burnout (apathy).

6.8 CONCLUSION

This chapter presented the findings of this study after analysis of all the participants' stories. The participants of this study were females with ages ranging from 37 to 55 years. I gave a

relatively comprehensive description of what lay counsellors go through and what their role consists of, which includes the worthwhile events as well as challenges that require mediation by the management of the clinic. The findings revealed several factors that contributed to the participants' stress and burnout, and they are discussed in section 6.3. The participants showed symptoms of burnout. However, they were not at the last stage of burnout which is apathy. Apathy is the last stage of burnout, where individuals are unable to perform their work effectively due to chronic workplace stress that has not been successfully managed. Since the participants were not at the apathy stage of burnout, they were able to continue with their everyday duties. This indicated that although the participants were burnt out, they were able to maintain a resilient state. The findings drew attention to the factors that made the lay counsellors be resilient while doing their job even though it was tough. Their needs were pointed out to indicate to the clinic's management what changes need to be made. The conclusions of this research are explained in the next chapter, and suggestions are made based on what I found in this research. These recommendations will be made known to the lay counsellors, organisations and the Department of Health.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

In the previous chapter, I reviewed the findings of my study, in which I explored the stories of the lay counsellors and their manifestations of burnout and resilience. In this chapter, I consider the purposes of this research, which were to go into and depict the life stories of HIV/AIDS lay counsellors at a clinic and what they encountered when doing their work. I also reflect on the themes as discussed in Chapter 6, which reveal factors that contributed to burnout and resilience among these lay counsellors, and I then propose some recommendations with regard to the main findings of this study. I further discuss the strengths and limitations of this study and make some suggestions for future research, and lastly, I come to a general conclusion.

With this study, my purpose was to let the six participants speak about and present a picture of their work as lay counsellors in a local clinic in the Tshwane area. The main purpose was to explore their life stories as lay counsellors and the extent of their burnout as well as their measure of resilience. It was therefore also important to explore the factors that contributed to their burnout and resilience as well as their coping strategies.

It is imperative to realise that this study did not intend to generalise its results and conclusions to a great number of counsellors. I believe that the aims of this study were achieved by presenting every participant's account individually and vividly by portraying their experiences and individual connotations. I obtained rich data as the participants were able to share what they go through, and that gave me some understanding of their level of burnout and resilience as well as how they cope and what their needs as lay counsellors are.

In the previous chapter, I discussed the findings of this study and the themes that I identified from each counsellor's account. That was followed by analysing the stories and comparing them to existing research reported in published works. It is a significant realisation that although each counsellor's account is exclusive, the investigation of the data showed that there are repetitive themes in most of their stories. The themes that were found appear throughout the stories of all the counsellors who participated in this research and were discussed in the previous chapter. A summary of the themes and the suggestions thereof are discussed in what follows.

7.2 A BRIEF SUMMARY OF THE THEMES AND SOME SUGGESTIONS

The research questions explored and the results discussed in the previous chapter contributed to solving the research questions and meeting the aims of the study. An initial research question was proposed when the research commenced, namely, how can the participants' life stories inform us about their burnout and resilience? Secondary questions were also proposed, asking about the participants' experiences, what support they receive, what factors contribute to their burnout and resilience and how their situation can be improved (see sections 1.6-1.7 in Chapter 1). In this section, I give a brief summary of the themes that emerged (my findings) while answering the research questions. Some suggestions on how to assist the participants with their experienced challenges are also provided in the discussion.

The research questions have been answered through identifying different themes that emerged as factors that contributed to the lay counsellors' burnout; as well as factors that contributed to resilience, strategies they use to cope with the work and what their needs are (see Chapter 6, sections 6.3-6.6).

On the theme about non-cooperative clients and clients who default from treatment, I have the following suggestions: clinics for HIV care and counselling should be made conscious of the counsellors' difficulties with non-cooperative clients who do not keep taking medicine provided to them. Skills training should be offered to the counsellors. Through courses or workshops, counsellors should be taught the necessary techniques to enable them to handle their work. Lay counsellors need to be empowered with skills that will enable them to motivate clients to take their medicine as prescribed, even those who want to quit the treatment completely. Due to the uncertainty with their role, I suggest that lay counsellors should be motivated to get better education, especially in HIV/AIDS counselling to empower them to perform their jobs effectively. Petersen et al. (2014) indicated that lay counsellors in the South African context could be effective if they are trained and supervised appropriately. Through training, lay counsellors may acquire new skills, technical knowledge, and problem-solving abilities. This improved knowledge and skills may facilitate personal resources such as self-efficacy, resilience, and optimism. Training may also directly focus on personal resources, and this was confirmed by Dewing et al. (2014).

The participants have language barriers as one of their challenges. Therefore, I suggest that all counsellors at HIV/AIDS clinics should be empowered with communication skills and a translation of the instructions on the medication package to accommodate people from foreign countries. The use of an interpreter can also be one of the measures to overcome language barriers, although it might be time-consuming. Language barriers should not prevent lay

counsellors from showing their concern for clients, even if they do not use the same language. Another alternative to overcoming the language barrier could be codeswitching. Van den Berg (2016) defines codeswitching as a linguistic phenomenon where speakers change between two languages in a single sentence. The lay counsellors can be taught or pick up some essential words that allow them to practise some independence in the absence of the interpreters. This method provides some direct communication with the patient, and it allows bonding and trust to develop between client and a counsellor (Van den Berg, 2016).

Cultural and traditional challenges presented as an obstruction to my participants while doing their job. It is therefore important for them to understand different cultural beliefs in their communities as lay counsellors. They should be skilled in handling situations like these when they arise. Van Dyk et al. (2017) indicated that counsellors should understand that traditional healers and Christianity have greater credibility in their communities than health care workers with regard to social and spiritual matters; therefore, they should understand these issues in order to assist their clients effectively. The participants of this study lack some knowledge and understanding of how to approach some of the problems that the clients present, interfering with their efficiency when doing their jobs. They acknowledge that they are not competent to handle certain situations (e.g. issues of language, cultural beliefs and discordant couples), which affects their way of handling the problems they encounter. Therefore, it would be imperative for the participants and all lay counsellors to attend more workshops to update their information about HIV and the cultural beliefs in their communities. I suggest that lay counsellors receive continuous training on how to provide counselling in problem situations, for example, with regard to conflicting couples and within the cultural context of their communities, especially where cultural and religious beliefs interfere with clients taking their medication.

The participants also complained about a lack of resources and a high workload. The managers should note that the lay counsellors will be unable to survive and thrive if they are not provided with adequate resources, role clarity and support. Maslach et al. (2001) supported the idea by indicating that a work setting should be designed to support the positive development and effectiveness of employees, and it should be effective in promoting their well-being and productivity. This will bring about employees who will put in a great deal of effort, engage with their job and identify with it. Therefore, it would be to the clinic's advantage to realise the difficulties that the lay counsellors encounter and to handle them as well as possible.

Lack of support from the management was also highlighted by the participants of this study. Therefore, organisations providing HIV/AIDS care and counselling should make changes in

their managerial practice and do some organisational interventions in order to support the counsellors in their service. Mwisongo (2015) indicated that counsellor support and supervision are important because they reduce stress and strengthen the quality of counselling procedures. It is also essential that the supervisors at the clinic have better interaction with and give more support to the lay counsellors. This will be beneficial for the lay counsellors, the organisation, as well as for the clients under their care. Leiter and Maslach (1999) highlighted that organisational interventions are necessary to make changes in the following areas of work-life: workload, control, reward, community, fairness, and values (see section 3.2.3.2 for an explanation of these areas). The management should take the individual skills and attitudes of their employees into consideration when making changes, and the recognition of the six areas of work-life could provide the managers with different options for organisational intervention.

Due to the lack of support from the organisation, the participants of this study ended up suffering from exhaustion and headaches. However, with proper help from the management of the organisations, the difficulties can be better handled, for example, through attending support groups for lay counsellors as a starting point. It seems to be vital that management make adaptations to address the need for more support and training and allow them to go for debriefing outings or start their own support group. My participants also reported standing on their feet for long hours and skipping lunch or taking on too much at once, which increased their exhaustion and stress. Therefore, the managers should, together with their employees, set strict rules about their working hours and the number of extra tasks they have to take. That can assist the lay counsellors to have enough time to rest and revive their strengths. My participants also complained about the physical setup at the clinic, for example, that there are not enough offices for all the counsellors or that the counselling rooms are not big enough and can become very hot. The management should be made aware that counsellors cannot work effectively in an uncomfortable environment.

The participants pointed out that their job description caused confusion about their roles and responsibilities. This caused a lot of frustration because they were not doing the duties that they were hired to perform. According to Grant and Kinman (2014), it should be emphasised that organisations have a responsibility to protect the well-being of their employees. Job redesign can change the source of employee well-being, their job demands and job resources. Job redesign is usually seen as the process through which the organisation or supervisor changes something in the job, tasks, or the conditions of the individual. There should be some changes in the tasks that the lay counsellors of this study are doing, and it would be imperative if they are also involved in these decisions. Maslach and Leiter (2016a) also highlighted that

the process of employees shaping their job involves physical and cognitive changes with regard to their tasks. Physical changes refer to changes in the form, scope or number of job tasks, whereas cognitive changes refer to changing how one sees the job (Maslach & Leiter, 2016a).

The participants of this study have an obligation to provide health services during the COVID-19 pandemic as lay counsellors. It is important for the organisation to recognise that they are doing difficult and invaluable work during this time of the pandemic. Since they are required to use PPE every day as the best protection for healthcare workers, it should be provided to them to increase safety and comfort. I believe that the availability of adequate information, effective preventative measures, positive attitude and support from managers can motivate the lay counsellors of this study to deal with the adjustments they have to make due to the pandemic – these measures can reduce their stress and also that of other counsellors in the same position. It is also recommended that lay counsellors must be informed about the changes that are implemented on a regular basis and that they are involved in decision making in order for them to adapt to the changes easily. They should also be given the opportunity to give feedback to their management about what their challenges are and how to be assisted.

My question about whether lay counsellors become resilient despite the challenges they encounter that led them to suffer from burnout has been answered. The question has been answered through different themes that emerged as factors that contributed to resilience among my participants, as discussed in Chapter 6 (see section 6.4). These themes include the following: concern for family, willingness to help others, God's calling, religious activities (e.g. prayer), clients' recovery and appreciation, self-development, being able to talk to somebody about their stressful work, and sometimes by just being alone and relaxing with music or watching TV. The presence of these factors assisted my participants to be resilient.

Although the participants are resilient, I suggest that the managers should create some form of assistance for their employees in the form of support groups or arranging for some kind of debriefing. In such groups or sessions with a professional person, they can be encouraged to explore and express their reasons and motivations for working in the HIV/AIDS field. They can then be assisted to work through their motivations; for example, some have joined the field due to concern for family, or some might be working in order to ease their guilt feelings for not helping others, and some may work as their own punishment for not being able to assist their loved ones in times of need. If these lay counsellors can be helped to cope with and accept their motivations, they could be more resilient and excel in their jobs.

Therefore, if the lay counsellors can be supported according to their needs and provided with a favourable working environment, they may continue to thrive. This was also found by Tims et al. (2013), who highlighted that the availability of well-designed jobs and working conditions could facilitate employee motivation and reduce stress and burnout. Lay counsellors in this study were not satisfied with the assistance they received from the organisation. I concluded that they have unfulfilled needs and are hoping that their circumstances will change because they are hoping for interventions from the stakeholders and are willing also to make contributions to that effect. Recommendations concerning interventions are made in what follows.

7.3 RECOMMENDATIONS

Based on the findings of this study, some recommendations are made for lay counsellors, managers of HIV/AIDS clinics, the Department of Health (DoH), as well as suggestions for future research.

7.3.1 Recommendations for lay counsellors

Lay counsellors must be encouraged to further their studies and be empowered with HIV and AIDS counselling skills, communication skills, presentation skills, report writing skills and problem-solving skills to improve the outcomes of their work as counsellors.

Since they complain that they feel the management does not give attention to their grievances, lay counsellors should appoint one counsellor to represent them in meetings with management. They should insist on job descriptions, and they should follow their job description. If they then can keep on doing only the specified tasks, it can ensure that they do not get involved in other tasks that are not their responsibility because doing work that is not part of their demarcated job may lead to stress and burnout.

Since my participants did not belong to a support group inside the clinic, it is recommended that all lay counsellors negotiate with their managements to offer such groups for lay counsellors. Should this be unsuccessful, lay counsellors should form their own support groups where they can talk about their problems and support each other. They may also start their own initiatives, such as an online support group on WhatsApp or other platforms that may be accessible to all of them. Trainers of lay counsellors can also include the advantages of support groups in their course.

7.3.2 Recommendations for managers

My participants' uncertainty with their role was made known as an important dilemma in the current study; they often had self-doubts and wondered if they provided enough assistance to their clients. Therefore, managers in the HIV/AIDS field should be aware of the importance of drawing up clear-cut descriptions of all the tasks of lay counsellors so that the counsellors can feel sure about what is expected of them. The tasks can then be included in a daily and weekly plan of tasks to be done. Managers at clinics should then implement the job description plans and supervise lay counsellors to adhere to such plans.

My participants also indicated that they need psychological support, implying that they need to talk to somebody about their frustrations. Managers should put in the effort to provide the opportunities for this kind of assistance, for example, arranging for debriefing sessions for their counsellors. They could further use the services of outside experts to give presentations to empower the lay counsellors at their clinic. They may furthermore initiate debriefing and counselling services to be available continually to assist the lay counsellors. It is further recommended that managers should plan that the training of lay counsellors includes how to cope with problematic situations during counselling.

The managers could also arrange that the nursing staff offer training in the form of regular meetings or workshops so that the lay counsellors can keep up with the newest information about HIV/AIDS care and support. This may be financially beneficial for the clinics that do not have funds to pay for the training of lay counsellors by outside organisations. The training programmes should include education about stress and burnout to assist lay counsellors to identify symptoms earlier and engaging in self-initiated interventions. Training by nurses can also contribute to better relationships between the nursing staff and lay counsellors.

The managers should take direct action to identify the source of the lay counsellors' frustrations and act deliberately to rectify the causes, even if it entails proposing new initiatives or systems to streamline the counsellors' work descriptions and improve their working environment.

My study's participants were older females from 37 to 55 years. It is recommended that the managers should see to it that younger counsellors be recruited and that the older (and more experienced) ones can work as consultants. They can also be given the responsibility of telephone counselling to avoid them standing the whole day and suffering from different kinds of pains.

I also suggest that managers develop a strategy to show their appreciation to the lay counsellors and reward them in some way. Because clinics may not have sufficient funds, they could reward the counsellors for their hard work with little gestures such as thank you notes for a job well done.

7.3.3 Recommendations for the Department of Health (DoH)

It is recommended that the DoH provide the necessary funds for all the NGOs working with people living with HIV and AIDS for the training of all lay counsellors. Otherwise, the DoH should provide training by experts in the field for all lay counsellors. There should be a clear criterion for the selection of lay counsellors and a specific pre-service training curriculum. The DoH and the organisation should liaise with academic institutions to develop a debriefing programme (also available online) that can accommodate all lay counsellors working in the HIV/AIDS field. Young people should be recruited in order to accommodate youth coming to the clinic. Since it is common knowledge that most of all lay counsellors are females, the department should encourage men to be trained as lay counsellors in order to assist the male clients who might not be comfortable with female counsellors. The DoH should therefore develop a model that could also motivate men to become lay counsellors.

They should also make use of the expertise of professional nurses with specialist training in AIDS care to assist the lay counsellors. It is essential for the DoH and organisations to create an environment resulting in the provision of rewards, recognition and incentives to raise the morale and increase the motivation of all lay counsellors.

Since the label “lay” does not sit well with the counsellors, the status of lay counsellors needs to be consolidated with a career path and a reliable system for payment, leave and other benefits in order to change the way clients and other health workers view them.

7.4 STRENGTHS OF THE STUDY

The following were noted as the strong points of the study:

This study presents the accounts of six lay counsellors portraying their experiences of being on their way to burnout and becoming resilient in the process. I did not have the goal to generalise the findings to a larger population of lay counsellors, but I wanted to give a platform for the voices of the six lay counsellors in order to get an understanding of their experiences. This topic has not been researched much, especially in qualitative research. Hence this study enriched the knowledge available on the experiences of HIV lay counsellors.

By giving the six lay counsellors a voice, I gained an understanding of the world from their viewpoint. The six lay counsellors got a chance to speak about their experiences, challenges and coping with the challenges. When I presented the findings, the participants' own words were quoted many times with the aim to give a truthful account of their experiences from their own unique viewpoint. I also consulted with colleagues and my supervisor to ensure that my version depicted the participants' experiences as correctly as possible.

I used qualitative research methods, and my way of collecting data was to use semi-structured interviews. My aim was to get a good understanding of my participants' words, stories, and explanations (Mertens, 2014). The semi-structured interviews enabled me to explore the participants' lived experiences, and it gave me a look into their truths.

My participants knew what the aims of my research were and what procedures I would follow to execute the research. They also knew that they could withdraw at any time should they wish to. Ethical considerations in terms of informed consent, privacy and confidentiality, as well as considerations of participants' rights, were taken into consideration.

7.5 LIMITATIONS OF THE STUDY

The study was exploratory in nature, and my intention is that it could lay the foundation for further research into exploring the life stories of lay counsellors and their experiences of burnout and resilience. The inadequacies of the study can be summed up as follows:

This research focused on one organisation that deals with HIV and AIDS clients. The clinic is located in the Gauteng province of South Africa (Tshwane-Soshanguve). Therefore, the results cannot be generalised to lay counsellors outside this organisation, area and province.

The sample of this study was relatively small. There were seven lay counsellors at the clinic, and one of them pulled out of the study due to a job opportunity in another institution. Therefore, I would not claim that the findings can be generalised to all lay counsellors in all existing organisations. This means that the chosen organisation and lay counsellors may not represent the demographics of the current South African lay counsellors.

The study could be seen as biased because all six participants were females.

7.6 SUGGESTIONS FOR FUTURE RESEARCH

Further research is necessary in this area, especially to explore various ways in which organisations can recognise and support lay counsellors in their work, even when funding is limited.

There should be research on whether the existing lay counsellors' training programmes that are available are indeed contributing to increasing their coping skills and assisting them in being effective. Research should therefore focus on developing a training programme that will empower lay counsellors and train them on how to cope with their daily experiences (including difficult and problematic situations) of working with people living with HIV and AIDS.

It is also recommended that research be conducted with a larger sample size in order to increase the statistical impact of the study and improve the reliability, validity and generalisation of the research findings.

It is also suggested that research be carried out on how to develop an effective, continuous lay counsellor support programme that could be used by all the organisations that are using the services of HIV/AIDS lay counsellors.

7.7 CONCLUSION

Through this study, the six lay counsellors were given the opportunity to speak about the events in their lives that motivated them to become and work as lay counsellors. This has further helped in obtaining rich information around their stories as lay counsellors. From their stories, it became clear that the need to help others was the main motivation of my participants to become counsellors. Some of them also mentioned that their need to help others also stemmed from the distressing trials in their lives with regard to loved ones. In addition, a calling from God or their spirituality also played a role. The results showed that lay counsellors play an important role in the lives of their clients and the clinic and also in their communities. Unfortunately, the efficiency of their services is hindered by the challenges pointed out in the findings and in the discussions above.

Through their life stories, I hoped that rich information would emerge around their unique experiences and meanings to answer the aim/objectives of the study and the research questions. My conclusion is that the study answered the research aims/objectives through the information that my participants provided during the interviews. I obtained answers to my primary question (to acquire information about their burnout and resilience) and the secondary research questions (about their experiences, factors contributing to burnout and resilience and how their situation can be improved). My findings are that the participants of this study reached a certain level of burnout but had developed coping mechanisms to help them obtain resilience. The results, therefore, indicate that there is indeed a transition from burnout to resilience in my participants.

Since I worked as a lay counsellor before, I have noticed that the previously experienced

challenges still continue. The only improvement is the number of clients the lay counsellors must see per day. The participants are expected to see at least 10 to 15 clients per day compared to 20 to 40 clients during my time as a lay counsellor. They also have a timer to gauge the duration of their sessions (which is 45 minutes to 1 hour) to help them regulate their time per session. Apart from their own coping mechanisms, these few improvements at the clinic could also help the lay counsellors persevere and continue with their duties and find fulfilment while they keep on providing counselling to clients living with HIV/AIDS.

I made several recommendations that stem from the findings of this study. It is envisaged that the implementation of the recommendations will lead to an improvement in service delivery in the clinic and that it will expand to other clinics and, in the end, have an impact on all organisations in South Africa employing lay counsellors.

The strengths and limitations of the research were also pointed out, and the strengths were convincing enough to consider this study to be meaningful. Therefore, I hope that this study will increase awareness of the huge role played by lay counsellors in this country and inspire more people to also contribute to the cause of helping people living with HIV/AIDS.

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APPENDICES

APPENDIX A: PERMISSION TO CONDUCT INTERVIEWS

Ref: K. Shirinda-Mthombeni
Tel nr: (012) 429-8317
Fax: (012) 429-3414
Cell: 082 714 1434
E-Mail: shirik@unisa.ac.za

To the Chief Director

Department of Health

Tshwane Metropolitan Municipality

Date:

Email: DG@health.gov.za

Re: Request for permission to conduct interviews for research studies on HIV/AIDS clients attending HCT and Adherence at your facilities.

Dear Sir/Madam

The above matter refers,

Background

I am a postgraduate student studying towards Master of Arts in Psychology by research with the University of South Africa. The title of my research is "HIV/AIDS PREVENTION STRATEGIES IN SOUTH AFRICA. My proposal has been accepted by UNISA and it has met all the university ethical clearance requirements. The purpose of this letter is to request permission to conduct interviews at the clinics where HIV/AIDS clients are attending HCT and Adherence counselling.

The broad objective of this study is to gain understanding as to why the offered prevention strategies are slow in decreasing and eliminating new HIV infections. Several literature searches agree that the current prevention methods are slow in decreasing new HIV infections and there is a gap since these strategies are not giving the envisaged results.

My approach

The study will require a minimum of thirty (20) participants to make up a sample. Twelve (10) participants will be made up of the clients that have come to test for HIV attending HCT. Ten (10) participants will be the clients who will be attending adherence counselling.

I envisage to carry out the interviews that at the following identified facilities:

- Clinic 2 Block BB Soshanguve

- Clinic 3 Block BB Soshanguve

Duration of study

A minimum of one month will be required to complete the interviews.

I thank you in advance in anticipation of your response

Yours sincerely

Keit Shirinda-Mthombeni

e-mail: shirik@unisa.ac.za

cell: XXX

PERMISSION GRANTED

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APPENDIX B: PERMISSION TO CONDUCT RESEARCH

Ref: K. Shirinda-Mthombeni
Cell: 082 714 1434
E-Mail addresses:
31583636@mylife.unisa.ac.za
Mthombenikeit503@gmail.com
Date: **09 September 2020**

The Manager

Soshanguve Clinic 3

1834 Block BB

Gauteng West

0183

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT YOUR ORGANISATION (HEALTH CLINIC)

Dear Sister Msiza

I hereby request permission to conduct research at your organisation (Health clinic) with lay counsellors of people living with HIV and Aids. I am registered for a Doctoral Degree (Psychology) at the University of South Africa. The research title is: **"Exploring the life stories of HIV/AIDS Lay counsellors: From burnout to resilience"** This study aims to identify the experiences of HIV/AIDS lay counsellors and the strategies they use to cope with challenges leading them to resilience. The results will help to empower and improve the lives of counsellors in future.

Participation is voluntary, no person, group or organisation will be advantaged or disadvantaged in any way by choosing to participate or not participate in the study. Participants will be asked to sign a consent form for their participation in the study. Furthermore, information will be gathered in the form of individual recorded interviews lasting approximately 45 minutes to 1 (one) hour. Based on the lockdown regulations, I will be guided by principles and activities supported by the UNISA Policy on Research Ethics, based on national guidelines and governmental directives. I will also be guided by the health clinics principles and guidelines. The situation will be assessed and if agreed with the

participants, we can move from face to face to remote data collection and follow-up visits. This could be in the form of online data collection (telephonic, e-mail and other platforms).

All interviews and transcripts will be kept in a safe place to ensure confidentiality, and all identifying information will be excluded in the report. Participants may refuse to answer any questions they feel uncomfortable with and may choose to withdraw from the study at any point should they feel unable to continue participating.

The results of the research will be presented in a report that will be kept at the university. This information may be shared with others in the form of conference presentations and publication in journals. Should you need any further information, please contact me or my supervisor, using the contact details provided.

Yours sincerely

Keit Shirinda-Mthombeni
Researcher – Psychology

Dr E.M. Cronje
Supervisor
(012) 333 4124/

Permission Granted

Clinic 2 Permission letter.pdf

APPENDIX C: PARTICIPANT INFORMATION SHEET

Dear Counsellor

My name is Keit Shirinda-Mthombeni; I am registered for a Doctoral Degree (Psychology) at the University of South Africa. The research title is **"Exploring the life stories of HIV/AIDS Lay counsellors: From burnout to resilience"** This study aims to identify the experiences of HIV/AIDS lay counsellors and the strategies they use to cope with challenges leading them to resilience. This research will add onto current knowledge about the impact of counselling among lay counsellors of people living with HIV and AIDS.

Participation is voluntary, and you will not be advantaged or disadvantaged if you choose to or not participate in the study. Your participation will entail an individual interview lasting approximately 45 minutes to one hour at a time that suits you. The interview will be recorded (audio tape) to ensure accuracy. The recorded information and transcript thereafter will be kept safe in a private locker to ensure privacy and confidentiality. All identifying information will be removed in the research report. On completion of the research, all audio tapes and transcripts will be kept in a locked-up place for a period of five years in case anyone would like to verify the authenticity of the research. After this period, the tapes and transcripts will be destroyed completely. Prior to participating you will be asked to sign a consent form, also permission to record the interview and quote some of your responses. You may refuse to answer questions that make you uncomfortable and you may withdraw from the research at any point should you feel unable to continue.

Results of the research will be presented in a report that will be kept in the university library. A copy of the summary of findings with recommendations will be given to the participating organisations. If you wish to participate in the study, please indicate in the participant informed consent form and leave the form sealed in the provided envelope with the manager of the organisation.

Yours sincerely

……

Keit Shirinda-Mthombeni

XXX/0124298317

APPENDIX D: PARTICIPANT INFORMED CONSENT FORM

I have read and understood the purpose and procedure of the study. I also agree and promise to keep information shared by others confidential. I have the right to withdraw at anytime, before and during the study. I have been informed that the researcher will be available to answer any questions during the research and I have received her contact details.

I have been given a copy of the participant information sheet.

Name:……...

Age:……..

Contact no:……

I……do wish to participate in this study.

…… …….

Participant's signature Date:

…… …….

Researcher's signature Date:

Interview date **Time**

Cut here for the participant.....

Name:.....

..... **.....**

Interview date **Time**

APPENDIX E: INTERVIEW & RECORDING CONSENT FORM

I……..consent to being interviewed by Keit Shirinda-Mthombeni for the research entitled **"Exploring the life stories of HIV/AIDS Lay counsellors: From burnout to resilience"**

I understand that participation is voluntary and that:

- I may refuse to answer any uncomfortable questions or withdraw from the study at any point.
- The interview will be recorded, and part of my responses may be quoted.
- My responses are confidential and no information identifying me will be included in the research report.

……	…….
Participant's signature	Date:
……	…….
Researcher's signature	Date:

APPENDIX F: INTERVIEW SCHEDULE

Biographical Questionnaire

Please mark the correct answer below with a tick

Personal Information

Age 19–25 ☐ 26–30 ☐ 31–35 ☐ 36–40.. ☐

41–45 ☐ 46–50 ☐ 51 -55 ☐ 56–60 ☐ 60+.. ☐

1. Gender: M Male… ☐ F Female ☐
2. Marital status: Single ☐ Married ☐ Widow ☐
3. Educational qualifications

Primary education ☐ Secondary education ☐ Tertiary education ☐

Training & Preparation

4. Did you receive any training in counselling? Yes ☐ No ☐
5. What type of training? Formal ☐ Informal ☐
6. Where did you train?

…….

7. How long was your training?

……

8. In what language did you receive your training?

English ☐ Afrikaans ☐ Other ☐ Specify…….

9. Are you a member of a support group? Yes ☐ No ☐
10. How long have you been with the organisation (Clinic)?

……

11. How many patients do you see per day/ currently have?

……

Semi-Structured Interview Schedule

HIV/AIDS lay counsellor's experiences of their role

What are your daily responsibilities regarding your counselling role?

What are some of the positive (good) experiences of providing counselling?

What are some of the negative (bad) experiences you have to face?

How has this role affected your physical & mental health? Indicate with a tick if you have experienced some of these symptoms in the last two months?

☐	Exhaustion and fatigue	☐	Frustration
☐	Muscular aches	☐	Anxiety
☐	Insomnia	☐	Confusion
☐	Headaches	☐	Poor concentration
☐	Loss of appetite	☐	Negative attitudes
☐	Skin complaints	☐	Resentment
☐	Gastrointestinal	☐	dull senses
☐	Disturbances	☐	Bad tempered
☐	Recurring colds	☐	Shortness of breath

How has this role affected your relationship with friends and family?

How has this role affected your relationship with colleagues?

Reason for doing HI/AIDS counselling

Why is your role as a counsellor for HIV/Aids people important to you?

- Your motivations

What motivate you to continue working even though the job is stressful? (Resilience)

Challenges of HIV/AIDS lay counsellor's/Stressors

What are the difficulties you face while providing counselling?

- Work difficulties
- Difficulties with patients

How do your patients feel about you?

What do you find most stressful about your counselling role?

Coping mechanisms of HIV/AIDS lay counsellor's

What do you usually do to relieve stress after an especially bad day?

☐ Talk about the situation	☐ Go to sleep
☐ Take part in physical activities	☐ Try to solve a problem
☐ Not doing anything	☐ Try to forget about it
☐ Pray	☐ Use drugs or alcohol to relieve stress
☐ Ask for help	☐ Accept the situation

What do you do to relax? (Calm down)

What kind of support do you receive?

- Inside the organisation (Clinic)
- Outside the organisation (Clinic)

What is your experience of the type of support you get? Are you satisfied or not?

Needs of HIV/AIDS lay counsellors and available resources

What would you like to change in your organisation that could have a direct effect on your everyday life?

What other support do you think will be beneficial to you?

Is there anything else you feel is important to mention?

COVID -19 Question

What are the experiences of your role during COVID-19 pandemic? How are you affected as a counsellor? there anything else you feel is important to mention?

……
……
……
……

Thank you for your time

APPENDIX G: EDITING CERTIFICATE

ACADEMIC EDITING SERVICES

Tel: 073 2768899
Email: vanessalynnneophytou@gmail.com

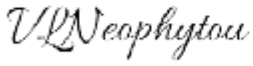
Title: Dissertation –Exploring the life stories of HIV/AIDS lay counsellors: from burnout to resilience
Degree: Doctor of Philosophy (PhD)
Institution: Unisa
Client: Ms Keit Shirinda-Mthombeni
Date: 27 December 2021

Declaration of professional edit

I declare that I have edited the above PhD. My involvement was restricted to language usage and spelling, completeness and consistency, referencing style of the references in the thesis and reference list, formatting of headings, table captions, automated page numbering and automated table of contents. I did no structural re-writing of the content. After my language editing, the author has the option to accept or reject suggestions/changes prior to submission.

This thesis was duly edited by me using track changes. I make no claim as to the accuracy of the research content. It is not the responsibility of the editor to check for plagiarism. I am not accountable for any changes made to this document by the author or any other party subsequent to my edit.

Yours sincerely



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APPENDIX H: TURNITIN REPORT

turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

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File size:	563.74K
Page count:	188
Word count:	74,457
Character count:	396,620
Submission date:	16-Feb-2022 10:09AM (UTC+0200)
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EXPLORING THE LIFE STORIES OF HIV/AIDS LAY COUNSELLORS: FROM BURNOUT TO RESILIENCE

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